

Provider guidance: Outcome 5.5 (updated guidance by OP&S based on the coroner's recommendation)

Proposed updates	Feedback/suggestions
measuring, <i>using a tool validated in aged care such as a fluid balance chart, the daily fluid intake of older people assessed as being at risk of, or experiencing, dehydration. This includes all older people living with dementia (Outcome 5.6) and older people being administered diuretic medication/s. Use the information to recognise and respond to inadequate fluid intake.</i>	Monitoring fluid intake and/or balance of individuals assessed as being at risk of or experiencing dehydration. The factors that put an older person at a higher risk of dehydration include but are not limited to, advanced cognitive impairment, medications (such as diuretics, laxatives), limited oral intake and acute illnesses such as diarrhoea and vomiting. Use information gathered to recognise and respond to inadequate fluid intake and dehydration risk. Ensure individualised approaches are implemented when monitoring hydration status that considers the needs and preferences of older people.
measuring, <i>using a tool validated in aged care, the daily food intake of older people assessed as being at risk of, or experiencing, malnutrition. This includes all older people living with dementia (Outcome 5.6).</i>	Monitoring food and fluid intake of individuals who are identified to be at risk of or experiencing malnutrition. Use the information on food and fluid intake to recognise and respond to inadequate intake in a timely manner, including referral to a dietitian and GP for further comprehensive clinical assessment.

S 47C

Preventing urinary tract infections: recognise dehydration poster

This is a resource that appears to have been created as part of the CPU program – To Dip of Not to Dip

Current	Feedback/suggestions
Signs of dehydration include Headache • Dry mouth or lips • Feeling of thirst • Dark/ smelly urine • Urinating less than 4 x a day • Sunken eyes • Tiredness • Cold hands	Additional signs of dehydration could be added. E.g.: • change in mental status (confusion, disorientation, altered consciousness) and drowsiness • constipation • increased breathing and heart rate
Prevent dehydration section states ‘Encourage residents to drink 1 – 2 litres of fluids every day (unless advised not to by GP).’	You may consider updating the amount of recommended fluid intake by including the information on the ‘Why meals matter’ page to ensure consistency. • ‘Dehydration amongst aged care residents is a common and dangerous problem. Meeting the hydration needs of older adults within residential aged care can be challenging. • Recommendations for fluid intakes are approximately 1.5L daily, yet achieving this target can be compromised by a range of factors ¹². • It is always best to liaise with the GP and relevant health practitioner/s to determine fluid needs and any key consideration for fluid intake.

s 47C

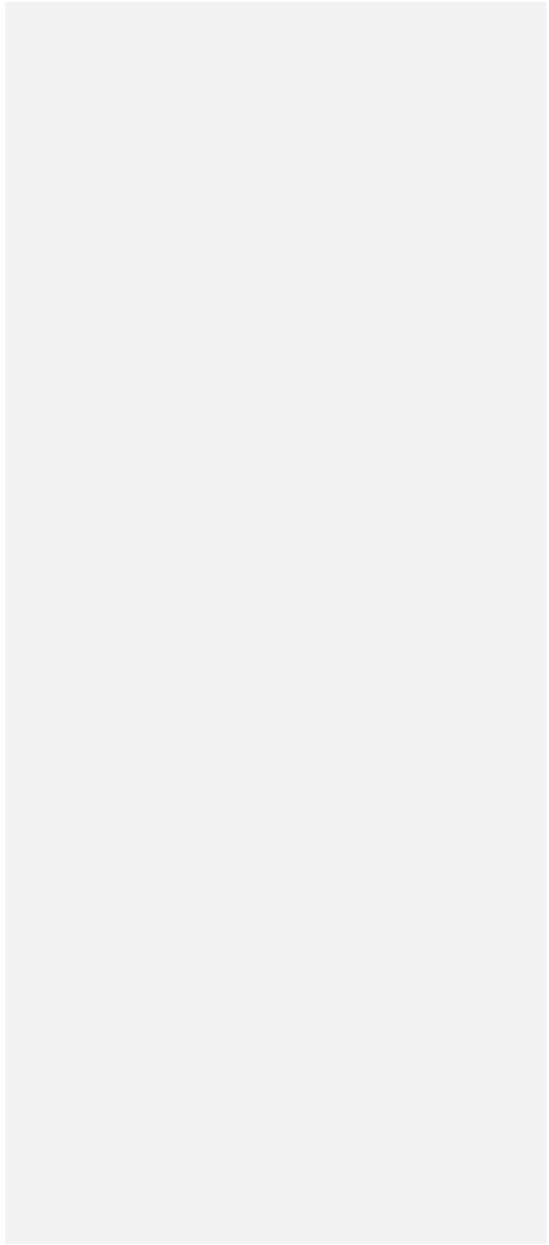
	• '[Older people receiving aged care] can be more prone to dehydration due to diminished sense of thirst, poor oral intake, swallowing disorders, refusal of fluids, inadequate staffing assistance, medication, illness, fear of [aspirating or choking], fluids offered are not to the individual preferences, poor access to fluids (being able to see and reach), inability to manage a cup or glass and dislike of thickened fluids. • Some residents may also intentionally limit their fluid intake to minimise incontinence or the need to go to the toilet ¹¹.'
Coroner recommendations regarding the following: That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.	• s 47C [REDACTED] • [REDACTED] • [REDACTED] • [REDACTED] • [REDACTED] • Providers should have processes in place to identify and monitor for dehydration, escalating concerns early to ensure appropriate management.

Keep your fluids up page: [Keep your fluids up!](#) | Food for thought article

This article can be taken down if required.

Current	Feedback/suggestions
Residents living in aged care homes can be more at risk of dehydration if they: • have advanced cognitive impairment • are receiving medication that increases fluid loss • have impaired mobility or dexterity.	It is worthwhile stating that the factors that put an older person more at risk of dehydration can include but is not limited to: • having advanced cognitive impairment • receiving medication that increases fluid loss • having impaired mobility or dexterity. Additional risk factors can include: • Inadequate intake of fluids due to reduced thirst sensation, dysphagia, food and fluid preferences not being met, reluctance to drink to manage frequency of urination and/or incontinence • acute illness and fluid loss through diarrhoea, vomiting, fever, sweating, heat and humidity • health status that affects cognitive functioning, such as sedation, delirium, depression
Ways to help people stay hydrated: • Use fluid balance charts for residents at risk of dehydration. Know the typical volume of fluid held in standard glassware,	In this section, the following could be added: • Monitor fluid status by regularly reviewing fluid balance charts to monitor the fluid intake and output.

crocery and high fluid content foods to help make your records accurate.	
The coroner recommended that educational resources be provided to aged care providers regarding the prevalence of dehydration in older people.	• Link through the clinical alert. • Consider linking 'Why meals matter' page to the 'Keep your fluids up' page



S 47C

S 47C

S 47C

From: s 22 (1)(a)(ii)
To: s 22 (1)(a)(ii) [Coroner Inquiries](#); s 22 (1)(a)(ii) s 22 (1)(a)(ii)
Cc: s 22 (1)(a)(ii) s 22 (1)(a)(ii) s 22 (1)(a)(ii) s 22 (1)(a)(ii) [Nick Holderness](#); s 22 (1)(a)(ii)
Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]
Date: Tuesday, 9 June 2026 6:35:37 PM
Attachments: [Outlook-Engage Emp.png](#)
[Outlook-Engage Emp.png](#)
[Outlook-Engage Emp.png](#)

OFFICIAL

Hello s 22 (1)(a)(ii)

s47F(1)

For example wrt hydration the standards simply say In Action 5.5.5. "The provider implements processes to maintain an individual's nutrition and hydration" - and similarly in Action 6.2. 1 - "As part of assessment and planning, the provider assesses and regularly reassesses each individual's nutrition, hydration and dining needs and preferences" - but no further guidance is given as to how to assess, monitor or maintain hydration - with all of the detail within each Action directed instead at managing nutritional risk

I see use of the words 'should' and 'must' more indicative of my expectations around the nature of the clinical care - rather than referring to regulatory obligations

It would also be fair to say that 'should' is used to indicate how seriously providers need to consider dehydration risk - given how tragic the outcome can be when providers do not

I hope this helps

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

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Available Monday, Wednesday, Thursday and Friday

Aged Care Quality and Safety Commission

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T s 22 (1)(a)(ii) | M s 22 (1)(a)(ii)

GPO Box 9819, Adelaide SA 5000

Kaurna Country

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Monday, June 8, 2026 7:30:00 AM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks Dr s 22 (1)(a)(ii)

@s 22 (1)(a)(ii) noting the 'provider should' comments throughout, I am thinking that the addition of direct reference to specific provider obligations might be helpful? What do you think ?

