THE COMMUNIQUÉS

VOLUME 21. ISSUE 2.

May 2026 Edition

Residential Aged Care Communiqué

ISSN 1834-318X

NEXT EDITION
AUGUST/2026

Editorial

Welcome to the second issue of the Residential Aged Care Communiqué for 2026. This edition builds on themes explored in the first issue of 2026 and examines two cases involving residents who lacked decision-making capacity. These cases raise important questions about the authorisation of restrictive practices and whether dignity of risk can justify suboptimal care.

Both cases involve departures from standard clinical care, prompting consideration of whether such variations reflect suboptimal practice, or are consistent with a person's documented authentic wishes or respect for a resident's current preference.

Reflecting on my opening statement leads to the realisation that these situations are making the delivery of aged care increasingly challenging. Staff must navigate not only clinical standards but also a fragmented legal framework, where federal aged care regulations intersect with State and Territory laws governing decision-making capacity and representation. These complexities are often poorly understood, contributing to avoidable harm.

A common source of confusion is the role of a guardian. In everyday language, a guardian is seen as a protector. However, in legal terms, guardians' powers are limited to what is necessary, and they must prioritise the will and preferences of the individual, applying the principle of substituted judgement. This includes identifying a person's authentic wishes which could draw on past statements, values, and previous choices as well as direct evidence (for example an Advance Care Directive) and ask, 'what would this specific person choose?' This appears counter to the common definition where the terms 'protector' and 'safeguard' create an expectation that the role should keep a person safe and to act in their best interest—that is, to choose what is most beneficial.

The two concepts align when we recognise that the role of a guardian is to protect the essence of the person—their values, identity, and autonomy. This is particularly important in aged care, where a focus on physical health and function may overshadow what matters most to the individual.

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PUBLICATION TEAM

Editor-in-Chief:
Joseph E Ibrahim

Consultant Editor
Nicola Cunningham

Designers:
Samuel Gillard
Paul Ikin

The Residential Age 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: Navigating Resource Constraints in Geriatric Medicine

We are holding a mid year one day short course on **Friday 24 July 2026** with the Australian Centre for Evidence Based Aged Care on **Navigating Resource Constraints in Geriatric Medicine**, available **in person (Collins St Melbourne) or online**.

This course is designed for consultant physicians, senior clinicians, and clinical leaders working at the frontline of care for older people. It directly addresses the real challenges of practising in constrained systems—defensible clinical decision making, duty of care, medico legal risk, patient and family expectations, moral distress and burnout, and the emerging role of AI. The program features senior clinical, legal and policy leaders and emphasises practical insights, discussion, and reflection rather than traditional conference presentations.

Places are limited.

Date: Friday 24 July 2026, 9:00 am–5:00 pm

Format: In person or online

Registration: https://pay.latrobe.edu.au/EvProvost/booking?e=PRO_EV361

Case #1
I said no

Case Number:
CCoV COR 2022 005792
Case Précis Author
Prof J Ibrahim PhD FRACP
Australian Centre for Evidence Based Aged Care, La Trobe University

i. Clinical Summary

Mr AB was a 74-year-old male who entered a metropolitan aged care facility for residential respite care following the Victorian Civil and Administrative Tribunal appointing a guardian from the Public Advocate with the authority to determine where he lived. Mr AB had a past medical history of Type II respiratory failure, diabetes mellitus, urinary and faecal incontinence, obesity, chronic lower back pain, chronic wounds and lymphoedema to the lower limbs, bipolar affective disorder and schizoaffective disorder. Mr AB required assistance with personal care and used a wheelchair to mobilise. He also exhibited ongoing aggressive, resistive behaviours that included declining assistance with personal hygiene, remaining in his wheelchair overnight to sleep and aspects of clinical care.

Approximately one month into the initial respite period of 40 days the aged care facility manager contacted Mr AB's guardian to advise his care needs were too complex for the facility. Attempts to relocate to other aged care facilities were unsuccessful.

Over the next six months Mr AB was admitted to the acute care hospital on eight occasions for either respiratory failure, bleeding leg ulcer or pressure injury.

A pressure injury to the buttock was identified five months after Mr AB entered the aged care facility.

"A few days later Mr AB was admitted to the acute care hospital with respiratory failure, on discharge the hospital clinicians advised 'tilt patient from side to side every hour' and directions for topical treatment of the wounds."

A wound chart was commenced and the general practitioner reviewed the wound. A few days later Mr AB was admitted to the acute care hospital with respiratory failure, on discharge the hospital clinicians advised 'tilt patient from side to side every hour' and directions for topical treatment of the wounds.