Thanks

s 22 (1)(a)(ii)

)(a)(ii) CPHRI (She/Her/Hers)

Assistant Commissioner

Knowledge Management & Operational Policy

Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission

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T 07 3740 0653 | M 0429 017 375

Working on the lands of the Yuggera and Turrbul people



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Sent: Friday, 5 June 2026 1:01 PM

To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>;

s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)

<s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>;

s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's

Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hello everyone

Please find attached our draft version of the Clinical Alert related to this case

Thank you to s 22 (1)(a)(ii) for their input

It will need plain language consideration

You will note that I have been a little prescriptive about the amount of fluid one would ordinarily expect an older person to drink. Please advise however if this is unhelpful

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Chief Clinical Advisor

BMBS FRACP Mst Gerontology Grad Cert Leadership GAICD

Chief Clinical Advisor Division

Available Monday, Wednesday, Thursday and Friday

Aged Care Quality and Safety Commission

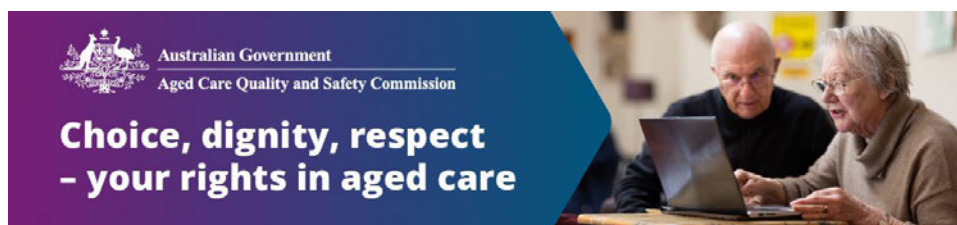
E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

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From: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Sent: Thursday, April 30, 2026 11:28 AM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi All

Confirming that the Coroner Inquiries team s 22 (1)(a)(ii) will coordinate a consolidated response to the recommendations, correspondence etc. We are developing a coordination framework (table of actions with lead business areas/officers, sharepoint folders etc) which I hope to circulate to all players shortly.

Kind regards

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

s 22 (1)(a)(ii)

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Larrakia Country

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: 24 April 2026 3:30 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks s 22 (1)(a)(ii)

I have included the request from the KMOP team reviewing the provider guidance for outcome 5.5, including their request to review the documents/resources:

- [Preventing Urinary Tract Infections: Recognising dehydration](#)
 - A resource that is part of the clinical pharmacy unit's program 'To dip or not to dip'
- [Keep your fluids up!](#)
 - A QB 'food for thought' article written January 2024
 - A follow up article with a focus on supporting choice, nutrition, hydration and safety was also published: [Thickened fluids: Supporting choice, nutrition, hydration and safety | Aged Care Quality and Safety Commission](#)

To support, we have also enlisted the support of the clinical unit and clinical education unit to review for any other resources, however they are lacking for aged care further highlighting support of a dedicated resource/communication (e.g. clinical alert). I believe KMOP are reviewing the guidance for outcome 5.5 and Action 5.5.5 only.

I am meeting with our advisors from CCAD's other units reviewing early next week to summarise and provide back to KMOP.

I will also support s 22 (1)(a)(ii) in drafting the clinical alert for publication.

For all teams requested to support and to consolidate recommendations, s 22 (1)(a)(ii) can I confirm you/your team are the central point of coordination for response, and where it is preferred our review and recommendations is forwarded to? I want to ensure what we provide is visible and an effective support for what has been requested.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD

Director

Food, Nutrition and Dining Unit

Chief Clinical Advisor Division

Aged Care Quality and Safety Commission

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s 22 (1)(a)(ii)

GPO Box 9819 Perth WA 6001

Whadjuk Country



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Thursday, 23 April 2026 3:36 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>;

s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)

agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks s 22 (1)(a)(ii) - I will flag with s 22 (1)(a)(ii) for discussion and follow up the actions in your email

See below for relevant actions everyone, this is going to take some coordination if you can lead that s 22 (1)(a)(ii) with the coronial response team.

Re Rec 4

§ 22 (1)(a) - I am just looking through your notes which I've attached as they seem to not be in this email chain

You note – you working with KMOP to review and provide SME on the Coroner's recommendations for the Commission's guidance outcome 5.5 and examples of key tasks providers can take (Action 5.5.5) regarding the implementation of processes to maintain an individual's nutrition and hydration. The team also advised that the Department has stated that they will commit to include these recommendations in the first 5-year periodic review of the Quality Standards (due 2030).

I'm not clear if this means we think hydration is already sufficiently addressed in the standards? Or it's a matter of updating the notifiable instrument for the Actions?

Be good to get your or KMOP advice on which aspects of the standards might be usefully updated within the standards architecture and how:

- Standard
- Outcome
- Actions
- Commission audit methodology

Are you able to specify against this list what is already being changed (through your work with KMOP) and what you would recommend changing in the future?

s 47C

§ 22 (1)(a)

§ 22 (1)(a)

§ 22 (1)(a)

§ 22 (1)(a)

For Rec's 5 and 6 - § 22 (1)(a) and § 22 (1) advised the Inspector General on the Clinical Alert and Quality Bulletin options.

s 22 (1)(a)(ii) - Taking into account s 22 (1)(a) and s 22 (1)(a)(ii) advice – can you work with s 22 (1)(a) and s 22 (1)(a)(ii) to draft a clinical alert from s 22 (1)(a)(ii) as our CCA on hydration – referencing the coroners findings and messaging on the importance of hydration and nutrition to older people and risks on not exercising good practice. In the alert we should take the opportunity to remind providers what we expect in simple terms and link to relevant guidance.

s 47E(d)

s 47E(d)

Kind Regards, s 22 (1)(a)(ii)

1)(a)(ii) (she/her)

Assistant Commissioner, Regulatory Strategy and Partnerships

Aged Care Quality and Safety Commission

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GPO Box 9819, Sydney NSW 2001

EA: E s 22 (1)(a)(ii) agedcarequality.gov.au W: s 22 (1)(a)(ii)

I live and work on Gadigal Country, land of the Eora Nation



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Thursday, 23 April 2026 11:59 AM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; Office of the Commissioner <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi everyone,

s 22 (1) and I just met with the IG who has been in contact with s 22(1)(a)(ii) .
s 22 (1)(a)(ii) received the same letter from the SA Minister.

s47F(1)

s 47E(d)

Happy to discuss further.

Kind regards

s 22 (1)(a)

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Tuesday, 21 April 2026 10:49 AM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

Thanks s 22 (1)(a)(ii)

I would actually retire the poster about preventing UTIs/assessing hydration status - as there is little evidence that any of the clinical symptoms or signs mentioned are accurate in predicting dehydration. It would be better also to provide resources to support providers to prevent dehydration for hydrations sake - rather than unnecessarily linking it to UTIs - as that tends to also cloud the messaging

s 47C

s 47C

The coroners case also certainly sets the scene for a clinical alert - which I am happy to write - once we are more certain of our recommendations

It is also worthwhile noting that the roll out of point of care (blood) testing is being considered for the aged care sector - although it is still very early days of consultation - but that would be very helpful too and we could prompt providers to consider

Let me know what next steps might be

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Geriatrician

BMBS FRACP Mst Gerontology Grad Cert Leadership GAICD

Chief Clinical Advisor

Chief Clinical Advisor Division

Available Monday, Wednesday, Thursday and Friday

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

T s 22 (1)(a)(ii) | M s 22 (1)(a)(ii)

GPO Box 9819, Adelaide SA 5000

Kaurna Country

#Everyone you meet is fighting a battle you know nothing about - be kind always

In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Monday, April 20, 2026 2:20 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Just bringing in s 22 (1)(a)(ii) as well

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake
- For Rec 4 regarding changes to the standards, the dept is the policy holder so we would take any requests to them. There is also a question of where in the standards to adjust, ie the outcomes (compliance obligations) or actions (guidance published as a notifiable instrument). The third option which is more in our direct control is to adjust our guidance and promote any more specified practice.

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution

must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.

- o That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

For Recs 5 and 6 – do we agree with updates recommended? Any risks?

Are there any plans under the current FNDU program to address hydration – perhaps the coroners rec's are a chance to do a clinical alter or Quality Bulletin article on it? Be good to get s 22(1)(a)(ii) thoughts here too

Kind Regards, s 22 (1)(a)(ii)

1)(a)(ii) (she/her)

Assistant Commissioner, Regulatory Strategy and Partnerships

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Sydney NSW 2001

EA: E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) W: s 22 (1)(a)(ii)

I live and work on Gadigal Country, land of the Eora Nation

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Monday, 13 April 2026 7:16 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hello

s47F(1)

Recommendations 5 and 6 seems reasonable

Recommendation 4 could be addressed through our FNDU RBM and/or outreach work

s 47F(1)

People with Lewy body dementia often experience periods (up to a week or less) of drowsiness which is usually self limiting. This is one of the Lewy Body diagnostic criteria along with cognitive impairment, parkinsonism and visual hallucinations

s47F(1)

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Geriatrician

BMBS FRACP Mst Gerontology Grad Cert Leadership GAICD

Chief Clinical Advisor

Chief Clinical Advisor Division

Available Monday, Wednesday, Thursday and Friday

Aged Care Quality and Safety Commission

E **s 22 (1)(a)(ii)** agedcarequality.gov.au | W www.agedcarequality.gov.au

T **s 22 (1)(a)(ii)** | M **s 22 (1)(a)(ii)**

GPO Box 9819, Adelaide SA 5000

Kaurna Country

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From: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**agedcarequality.gov.au>

Sent: Friday, March 27, 2026 3:23 PM

To: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**agedcarequality.gov.au>; **s 22 (1)(a)(ii)**
<**s 22 (1)(a)(ii)**agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)agedcarequality.gov.au>; Coroner Inquiries
<CoronerInquiries@agedcarequality.gov.au>

Subject: FW: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's
Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Below is the email thread that originally arrived with Government Relations that made its way to the Coroner team. The original attachments are the PDF that came through from the SA Minister (not directly from the SA Coroner). The attached email is advice from DCSCRS that they replied to the minister acknowledging receipt. As discussed with you this week, the Coronial team will develop a procedure and log for when these types of recommendations come through to us. This includes supporting senior executive decision-making on whether to implement the recommendation, and a process for overseeing its implementation via the SRPC.

The recommendations to the Commission are at the end of the coroner's report, the PDF labelled Attachment 1. I've pasted them below.

Recommendations to the Commission:

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster “Preventing Urinary Tract Infections - Recognise Dehydration”, published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
 - That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

§ 22 (1)(a)(ii)

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From: S 47E(d) <[REDACTED]@agedcarequality.gov.au>

Sent: Tuesday, 24 March 2026 10:09 AM

To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Cc: S 47E(d) <[REDACTED]@agedcarequality.gov.au>; § 22 (1)(a)(ii)

s 22 (1)(a)(ii) agedcarequality.gov.au; s 22 (1)(a)(ii)
<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)
<s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii)
<s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi Team,

Please see attached Commissioner correspondence from the South Australian Minister for Health and Wellbeing, providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) Page 35 of the report lists recommendations for the Commission. Kindly for your review and action as appropriate.

@s 22 (1)(a)(ii) I believe the OOC were drafting a response from the Commissioner – I will follow up where this is at and confirm.

@s 22 (1)(a)(ii) Copying you in for visibility as some of the recommendations relate to Commission posters and educational resources.

Kind regards,

s 22 (1)(a)(ii) (She/Her)

Executive Officer to s 22 (1)(a)(ii) Deputy Commissioner

Sector Capability and Regulatory Strategy Division

E | s 22 (1)(a)(ii) agedcarequality.gov.au T | s 22 (1)(a)(ii)

Deputy Commissioner SCRS

Deputy Commissioner, Sector Capability & Regulatory Strategy

Aged Care Quality and Safety Commission

E s 47E(d) [REDACTED]@agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city

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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Sent: Monday, 23 March 2026 3:53 PM

To: s 47E(d) [REDACTED]@agedcarequality.gov.au>

Subject: FW: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Yes, this can go to the coronial team etc. Can they draft a response for s 22 (1) to send to the SA Minister?

Kind regards

In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 47E(d) <s 47E(d) agedcarequality.gov.au>
Sent: Friday, 6 March 2026 4:57 PM
To: Office of the Commissioner <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: s 47E(d) <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii) (and s 22 (1)(a)(ii) absence next week)

See attached a letter from the South Australian Minister for Health and Wellbeing, the Hon Chris Picton MP to addressed to you providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) There are several recommendations that have been directed to the Commission within.

Please let us know if you require assistance preparing a response to the Minister. Otherwise, we will leave with your office to action as appropriate.

Kind regards

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Assistant Director, Parliamentary Services

Engagement, Education and Communication

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) @agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Sydney 2001

I work part time and do not work on Tuesdays.

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From: s 22 (1)(a)(ii)
 To: s 22 (1)(a)(ii)
 Cc: Coroner Inquiries s 22 (1)(a)(ii)
 Subject: Urgent - Coordination approach - Coroner's Recommendations - Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL:Sensitive]
 Date: Wednesday, 13 May 2026 12:45:15 PM
 Attachments: image002.png
 image445176.png
 image003.png

OFFICIAL: Sensitive

Hi s 22 (1)(a)(ii)

We are seeking your review and approval on our coordinated approach and confirm our role in coordinating this work. Once you have approved:

- s 22 (1)(a) can book a meeting asap with relevant internal stakeholders and follow with an email
- s 22 (1)(a) to send s 22 (1)(a) and s 22 (1)(a) an email by end of week with a summary of our coordination and status

s 47E(d)

The first table is the recent actions following the meeting with the Department on 11/5:

Actions from Department/ACQSC meeting: Discussion: Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) s 22 (1)(a)(ii) s 22 (1)(a)(ii) s 22 (1)(a) s 22 (1)(a)(ii) on 11/5/2026 at 4.30pm.	Action for	Due date
• The Department has responded to Minister Butler and sent the response to s 22 (1)(a) for information. Can you get a copy from s 22 (1)(a) • The Department acknowledged the coronial outcomes. The Department noted that elements of the Quality Standards already relate to hydration. However, the Department's answer to changing the Quality Standards was no in their letter.	NA – we have a copy Rec 4 - Note the Commission is reviewing guidance in outcome 5.5 and examples of key tasks providers can take (Action 5.5.5).	
• s 47E(d)	s 22 (1)(a) Rec 5 - response to Rec 6 covers it. Rec 6 - Clinical Alert, referencing the coroner's findings and messaging about the importance of hydration and nutrition to older people and risks on not exercising good practice. Rec 6 - Quality Bulletin based on literature review and informed by good practice in the sector	
• The family has written to s 22 (1)(a)(ii), the Inspector-General of Aged Care. s 22 (1)(a)(ii) s 47F • s 22 (1)(a) responded and told the family she would raise the matter with the Dept and Commission. s 47E(d)	s 22 (1)(a) Confirmation required: 1. s 47E(d)	
• s 22 (1)(a) will publish the Commission's response in the Commission's coronial recommendations register. The Department is required to maintain a public register of relevant coronial reports and recommendations relating to the death of an individual accessing aged care services. The register includes the circumstances of the death, the recommendations made to the Department, and a summary of actions taken by the Department in response.	For xx (see table below) Department's Aged Care Register of Coroners' Recommendations Australian Government Department of Health, Disability and Ageing (not yet published)	
• Separately, s 22 (1)(a) is managing the Department's response and position to hydration requirements and policy. This is separate from the Department's register publication process. s 47E(d)	New Action – s 22 (1) – s 22 (1)(a) – find Department contact to connect (from s 22 – I think the s 22 (1)(a) 'mentioned' might be s 22 (1)(a) from engagement team?)	

The second table is a table with a clear list of the actions we are taking to respond to coroner's recommendations, including delivery dates:

Recommendation	Action	Business Lead/SME	Business Lead/SME DUE date	Implementation Lead	Contacts	Oversight / Reporting	Delivery Date	Status
Recommendation 4 (Department responded) we are looking at guidance materials for outcome 5.5	Adjust / strengthen guidance for outcome 5.5 and action 5.5.5	OP&S/KMOP/FNDU/CU		OP&S	§ 22 (1)(a)(i)	Sector Risk and Performance Committee (SRPC)	Post 1 July	In progress
	Review documents/resources - Preventing Urinary Tract Infections: Recognising dehydration - Keep your fluids up!	CCAD		OP&S	§ 22 (1)(a)(i)			
	§ 47E(d)							
	Update digital guidance tool			OP&S				
	Coordinate liaison with Department	OP&S		OP&S				
Recommendation 5 to amend poster 'preventing urinary tract infections'.	§ 47E(d)	CCAD/RSP						
Recommendation 6 Provide educational resources to providers	§ 47E(d)	CCAD/FNDU/RCE		CCAD	§ 22 (1)(a)(i) § 22 (1)(a)(i)	Sector Risk and Performance Committee (SRPC)		
	Quality Bulletin - based on literature review and informed by sector insights. Condensed into fact sheets or similar	CCAD/FNDU/RCE		FNDU	§ 22 (1)(a)(i)	Sector Risk and Performance Committee (SRPC)		
External engagement	Prepare response correspondence to coroner re recs 5,6	RSP						
	§ 47E(d)							

	s 47E(d)							

* Source - master table - [b. Coordination table - s 22 \(1\)\(a\)\(ii\) docx](#)

Background:

- 5/3/2026 – letter from Hon Chris Picton MO, Minister for Health and Wellbeing to ACQSC Commissioner, attaching the Deputy State Coroner's Inquest Findings in relation to death of s 22 (1)(a)(ii). Drawing attention to recommendations directed toward the ACQSC
- 16/3/2026 – an acknowledgement was sent from the A/g Commissioner s 22 (1)(a)(ii) to Chris Picton MP, Minister for Health and Wellbeing SA and no separate response needs to be drafted (email from DC SCRS 24/3 at 1.11pm)
- 23/4/2026 – meeting between s 22 (1)(a)(ii), Inspector General of Aged Care, Commissioner, Deputy Commissioner s 22 (1)(a)(ii)
- 11/05/2026 – meeting with the Department - s 22 (1)(a)(ii)