Two months later Mr AB's long standing lower leg wounds deteriorated prompting referrals to the general practitioner and a Registered Nurse wound specialist. The acute care hospital's 'Behavioural and Specialist Intervention Consultation Services' provide advice about how to manage Mr AB's defiant behaviour and mental health. Advice to assist managing his pressure injuries included the need to provide a specialised wheelchair, bariatric bed and pressure mattress.

The wound care nurse considered the stage 3 pressure wound of the left heel and right buttock as infected and provided instructions for care. Unfortunately, Mr AB continued to exhibit intermittent resistive behaviours including declining to take his medication, not allowing staff clean him after episodes of incontinence or apply wound care.

Approximately, two weeks later a registered nurse observed the sacral wound was unstageable and had a 'foul smell like dead flesh'. Several days later the general practitioner was contacted as Mr AB had a poor oral intake, with hands and feet that were purple and cold to the touch. An urgent transfer to acute care hospital was organised where Mr AB was admitted and palliated, dying within a week.

ii. Pathology

A forensic pathologist conducted an examination on the body, a post-mortem computed tomography scan, and review of the hospital and the aged care facility records. The CT scan demonstrated a skin defect of the right buttock, with subcutaneous emphysema of the right buttock, both upper legs.

There were also necrotising pressure injuries on both heels.

The cause of death was 'sepsis secondary to infected pressure wounds (necrotising fasciitis) in a man with multiple medical co-morbidities'.

iii. Investigation

The death fell within the definition of a reportable death in the Coroners Act 2008 (the Act). The Court sought statements from the aged care provider about the care provided and management of wounds as well as information from the acute care hospital, general practitioner and Office of the Public Advocate. The coroner investigated the following matters:

1. The aged care facility's overall management of wounds and sacral pressure injury
2. Mr AB's decision-making capacity to refuse medical treatment
3. Escalation to a substitute medical decision-maker

There was evidence that Mr AB was a 'very high risk of pressure ulcer' based on the Waterlow risk assessment completed by the aged care facility staff, and information from the acute care hospital. Statements from the aged care facility staff and progress notes did not address whether preventive measures such alternating pressure mattress, seating cushion were put in place.

The aged care facility wound management policy, stipulated when a new wound is identified, staff should commence 'initial and ongoing comprehensive documentation' which includes a wound chart and an entry in the resident's progress notes.

The coroner found that it took six days after the wound specialist appointment for an initial wound assessment to be completed and another four days to commence a wound chart. The wound chart captured minimal information and did not record the size of the wound, the appearance of the wound's edges or surrounding skin, signs or symptoms of infection or associated pain.

The investigation into capacity to refuse medical care identified that MR AB did not have an advanced care directive or substitute medical decision maker. The aged care staff maintained that Mr AB had capacity to refuse medical treatment, citing the facility's 'Dignity of Risk Policy' and as a consequence staff were obliged to respect Mr AB's preference. The aged care facility conceded that Mr AB's awareness of the importance of care declined over time and that his capacity for decision-making fluctuated.

A neuropsychologist's report completed five months prior to Mr AB entering the aged care facility documented that he had *'reduced capacity to fully comprehend the extent of his physical condition and cognitive limitations'*. The report concluding there were concerns about Mr AB's ability to make fully informed and reasoned decisions.

A geriatrician from the acute care hospital recalled a medical assessment with Mr AB approximately six weeks before his death.

The geriatrician reported Mr AB had *'very limited insight into his medical conditions and their management and the consequences of suboptimal care.'* That he 'did not appear to have capacity to make decisions about non-invasive ventilation therapy as he could not understand why it is given and its risks and benefits'. Interestingly, a review by the acute care hospital mental health key clinician one week later conclude Mr AB had capacity.

The coroner considered at times the care provided was at best suboptimal, and at worst, void of dignity referring to instances of Mr AB being left in urine-soaked clothing and with faeces on his hands for an unknown period of time.

It was unclear whether the general practitioner consider if Mr AB maintained decision-making capacity and whether he would benefit from a substitute medical treatment maker. The aged care facility did not inform Mr AB's guardian, that he was refusing care as the guardian did not have decision making capacity about medical treatment. The Office of the Public Advocate explained what if they had been advised of Mr AB's refusal of treatment 'it would be standard practice..., for a guardian to provide advocacy around these issues to promote the person's interests and human rights'.