Stakeholders – ACQSC:

- CCAD
 - FNDU
 - s 22 (1)(a)(ii)
 - s 22 (1)(a)(ii)
 - CU
 - Clinical Education team
- OP&S (SQS team):
 - s 22 (1)(a)(ii) and her team s 22 (1)(a)(ii) s 22 (1)(a)(ii)
- Digital Communications
 - s 22 (1)(a)(ii)
- Digital Guidance tool? Is this a team e.g. Digital tools team?
 - [Director]
- Regulatory Strategy:
 - s 22 (1)(a)(ii) and his leg team - s 22 (1)(a)(ii)
- Regulatory Campaigns and Evaluation
 - s 22 (1)(a)(ii) and team
- Audit
 - [Director] and [EL1]

Stakeholders – external

- s 22 (1)(a)(ii) Inspector General of Aged Care
- Department:
 - s 22 (1)(a)(ii)
 - s 22 (1)(a)(ii)
 - s 22 (1)(a)(ii) I think the s 22 (1)(a)(ii) mentioned might possibly be s 22 (1)(a)(ii) from engagement team?
 - managing the Department's response and position to hydration requirements and policy
- Department:
 - s 22 (1)(a)(ii) AS Legislative Reform and s 22 (1)(a)(ii) AD, PMO and Engagement section (Department's Register of Coroners' Recommendations)

We will bring this email to our meeting with you at 2pm today. Following this meeting we will load the tables into excel or word and upload to SharePoint folder s 22 (1)(a)(ii) and subject to your approval, continue to build out the tables and use for future updates on progress.

Kind Regards

s 22 (1)(a)(ii)

Assistant Director

Sector Risk and Partnerships Section

Regulatory Strategy and Partnerships Branch

Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Melbourne VIC 3001

Woiworung Country

From: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Sent: Wednesday, 13 May 2026 10:35 AM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Subject: Re: Urgent - Coordination approach - Coroner's Recommendations - Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

See changes below - I added a contacts column. Im not sure what to put in all the cells or if all the tasks are captured. Comments/suggestions welcome.

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

s 22 (1)(a)(ii)

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

Larrakia Country

Coroner Inquiries

Aged Care Quality and Safety Commission

E CoronerInquiries@agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: 13 May 2026 7:16 AM

To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: Urgent - Coordination approach - Coroner's Recommendations - Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL:Sensitive]

OFFICIAL: Sensitive

Hi s 22 (1)

I can't seem to find the s 22 (1)(a)(ii) s 22 (1)(a)(ii) in the CI inbox sub folder and is all the communications and actions in the SP folder? CI Inbox - AA Current Work - Coroner Recommendations - s 22 (1)(a)(ii) SP folder not up to date.

I think it will be a good idea to bring the actions into a simple table to include actions s 22 (1)(a)(ii) captured from the meeting with the Department on 11/5 as well as a table for a clear list of the actions we are taking to respond to coroners recommendations, including delivery dates. s 47E(d)

[Redacted content]

Can you please move your content from your email below into the relevant table/s.

I have also attached our proposed process for coronial recommendations, approved by s 22 (1)(a)(ii) and currently with s 22 (1)(a)(ii)

I have forwarded and attached ^{s 22 (1)(a)(ii)} email 11/5 at 5.55pm to the CI inbox for your information (as CI was not cc'd in).

Actions			
from Department/ACQSC meeting: Discussion: Coroner's Inquest Findings into the death of ^{s 22 (1)(a)(ii)} ^{s 22 (1)(a)(ii)} on 11/5/2026 at 4.30pm.		Action for	Due date
- The Department has responded to Minister Butler and sent the response to ^{s 22 (1)(a)(ii)} for information. Can you get a copy from ^{s 22 (1)(a)(ii)} - The Department acknowledged the coronial outcomes. The Department noted that elements of the Quality Standards already relate to hydration. However, the Department's answer to changing the Quality Standards was no in their letter.		NA – we have a copy	
Commission teams have already had discussions about possible communication products. ^{s 47C}		Rec 5 - response to Rec 6 covers it. Rec 6 - Clinical Alert, referencing the coroner's findings and messaging about the importance of hydration and nutrition to older people and risks on not exercising good practice. Rec 6 - Quality Bulletin based on literature review and informed by good practice in the sector	
Commission teams have already had discussions about possible communication products. ^{s 47C}		Duplicate	
- The family has written to ^{s 22 (1)(a)(ii)} the Inspector-General of Aged Care. ^{s 22 (1)(a)(ii)} has submitted her resignation, effective 31 July 2026. ^{s 22 (1)(a)(ii)} responded and told the family she would raise the matter with the Dept and Commission. ^{s 47E(d)}		^{s 47E(d)}	
Department's Aged Care Register of Coroners' Recommendations Australian Government Department of Health, Disability and Ageing (not yet published) ^{s 22 (1)(a)(ii)} will publish the Commission's response in the Commission's coronial recommendations register. The Department is required to maintain a public register of relevant coronial reports and recommendations relating to the death of an individual accessing aged care services. The register includes the circumstances of the death, the recommendations made to the Department, and a summary of actions taken by the Department in response.			
Separately, ^{s 47F(1)} is managing the Department's response and position to hydration requirements and policy. This is separate from the Department's register publication process. The Commission may be able to provide input to the Department once the Commission's own position and communication products are confirmed. There is currently no mandatory dementia training requirement, but the Department is working on the issue.		New Action – ^{s 22 (1)(a)(ii)} – find Department contact to connect (from ^{s 22} - I think the ^{s 22 (1)(a)(ii)} mentioned' might be ^{s 22 (1)(a)(ii)} from engagement team?)	

Recommendation	Action	Business Lead/SME	Implementation Lead	Contacts	Oversight / Reporting	Delivery Date	Status
Recommendation 4 (Department responded) we are	Adjust / strengthen guidance for outcome 5.5 and action 5.5.5	OP&S/KMOP/FNDU/CU	OP&S	^{s 22 (1)(a)(ii)}	Sector Risk and Performance Committee (SRPC)	Post 1 July	In progress

looking at guidance materials for outcome 5.5				§ 22 (1)(a)(ii)			
	Review documents/resources - Preventing Urinary Tract Infections: Recognising dehydration - Keep your fluids up!	CCAD	KMOP	§ 22 (1)(a)(ii)			
	§ 47E(d)						
	Update digital guidance tool						
	Coordinate liaison with Department	OP&S	OP&S				
Recommendation 5	§ 47E(d)	CCAD/RSP					
to amend poster 'preventing urinary tract infections'.							
Recommendation 6	§ 47E(d)	CCAD/FNDU/RCE	CCAD	§ 22 (1)(a)(ii)	Sector Risk and Performance Committee (SRPC)		
Provide educational resources to providers							
	Quality Bulletin - based on literature review and informed by sector insights. Condensed into fact sheets or similar	CCAD/FNDU/RCE	FNDU	§ 22 (1)(a)(ii)	Sector Risk and Performance Committee (SRPC)		
External engagement	Prepare response correspondence to coroner re recs 5,6	RSP					
	§ 47E(d)						

This can be sourced from the great and detailed master table you have developed - [a. Coordination table - § 22 \(1\)\(a\)\(ii\) docx](#)

Background:

- 5/3/2026 – letter from Hon Chris Picton MO, Minister for Health and Wellbeing to ACQSC Commissioner, attaching the Deputy State Coroner's Inquest Findings in relation to death of § 22 (1)(a)(ii). Drawing attention to recommendations directed toward the ACQSC
- 16/3/2026 – an acknowledgement was sent from the A/g Commissioner § 22 (1)(a)(ii) to Chris Picton MP, Minister for Health and Wellbeing SA and **no separate response needs to be drafted (email from DC SCRS 24/3 at 1.11pm)**
- 23/4/2026 – meeting between § 22 (1)(a)(ii), Inspector General of Aged Care, Commissioner, Deputy Commissioner § 22 (1)(a)(ii)
- 11/05/2026 – meeting with the Department – § 22 (1)(a)(ii)

Stakeholders – ACQSC:

- CCAD
 - FNDU
 - s 22 (1)(a)(ii)
 -) (ii)
 - CU
 - Clinical Education team
- OP&S (SQS team):
 - s 22 (1)(a)(ii) and her team s 22 (1)(a)(ii)
- Digital Communications
 - s 22 (1)(a)(ii)
- Digital Guidance tool? Is this a team e.g. Digital tools team?
 - [Director]
- Regulatory Strategy:
 - s 22 (1)(a)(ii) and his leg team – s 22 (1)(a)(ii)
- Regulatory Campaigns and Evaluation
 - s 22 (1)(a)(ii) and team

Stakeholders – external

- s 22 (1)(a)(ii) Inspector General of Aged Care
- Department:
 - s 22 (1)(a)(ii)
 -)
 - I think the s 22 (1)(a) mentioned might possibly be s 22 (1)(a)(ii) from engagement team?
 - managing the Department's response and position to hydration requirements and policy
- Department:
 - s 22 (1)(a)(ii) AS Legislative Reform and s 22 (1)(a)(ii) AD, PMO and Engagement section (Department's Register of Coroners' Recommendations)

Kind Regards

s 22 (1)(a)(ii)

Assistant Director

Sector Risk and Partnerships Section

Regulatory Strategy and Partnerships Branch

Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Melbourne VIC 3001

Woiworung Country



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Tuesday, 12 May 2026 1:43 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Subject: For review before I send to Andrew [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Overview of communication products underway for the s 22 (1)(a)(ii) response follows. I am in the process of checking the current status of the quality bulletin and the Clinical alert is and will advise you ASAP.

There are three key communication products being developed:

For Rec 4 - s 22 (1) OP&S s 22 (1)(a)(ii) is working with KMOP s 22 (1)(a)(ii) to review and provide SME on the Coroner's recommendations for the Commission's guidance outcome 5.5 and examples of key tasks providers can take (Action 5.5.5). s 47E(d)

Recs 5 & 6

s 47E(d)

Also a Quality Bulletin based on literature review - led by s 22 (1)(a)(ii) - to be informed by what is happening out there in the sector - s 22 (1)(a)(ii)

s 47C

s 47E(d)

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

s 22 (1)(a)(ii)

E s 22 (1)(a)(ii)@agedcarequality.gov.au | W www.agedcarequality.gov.au

Larrakia Country



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From: s 22 (1)(a)(ii)
To: s 22 (1)(a)(ii) [Coroner Inquiries](#)
Subject: coordination of Commission response to D'Angelo inquest recommendations [SEC=OFFICIAL]
Date: Tuesday, 14 April 2026 12:57:07 PM

OFFICIAL

Hi s 22 (1)(a)(ii)

In the meeting with s 22 (1)(a)(ii) and s 22 (1)(a) last month the relevant business areas in relation to this particular matter were considered to be CCAD and 'product people' (who I'm taking to mean External Comms eg Dir s 22 (1)(a)(ii)). s 22 (1)(a)(ii) has already expressed interest and views in relation to the recommendations.

Stage one of coordination was agreed at the meeting, to be framed around establishing that the recommendation was 'doable and desirable' in consultation with SMEs - as a measure of whether or not the Commission accepts recommendations. s 47C

s 47E(d)

Note I am capturing the above steps in a SOP and will additionally draft up some processes for the oversight and accountability mechanisms for implementation of coroner recommendations we accept.

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

T s 22 (1)(a)(ii)

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

Larrakia Country

From: s 22 (1)(a)(ii)
To: s 22 (1)(a)(ii) s 22 (1)(a)(ii)
Cc: [Coroner Inquiries](#); s 22 (1)(a)(ii) s 22 (1)(a)(ii)
Subject: Urgent - RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]
Date: Tuesday, 14 April 2026 2:26:46 PM
Attachments: [image001.png](#)
[image906885.png](#)
Importance: High

OFFICIAL

Hi s 22 (1)(a)

I just had a chat to s 22 (1)(a)(ii) from the Department who confirmed the Department has received Recommendation 4, via the Minister and their policy team have responded. s 22 (1)(a)(ii) is going to check whether they can share their response with us.

s47F(1)

As a result, we will coordinate input from CCAD for Rec 5 and 6.

@s 22 (1)(a)(ii) can you please start coordinating input from CCAD, as per the agreed approach as per the meeting with s 22 (1)(a)(ii) on 25/3.

s 22 (1)(a)(ii) would also like to be kept in the loop regarding the upcoming meeting between the Commissioner, s 22 (1)(a)(ii) and IG if possible.

s 47E(d)

Kind Regards

s 22 (1)(a)(ii)

Assistant Director
Sector Risk and Partnerships Section
Regulatory Strategy and Partnerships Branch
Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) [agedcarequality.gov.au](#) | W [www.agedcarequality.gov.au](#)

s 22 (1)(a)(ii)

GPO Box 9819, Melbourne VIC 3001
Woiworung Country



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From: s 22 (1)(a)(ii)

Sent: Tuesday, 7 April 2026 4:38 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: Urgent - RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

Importance: High

OFFICIAL

Hi s 22 (1)(a)

Further to your email below, and coroner recommendations.

Rec 4 has been addressed to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing. Can you please confirm whether the Department has formally received this recommendation or been consulted, given their responsibility for aged care policy including the design and content of the Quality Standards?

Could you please confirm whether it has been agreed that the Commission will take carriage of Rec 4 for the purposes of clinical guidance and education. I have been on leave and just want to ensure I am aligned with the current approach.

I understand that a meeting is being arranged between the Commissioner, s 22 (1)(a)(ii) and IG to discuss these recommendations, SCRSD will be reaching out to us for input

in preparation for this meeting. At this stage, I am not aware of whether the Department will be attending and please let me know if you think it is appropriate to note this or follow up on their involvement.

Rec 5 and 6 fall within our remit and we will coordinate input from CCAD.

Please let me know if there is anything further you would like us to do, noting that the timing of the meeting has not yet been confirmed.

Kind Regards

s 22 (1)(a)(ii)

Assistant Director
Sector Risk and Partnerships Section
Regulatory Strategy and Partnerships Branch
Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission

E **s 22 (1)(a)(ii)** [s22\(1\)\(a\)\(ii\)@agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au) W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Melbourne VIC 3001
Woiworung Country

From: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**[agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Sent: Friday, 27 March 2026 3:53 PM

To: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**[agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>; **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**[agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Cc: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)**[agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: FW: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of **s 22 (1)(a)(ii)** [SEC=OFFICIAL]

OFFICIAL

Hi **s 22 (1)(a)(ii)**

Below is the email thread that originally arrived with Government Relations that made its way to the Coroner team. The original attachments are the PDF that came through from the SA Minister (not directly from the SA Coroner). The attached email is advice from DCSCRS that they replied to the minister acknowledging receipt. As discussed with you this week, the Coronial team will develop a procedure and log for when these types of recommendations come through to us. This includes supporting senior executive decision-making on whether to implement the recommendation, and a process for overseeing its implementation via the SRPC.

The recommendations to the Commission are at the end of the coroner's report, the PDF labelled Attachment 1. I've pasted them below.

Recommendations to the Commission:

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
 - That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

s 22 (1)(a)(ii)



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From: S 47E(d) <[REDACTED]@agedcarequality.gov.au>
Sent: Tuesday, 24 March 2026 10:09 AM
To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>
Cc: S 47E(d) SCRS <DeputyCommissionerSCRS@agedcarequality.gov.au>; s 22 (1)(a)(ii) <[REDACTED]@agedcarequality.gov.au>; s 22 (1)(a)(ii) <[REDACTED]@agedcarequality.gov.au>; s 22 (1)(a)(ii) <[REDACTED]@agedcarequality.gov.au>; s 22 (1)(a)(ii) <[REDACTED]@agedcarequality.gov.au>; s 22 (1)(a)(ii) <[REDACTED]@agedcarequality.gov.au>
Subject: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi Team,

Please see attached Commissioner correspondence from the South Australian Minister for Health and Wellbeing, providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) Page 35 of the report lists recommendations for the Commission. Kindly for your review and action as appropriate.

@s 22 (1)(a)(ii) I believe the OOC were drafting a response from the Commissioner – I will follow up where this is at and confirm.

@s 22 (1)(a)(ii) Copying you in for visibility as some of the recommendations relate to Commission posters and educational resources.

Kind regards,

s 22 (1)(a)(ii) (She/Her)

Executive Officer to s 22 (1)(a)(ii) Deputy Commissioner
Sector Capability and Regulatory Strategy Division
E | s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au) T | s 22 (1)(a)(ii)

Deputy Commissioner SCRS

Deputy Commissioner, Sector Capability & Regulatory Strategy

Aged Care Quality and Safety Commission

E s 47E(d) [@agedcarequality.gov.au](mailto:s47E(d)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Sent: Monday, 23 March 2026 3:53 PM

To: s 47E(d) [@agedcarequality.gov.au](mailto:s47E(d)@agedcarequality.gov.au)

Subject: FW: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Yes, this can go to the coronial team etc. Can they draft a response for s 22 (1) to send to the SA Minister?

Kind regards



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From: s 47E(d) <s 47E(d) agedcarequality.gov.au>
Sent: Friday, 6 March 2026 4:57 PM
To: Office of the Commissioner <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
cc: s 47E(d) <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii) (and s 22 (1)(a)(ii) s 22(1)(a)(ii)

See attached a letter from the South Australian Minister for Health and Wellbeing, the Hon Chris Picton MP to addressed to you providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii). There are several recommendations that have been directed to the Commission within.

Please let us know if you require assistance preparing a response to the Minister. Otherwise, we will leave with your office to action as appropriate.

Kind regards

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Assistant Director, Parliamentary Services
Engagement, Education and Communication

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) @agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Sydney 2001

I work part time and do not work on Tuesdays.