Mr AB's care needs were increasing and his decision-making capacity declining over the six months before his death.

There was no indication that the aged care facility staff made any repeated attempts to contact the Office of the Public Advocate to transition Mr AB to higher-level care or to alternative accommodation options.

A review of Mr AB's clinical care was commenced by the aged care provider when the court requested statements. The review identified the need for earlier referrals for mental health support and to general practitioners when there is a 'continuous refusal of care'. The staff were provided with updated training on pressure injury recognition, assessment and management. Attending general practitioners were reminded to complete progress notes after every visit. At an organisational level four Clinical Nurse Specialist roles were introduced to address Wound & Ostomy Management; Diabetes Management; Dementia & Mental Health Wellbeing; and Palliative Care.

iv. Coroner's Findings

The coroner accepted the medical cause of death and was unable to conclude that earlier hospitalisation would have prevented Mr AB's death.

The coroner acknowledged the challenges faced by nursing staff when managing residents with complex needs who have multiple comorbidities which complicate their management and the difficulty balancing the person's need for care and respecting their dignity of risk. The coroner considered that in Mr AB's situation that staff's deference to dignity of risk especially where he was left in unhygienic conditions compromised his wellbeing, the ability of staff to undertake their duties, and wellbeing of other residents.

"A person's decision-making capacity is determined in accordance with the context of their situation."

The coroner found that the aged care facility 'fell short of its own policy by failing to adequately implement pressure wound prevention strategies or equipment for Mr AB despite recognising he was at a markedly elevated risk of developing pressure wounds. The coroner also found that poor record keeping and tracking of Mr AB's wounds reduced staff's ability to effectively monitor and to act early when deterioration occurred.

The coroner also found that there was a missed opportunity to contact the Office of the Public Advocate to explore options to help facilitate Mr AB's treatment.

The coroner concluded by acknowledging measures implemented by the aged care facility to prevent harm in the future.

v. Author's Comments

The understanding and respecting a person's human rights, in particular autonomy and dignity of risk has evolved considerable in the past decade. As with any new changes there is a degree of overcompensation with implementation and there are occasions when 'dignity of risk' is used as a justification to defer or not deliver essential clinical care.

The Aged Care Quality and Safety Commission describes 'dignity of risk' as 'the right of consumers to make their own decisions about their care and services, as well as their right to take risks'. When staff take a literal interpretation of this description confusion will always arise as the terms 'care and services' are not defined. There are substantial differences between the need for clinical care, a person's preferences for lifestyle and accommodation matters. While it may be simpler to take the resident's expressed preference at face value along with the new Aged Care Act 2024 statement that older people have the right to make their own choices and take risks, even if those choices involve potential harm. A better and more correct approach is to recall the whole description 'that residents must be supported in understanding and managing risks.' This implies that a resident's decision-making capacity is determined.

A person's decision-making capacity is determined in accordance with the context of their situation. Questions about a person's capacity to consent or decline clinical care are governed by different laws compared to making decisions about lifestyle and accommodation.

The concept that a person has the right to choose their preferred option is a guiding principle in every circumstance—however, how it is applied must take into consideration the relevant laws. The core issue is whether a person has the decision-making capacity to choose their preferred option.

In Victoria, decisions about health and medical care are made by the Medical Treatment Decision Maker (MTDM) and governed by the *Medical Treatment Planning and Decisions Act 2016*. Decisions about a person's accommodation, support services and lifestyle arrangements are governed by the *Guardianship and Administration Act 2019*. The legal tests for determining decision-making capacity in Australia are defined by the state and territory jurisdictions.

The guardian from the Office of the Public Advocate was appointed to make decisions about his accommodation. The guardian did not have the legal authority to make decisions about his clinical care because they had not been appointed as the Medical Treatment Decision Maker.

vi. Keywords

Residential aged care facility, pressure injury, pressure wound, bed sores, dignity of risk, refusal of treatment

Case #2
What mum wanted

Case Number:
[2025] SACC 22
Case Précis Author
Prof J Ibrahim PhD FRACP
Australian Centre for
Evidence Based Aged Care,
La Trobe University

i. Clinical Summary

Mrs AA was an 80-year-old widow with a past medical history of mixed dementia, predominantly Alzheimer's Type and a rectal mass for which she had declined further investigation and treatment.

Mrs AA was supported to live at home by daughters after being diagnosed with dementia. However, after her care needs increased with exhibited behaviours that placed her safety in jeopardy, such as placing candles in the combustion fire and leaving the stove on after cooking the decision to enter a residential aged care facility was made.