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From: [Coroner Inquiries](#)
To: [s 22 \(1\)\(a\)\(ii\)](#)
Subject: Fw: For FNDU review - Updated provider guidance 14 May - Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of [s 22 \(1\)\(a\)\(ii\)](#) [SEC=OFFICIAL]
Date: Friday, 7 August 2026 2:02:05 PM
Attachments: [image002.png](#)
[image009.png](#)
[image012.png](#)
[image013.png](#)
[image014.png](#)
[image015.png](#)
[image016.png](#)
[image017.png](#)
[image262678.png](#)

OFFICIAL

Coroner Inquiries

Aged Care Quality and Safety Commission

E CoronerInquiries@agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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From: [s 22 \(1\)\(a\)\(ii\)](#) <[s 22 \(1\)\(a\)\(ii\)](#)@agedcarequality.gov.au>
Sent: 14 May 2026 7:29 PM
To: [s 22 \(1\)\(a\)\(ii\)](#) <[s 22 \(1\)\(a\)\(ii\)](#)@agedcarequality.gov.au>
Cc: [s 22 \(1\)\(a\)\(ii\)](#) <[s 22 \(1\)\(a\)\(ii\)](#)@agedcarequality.gov.au>; [s 22 \(1\)\(a\)\(ii\)](#) <[s 22 \(1\)\(a\)\(ii\)](#)@agedcarequality.gov.au>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>
Subject: RE: For FNDU review - Updated provider guidance 14 May - Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of [s 22 \(1\)\(a\)\(ii\)](#) [SEC=OFFICIAL]

OFFICIAL

Thanks [s 22 \(1\)\(a\)\(ii\)](#)

I have responded to the changes made within the shared document below, and have also shared with the small team who supported the initial review for any feedback they may have. I anticipate the latest I would hear back from others would be Monday when we are all meeting to discuss a clinical alert on the same topic.

With regards to the updates to the other sections of the guidance, I have provided comment in blue for each, with further detail to provide context where required.

Please don't hesitate to reach out if you wanted to discuss.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD

Director

Food, Nutrition and Dining Unit

Chief Clinical Advisor Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819 Perth WA 6001

Whadjuk Country



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From: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au

Sent: Thursday, 14 May 2026 2:32 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) [s 22 \(1\)\(a\)\(ii\)@agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: For FNDU review - Updated provider guidance 14 May - Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Thank you for providing feedback about the proposed updates to section 5.5.5 of the provider guidance to address Rec 4 – much appreciated

We have reviewed and have made some further edits to page 1, for your consideration. **Can you please confirm that our track changes still align with the intent of your feedback/suggestions?** I have

added some comments to help explain our thinking.

 [20260405REC s 22\(1\)\(a\)\(ii\) CCAD Feedback on provider guidance and resources - OP updates 14 May 2026.docx](#)

Please note:

- We have only looked at the feedback on page 1, related to provider guidance updates, re: Rec 4.
- We haven't reviewed feedback related to other Recommendations re: *Preventing urinary tract infections: recognise dehydration* poster or the *Keep your fluids up* page, as we are not the business owners of this content.
- If it's determined that any published dehydration-related content is no longer useful, we can work with Digital Comms to remove from the Quality Standards Resource Centre (if it's included there).
- External Comms can support removal from other areas of the Commission website if required, such as web content or resource library.

If possible can you please provide an estimated timeframe for FNDU response for the attached updated provider guidance edits + the additional suggested edits included in the email below? (Noting we only sent the additional suggested minor updates through to you on Monday!).

I have cc'd in Coroner Inquiries inbox as **s 22 (1)(a)(ii)** from Sector Risk and Partnerships has requested advice on the anticipated timing re: response to the SA Coroner's recommendations. An estimated FNDU review timeframe will help us update **s 22 (1)(a)** with timelines to respond to **s 22 (1)(a)(ii)**

Happy to chat further

Thank you again!

Kind regards

s 22 (1)(a)(ii) (She/Her/Hers)
Senior Policy Officer
Operational Policy and Support
Regulatory Strategy and Policy (RSP) Group

Aged Care Quality and Safety Commission
E **s 22 (1)(a)(ii)** agedcarequality.gov.au W www.agedcarequality.gov.au
s 22 (1)(a)(ii)
GPO Box 9819 Adelaide SA 5001
Adelaide, Kurna Country
I work Monday, Tuesday, Thursday, Friday



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Sent: Monday, 11 May 2026 5:22 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Subject: RE: For FNDU review - Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks s 22 (1)(a)(ii)

I caught up with the Coroner Inquiries team today on the recommendations and Commission's actions, and have cc'd the team in for visibility. I understand the Coroner Inquiries team will be coordinating the response and actions outlined for each area engaged.

I have attached an initial overview of our review and recommendations (FNDU, CU and CEU) for your awareness and we would be happy to support with a coordinated ongoing review.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD

Director

Food, Nutrition and Dining Unit

Chief Clinical Advisor Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii)@agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819 Perth WA 6001

Whadjuk Country



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From: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Monday, 11 May 2026 3:41 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) [s 22 \(1\)\(a\)\(ii\)@agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Subject: For FNDU review - Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

s 22 (1)(a)(ii) emailed you last month about the analysis we had undertaken of the current SQS guidance in relation to addressing Rec 4 of the Coroner's Inquest. Please see email trail below/attached.

The guidance updates that were sent through at the time were specific to action 5.5.5.

In addition to the suggested edits to 5.5.5, we have also identified additional opportunities for amendments to the provider guidance, with the purpose of adding references to hydration/dehydration in other areas of the guidance to strengthen the content in consideration of the recommendations.

As part of the consultation your area is undertaking for 5.5.5, can you please also consider and provide any input/feedback into the below suggested minor updates? It would be great to have your feedback and expertise.

s 22 (1)(a)(ii) has (sadly!) moved to a new role outside of the Commission. If a response on the consultation request for edits to 5.5.5 provider guidance was already returned, can you please forward through to me.

Please reach out if you'd like to chat through the below

Thank you!

Additional opportunities for amendments to the provider guidance

Note: yellow highlighted text is added text / red with strikethrough shows removal.

Guidance for [action 5.6.1](#)

s 47C

- Put in place processes for ongoing monitoring and response to:
 - changing clinical care needs which could include changes in behaviour, changes to medication
 - changing communication needs
 - **changing daily care needs such as personal hygiene and dietary requirements.**
 - need for additional care minutes from registered health practitioners and allied health professionals and workers.

Guidance for [action 5.6.3](#)

s 47C

s 47C

- Put in place assessment processes to respond to changed behaviours that include:
 - making sure the immediate safety of the older person and others is maintained
 - **identifying factors that could cause changes, including unmet needs, environmental, malnutrition, delirium, pain, eating, drinking, swallowing and medication changes**
 - identifying each older person's psychosocial and support needs
 - involving supporters, carers and family, or others who know the person (when relevant)
 - referring to behavioural support specialists/ services and allied health professionals when needed for aged care services delivered in a residential care home, home or community setting, as outlined in Action 7.2.3.

Guidance for [outcome 6.1](#)

Note: The Coroner's Inquest refers to action 6.1.2 in section 60 and 61.

s 47C

Make sure workers are in line with, understand and provide appropriate assistance when:

- partnering with older people on their food, nutrition and dining needs
- delivering and improving food, nutrition and hydration services
- **recognising clinical change that impacts food intake and nutrition** (Outcome 5.5)
- supporting older people with modified diets and thickened fluids (Outcome 6.4)
- helping older people with eating and drinking

Guidance for [Outcome 6.2](#) Assessment of nutritional needs and preferences

Note: The Coroner's Inquest refers to action 6.2.1 in section 60 and 61.

s 47C

- clinical, physical and cognitive issues that may affect the older person's ability to eat, drink and swallow. **For example, poor oral health or the effects of medication on appetite.**

Kind regards

s 22 (1)(a)(ii) She/Her/Hers)
Senior Policy Officer
Operational Policy and Support
Regulatory Strategy and Policy (RSP) Group

Aged Care Quality and Safety Commission
E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) W www.agedcarequality.gov.au
s 22 (1)(a)(ii)
GPO Box 9819 Adelaide SA 5001
Adelaide, Karna Country
I work Monday, Tuesday, Thursday, Friday



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Tuesday, 7 April 2026 2:15 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Cc: s 22 (1)(a)(ii) s 22 (1)(a)(ii)@agedcarequality.gov.au; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii)@agedcarequality.gov.au
Subject: Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

I hope you are well.

I am reaching out as Sector Ed and the Department has alerted us to the Coroner's Court of SA's inquest into the death of an aged care resident in 2020 - s47F(1)

These included the following recommendations for the Commission to action:

Strengthened Quality Standards

194 I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:

Four That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):

The provider implements processes to maintain an older person's hydration by:

- a. Measuring the daily fluid intake of residents who are clinically dehydrated*
- b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s*
- c. Recognising inadequate fluid intake*
- d. Responding to inadequate fluid intake*

While the Department has stated that they will commit to include these recommendations in the first 5 year periodic review of the Quality Standards (due 2030), they have suggested working with the Commission to consider if/how the guidance supporting [Outcome 5.5/Action 5.5.5](#) can incorporate the suggestions included in the above recommendation, to further support the sector's understanding of the importance of hydration in the delivery of aged care services.