Mrs AA initially entered the general section of the facility before being transferred to the secure memory support unit due to concerns about her leaving the facility unaccompanied.

Mrs AA's health deteriorated as the rectal tumour grew to become externally visible causing ongoing pain and anaemia.

Mrs AA had three falls over a five-week period. The first fall was unwitnessed and she did not suffer an injury, the second resulted in a graze to the forehead, the third resulted in left hip pain and a fracture hip was suspected. No further investigations were made and Mrs AA died 11 days later.

ii. Pathology

A post-mortem examination conducted by forensic pathologist comprised an external examination and CT scan. The imaging identified cerebral atrophy confirmed the clinically suspected left neck of femur fracture, and presence of rectal thickening with indurated perianal mass.

The cause of death was a fractured neck of femur which occurred on a background of rectal carcinoma and dementia.

iii. Investigation

A mandatory inquest was required as the fall leading to Mrs AA death occurred in the memory support unit. In South Australia a *'death in custody means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was being detained in any place within the State under any Act or law…'*

This arose because Mrs AA was to be accommodated within the secure memory support unit of the facility which was a form of environmental restrictive practice. As such an application was made to the South Australian Civil and Administrative Tribunal, to authorise her detention at her place of residence pursuant to section 32 of the Guardianship and Administration Act. The order was granted, reviewed and extended 9 months later and was in place at the time of her death.

"Mrs AA did not want life sustaining measures or other interventions when the expected outcome is poor. "

Mrs AA's family had adhered to their mother's wishes documented in an Advanced Care Directive made several years earlier. Mrs AA did not want life sustaining measures or other interventions when the expected outcome is poor. This included not investigating the rectal tumour and not transferring her to the Emergency Department after the third fall. Mrs AA's did receive appropriate therapy including medication for her symptoms.

The facility had assessed Mrs AA following her falls which included an occupational therapy review and put in place strategies to reduce the risk of falls.

These included an uncluttered environment, sensor beam at night, discrete supervision for transfers and mobility, appropriate footwear and the bed at correct height.

iv. Coroner's Findings

The coroner concluded that the investigation did not establish any shortcomings in the care. The falls management plan appropriately balanced risk reduction with respect for autonomy and that Mrs AC was lawfully and appropriately detained.

The coroner did not make any recommendations.

v. Author's Comments

In this case involving environmental restrictive practice, most of our readers will not be aware that in South Australia this requires an application to the state's Civil and Administrative Tribunal to obtain a formal order.

The rules around restrictive practice are complex and it is important to obtain legal advice relevant to the States and Territories of Australia in which the care is provided.

Also be aware that a person who is appointed as an aged care resident's guardian, attorney or medical treatment decision maker does not automatically become their restrictive practices substitute decision-maker.

vi. Keywords

Death in Custody; Section 32 Powers

List of Resources

Dignity of risk

Foundas M. Dignity of risk in residential aged care: a call to reframe understandings of risk. *Med J Aust*. 2025;223(4):186-188. doi:10.5694/mja2.70002. Available at: https://www.mja.com.au/journal/2025/223/4/dignity-risk-residential-aged-care-call-reframe-understandings-risk.

Ibrahim JE, Davis MC. *Impediments to applying the "dignity of risk" principle in residential aged care services.* Australasian Journal on Ageing. 2013;32(3):188-193. doi:10.1111/ajag.12014. This article examined four key barriers of fluctuating resident cognitive capacity, multiple stakeholders in decision-making, gaps between organizational values and daily actions, and fear of legal liability on applying dignity of risk.

Woolford MH, de Lacy-Vawdon C, Bugeja L, Weller C, Ibrahim JE. *Applying dignity of risk principles to improve the quality of life for vulnerable persons.* International Journal of Geriatric Psychiatry. 2020;35(1):122-130

Pressure Injury

Victoria State Government Department of Health. Pressure Injuries: Standardised Care Process. Victoria State Government; 2023. Accessed May 22, 2026. https://content.health.vic.gov.au/sites/default/files/2023-11/standardised-care-pressure-injuries.pdfhttps://content.health.vic.gov.au/sites/default/files/2023-11/standardised-care-pressure-injuries.pdf.

The Australian Guardianship and Administration Council

Lists the 23 state and territory government agencies, public advocates, public guardians, and tribunals responsible for protecting adults with impaired decision-making capacity. Available at: https://www.agac.org.au/about-us scroll down the page to find 'Member organisations'.

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Acknowledgements

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