We have undertaken an analysis of the current SQS guidance (see attached) and found that while the provider guidance addresses hydration/dehydration recommendations in part or at a broader level, there is opportunity to strengthen the guidance to address these recommendations more specifically. We are looking to update these changes as part of continuous improvement processes.

We have made a start with some minor track changes to the provider guidance for Outcome 5.5/Action 5.5.5, and are now welcoming your consultation and expertise on how we can better revise these suggestions in line with best practice – [📎 SQS Guidance updates for 5.5.5 24032026 DRAFT.docx](#)

We are keen to hear your insights and any further suggestions you may have.

Commission posters/educational content

195 I make the following recommendations to the Aged Care Quality and Safety Commissioner:

- Five* That the poster “Preventing Urinary Tract Infections - Recognise Dehydration”, published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
- Six* That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

The inquest also made recommendations to amend the [Preventing Urinary Tract Infections: Recognising dehydration](#) poster – I am not sure if this had already been forwarded to your team for consideration.

We also found Commission web content that would benefit from your review: [Keep your fluids up!](#)

.....

Please reach out if you have any questions – happy to offer a discussion to talk through this in more detail if you would like.

Kind Regards,

s 22 (1)(a)(ii) (she/her/hers)

A/Assistant Director

Operational Policy and Support

Knowledge Management and Operational Policy

Aged Care Quality and Safety Commission

E **s 22 (1)(a)(ii)** agedcarequality.gov.au | W www.agedcarequality.gov.au

T **s 22 (1)(a)(ii)**

GPO Box 9819, Sydney NSW 2001

Dharug Country



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From: s 22 (1)(a)(ii)
To: [Coroner Inquiries](#)
Cc: [Food, Nutrition and Dining Unit](#)
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]
Date: Thursday, 14 May 2026 7:18:36 PM
Attachments: [image001.png](#)
[image003.png](#)

OFFICIAL

Hi s 22 (1)(a)(ii)

Regarding point 1, We have provided feedback on outcome 5.5 and action 5.5.5 to OP&S. In response, the OP&S team have sent back further changes for review and requested review of other points within the guidance listed under other standards/outcomes (not as per the recommendation of the Coroner, but another action in support of the topic).

I understand you have received the document in another email from OP&S whereby they have requested the additional review: [20260405REC s 22\(1\)\(a\)\(ii\) CCAD Feedback on provider guidance and resources - OP updates 14 May 2026.docx](#). This document also includes our initial review of the resources and Quality bulletin article requested by OP&S. I have reviewed OP&S suggestions this evening and made comment directly into the document.

For point 2 and 3, my understanding was that it was proposed to be either be a quality bulletin or clinical alert. We have commenced the clinical alert drafting when initially reviewing the standards guidance and posters and QB that were listed for review.

We have a meeting with those supporting across the clinical and clinical education units scheduled for Monday to pull together the key points for a draft clinical alert for s 22 (1)(a)(ii) to then review and update, publishing with the Sector Comms team as per their processes.

I anticipate this can be turned around quickly, and could anticipate by next Friday, however will check with s 22 (1)(a)(ii) what her requirements and anticipated timeline to complete would be.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD
Director
Food, Nutrition and Dining Unit
Chief Clinical Advisor Division

Aged Care Quality and Safety Commission

E **s 22 (1)(a)(ii)** agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819 Perth WA 6001

Whadjuk Country



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From: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Sent: Thursday, 14 May 2026 12:51 PM

To: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** agedcarequality.gov.au>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of **s 22 (1)(a)(ii)** [SEC=OFFICIAL]

OFFICIAL

Thank you for that **s 22 (1)(a)(ii)**

As per our other conversation I am seeking explicit advice from Exec to confirm the response products below are what they understand has been agreed to.

1. Review/strengthening guidance for outcome 5.5 and action 5.5.5 with reference to coroner's recommendations
2. Quality Bulletin to adjust guidance and promote specified practice

3. Clinical Alert on hydration

Iv reached out in the first instance to whoever I understood to be the lead business area for each of the products to get timeline expectations.

Can you advise (roughly) a delivery timeline for the Clinical Alert?

Kind regards

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

T s 22 (1)(a)(ii)

E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

Larrakia Country

Coroner Inquiries

Aged Care Quality and Safety Commission

E CoronerInquiries@agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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return e-mail and delete the transmission without making a copy.

From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: 14 May 2026 8:40 AM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; Coroner Inquiries
<CoronerInquiries@agedcarequality.gov.au>

Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's
Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks s 22 (1)(a)(ii)

s 47E(d)

s 47C

We will make a head start on the clinical alert pending approval as we can always use the information in other ways - I have engaged the clinical and clinical education units to support.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD

Director

Food, Nutrition and Dining Unit

Chief Clinical Advisor Division

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819 Perth WA 6001

Whadjuk Country



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Thursday, 14 May 2026 5:30 AM

To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi there s 22 (1)(a)(ii)

The FNDU are drafting the clinical alert with s 22 (1)(a)(ii) – s 22 (1)(a)(ii) have cc'd you here, hoping

you could pls give § 22 (1)(a)(ii) a bit of info on progress and timing?

many thanks

§ 22 (1)(a)(ii)

(1)(a)(ii) (she/her/hers)

Director

Regulatory Campaigns and Evaluation

Regulatory Strategy and Partnerships

§ 22 (1)(a)(ii) agedcarequality.gov.au

§ 22 (1)(a)(ii)

Canberra, Ngannawal Country

I work Monday – Friday

Aged Care Quality and Safety Commission

www.agedcarequality.gov.au

GPO Box 9819, in your capital city



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From: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Sent: Wednesday, 13 May 2026 4:43 PM

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Subject: Fw: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

s 22 (1)(a)(ii) has requested advice on the status and anticipated timing of the products being prepared in response to the SA Coroner's recommendations. Is this something you can help me with in respect of the Clinical Alert in response to recommendation 6? (highlighted in the previous email below)

Kind regards

s 22 (1)(a)(ii) (she/her)

Senior Policy Officer

Sector Risk and Partnerships

Sector Capability and Regulatory Strategy

Aged Care Quality and Safety Commission

T s 22 (1)(a)(ii)

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

Larrakia Country

From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Thursday, 23 April 2026 3:36 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Thanks s 22 (1)(a)(ii) - I will flag with s 22 (1)(a)(ii) for discussion and follow up the actions in your email

See below for relevant actions everyone, this is going to take some coordination if you can lead that s 22 (1)(a)(ii) with the coronial response team.

Re Rec 4

s 22 (1)(a)(ii) - I am just looking through your notes which I've attached as they seem to not be in this email chain

You note – you working with KMOP to review and provide SME on the Coroner's recommendations for the Commission's guidance outcome 5.5 and examples of key tasks providers can take (Action 5.5.5) regarding the implementation of processes to maintain an individual's nutrition and hydration. The team also advised that the Department has stated that they will commit to include these recommendations in the first 5-year periodic

review of the Quality Standards (due 2030).

I'm not clear if this means we think hydration is already sufficiently addressed in the standards? Or it's a matter of updating the notifiable instrument for the Actions?

Be good to get your or KMOP advice on which aspects of the standards might be usefully updated within the standards architecture and how:

- Standard
- Outcome
- Actions
- Commission audit methodology

Are you able to specify against this list what is already being changed (through your work with KMOP) and what you would recommend changing in the future?

s 47C

For Rec's 5 and 6 - § 22 (1)(a) and § 22 (1) advised the Inspector General on the Clinical Alert and Quality Bulletin options.

§ 22 (1)(a)(ii) - Taking into account § 22 (1)(a) and § 22 (1)(a)(ii) advice – can you work with § 22 (1)(a) and § 22 (1)(a)(ii) to draft a clinical alert from § 22 (1)(a)(ii) as our CCA on hydration – referencing the coroners findings and messaging on the importance of hydration and nutrition to older people and risks on not exercising good practice. In the alert we should take the opportunity to remind providers what we expect in simple terms and link to relevant guidance.

s 47E(d)

s 47E(d)

Kind Regards, s 22 (1)(a)(ii)

1)(a)(ii) (she/her)

Assistant Commissioner, Regulatory Strategy and Partnerships

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

T s 22 (1)(a)(ii) | M s 22 (1)(a)(ii)

GPO Box 9819, Sydney NSW 2001

EA: E s 22 (1)(a)(ii) agedcarequality.gov.au W: s 22 (1)(a)(ii)

I live and work on Gadigal Country, land of the Eora Nation



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Thursday, 23 April 2026 11:59 AM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; Office of the Commissioner <s 47E(d) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi everyone,

s 22 (1) and I just met with the IG who has been in contact with s 22 (1)(a)(ii) s 47F
s 22 (1)(a)(ii) received the same letter from the SA Minister.

s47F(1)

s 47E(d)

Happy to discuss further.

Kind regards

s 22 (1)(a)



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Tuesday, 21 April 2026 10:49 AM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

Thanks s 22 (1)(a)(ii)

I would actually retire the poster about preventing UTIs/assessing hydration status - as there is little evidence that any of the clinical symptoms or signs mentioned are accurate in predicting dehydration. It would be better also to provide resources to support providers to prevent dehydration for hydrations sake - rather than unnecessarily linking it to UTIs - as that tends to also cloud the messaging

s 47C

The coroners case also certainly sets the scene for a clinical alert - which I am happy to write - once we are more certain of our recommendations

It is also worthwhile noting that the roll out of point of care (blood) testing is being

considered for the aged care sector - although it is still very early days of consultation - but that would be very helpful too and we could prompt providers to consider

Let me know what next steps might be

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Geriatrician

BMBS FRACP Mst Gerontology Grad Cert Leadership GAICD

Chief Clinical Advisor

Chief Clinical Advisor Division

Available Monday, Wednesday, Thursday and Friday

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

T s 22 (1)(a)(ii) | M s 22 (1)(a)(ii)

GPO Box 9819, Adelaide SA 5000

Kaurna Country

#Everyone you meet is fighting a battle you know nothing about - be kind always



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Monday, April 20, 2026 2:20 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Just bringing in s 22 (1)(a)(ii) s 22 (1)(a)(ii) and s 22 (1)(a)(ii) as well

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake
- For Rec 4 regarding changes to the standards, the dept is the policy holder so we would take any requests to them. There is also a question of where in the standards to adjust, ie the outcomes (compliance obligations) or actions (guidance published as a notifiable instrument). The third option which is more in our direct control is to adjust our guidance and promote any more specified practice.

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
 - That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

For Recs 5 and 6 – do we agree with updates recommended? Any risks?

Are there any plans under the current FNDU program to address hydration – perhaps the coroners rec's are a chance to do a clinical alter or Quality Bulletin article on it? Be good to get s 22 (1)(a)(ii) thoughts here too

Kind Regards, s 22 (1)(a)(ii)

1)(a)(ii) (she/her)

Assistant Commissioner, Regulatory Strategy and Partnerships

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

T s 22 (1)(a)(ii) | M s 22 (1)(a)(ii)

GPO Box 9819, Sydney NSW 2001

EA: E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) W: s 22 (1)(a)(ii)

I live and work on Gadigal Country, land of the Eora Nation



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Monday, 13 April 2026 7:16 PM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>
Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hello

s47F(1)

Recommendations 5 and 6 seems reasonable

Recommendation 4 could be addressed through our FNDU RBM and/or outreach work

s 47F

People with Lewy body dementia often experience periods (up to a week or less) of drowsiness which is usually self limiting. This is one of the Lewy Body diagnostic criteria along with cognitive impairment, parkinsonism and visual hallucinations

s47F(1)

s47F(1)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Geriatrician

BMBS FRACP Mst Gerontology Grad Cert Leadership GAICD

Chief Clinical Advisor

Chief Clinical Advisor Division

Available Monday, Wednesday, Thursday and Friday

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T **s 22 (1)(a)(ii)** | M **s 22 (1)(a)(ii)**

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From: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** agedcarequality.gov.au>

Sent: Friday, March 27, 2026 3:23 PM

To: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** agedcarequality.gov.au>; **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** agedcarequality.gov.au>

Cc: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** agedcarequality.gov.au>; Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>

Subject: FW: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of **s 22 (1)(a)(ii)** [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Below is the email thread that originally arrived with Government Relations that made its way to the Coroner team. The original attachments are the PDF that came through from the SA Minister (not directly from the SA Coroner). The attached email is advice from DCSCRS that they replied to the minister acknowledging receipt. As discussed with you this week, the Coronial team will develop a procedure and log for when these types of recommendations come through to us. This includes supporting senior executive decision-making on whether to implement the recommendation, and a process for overseeing its implementation via the SRPC.

The recommendations to the Commission are at the end of the coroner's report, the PDF labelled Attachment 1. I've pasted them below.

Recommendations to the Commission:

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care

Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.

- That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

s 22 (1)(a)(ii)



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From: s 47E(d) <[redacted]@agedcarequality.gov.au>
Sent: Tuesday, 24 March 2026 10:09 AM
To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>
Cc: s 47E(d) SCRS <DeputyCommissionerSCRS@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Subject: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi Team,

Please see attached Commissioner correspondence from the South Australian Minister for Health and Wellbeing, providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) Page 35 of the report lists recommendations for the Commission. Kindly for your review and action as appropriate.

@s 22 (1)(a)(ii) I believe the OOC were drafting a response from the Commissioner – I will follow up where this is at and confirm.

@s 22 (1)(a)(ii) Copying you in for visibility as some of the recommendations relate to Commission posters and educational resources.

Kind regards,

s 22 (1)(a)(ii) (She/Her)

Executive Officer to s 22 (1)(a)(ii) Deputy Commissioner

Sector Capability and Regulatory Strategy Division

E | s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au) T | s 22 (1)(a)(ii)

Deputy Commissioner SCRS

Deputy Commissioner, Sector Capability & Regulatory Strategy

Aged Care Quality and Safety Commission

E s 47E(d) [@agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>

Sent: Monday, 23 March 2026 3:53 PM

To: s 47E(d) @agedcarequality.gov.au>

Subject: FW: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Yes, this can go to the coronial team etc. Can they draft a response for s 22 (1) to send to the SA Minister?

Kind regards

s 22 (1)(a)



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From: s 47E(d) <s 47E(d) [agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>
Sent: Friday, 6 March 2026 4:57 PM
To: Office of the Commissioner <s 47E(d) [agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>
Cc: s 47E(d) <s 47E(d) [agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>
Subject: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii) (and s 22 (1)(a)(ii) absence next week)

See attached a letter from the South Australian Minister for Health and Wellbeing, the Hon Chris Picton MP to addressed to you providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) There are several recommendations that have been directed to the Commission within.

Please let us know if you require assistance preparing a response to the Minister. Otherwise, we will leave with your office to action as appropriate.

Kind regards

Assistant Director, Parliamentary Services

Engagement, Education and Communication

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) @agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Sydney 2001

I work part time and do not work on Tuesdays.



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From: Aged Care Quality and Safety Commission
s 47E(d) .agedcarequality.gov.au>
Sent: Thursday, 18 June 2026 4:41 PM
To: s 22 (1)(a)(ii) agedcarequality.gov.au
Subject: Clinical Alert - Preventing and responding to dehydration in older people receiving aged care services

[View this email in your browser](#)

Clinical Alert

from the Chief Clinical Advisor



Australian Government
Aged Care Quality and Safety Commission

18 June 2026

Preventing and responding to dehydration in older people receiving aged care services

We are publishing this alert in response to a recent [coronial inquest](#) in South Australia where an older person living in residential aged care died from acute renal failure caused by severe dehydration. The coroner found the death to be preventable, occurring due to lack of a systemic mechanism to monitor fluid intake or recognition of the potential seriousness of dehydration in aged care residents.

Key points

- Aged care providers must be alert to the dehydration risks for the older people they care for.

Providers must support their staff to be able to recognise:

- who is at risk of dehydration
 - when to escalate their concerns about an older person's hydration status.
- Providers must make sure they implement strategies to prevent dehydration and maintain these on an ongoing basis.
- A comprehensive assessment must be undertaken on entry. Ongoing assessment of the older person must also occur whenever there is a change in condition, a dehydration risk is identified, or symptoms present.

- Providers should exercise caution when assessing older people for the signs and symptoms of dehydration. They can be unreliable and appear too late. Assessment should consider the person's recent fluid intake and fluid losses.
- If dehydration is suspected, encourage fluid intake and refer promptly to the older person's GP or other medical practitioner for medical assessment, diagnosis, and a treatment plan. The medical assessment should include a discussion regarding the benefit of blood testing for more accurate hydration assessment and monitoring.

What providers need to know

To reduce the risk of harm to older people, aged care providers:

- must understand and be alert to dehydration risks for older people
- must understand the importance of effectively monitoring and managing people's fluid intake and loss
- need to identify and quickly escalate hydration concerns, in line with the older person's preferences
- should talk to older people and their supporters about the importance of maintaining adequate fluid intake.

Risk factors for dehydration

Risk factors for dehydration in older people living in residential care homes include:

- ageing-related physiological changes such as reduced thirst, reduced body fluid reserves, and reduced ability of the kidneys to conserve fluids
- certain medical conditions – such as the use of diuretic medication (medicines that make the kidneys flush extra salt and water out of the body as urine)
- barriers to adequate fluid intake - such as access to fluids, reduced functional or cognitive capacity, acute illness, increased fluid losses, and polypharmacy (taking multiple medications regularly)
- environmental factors such as increased temperatures or exposure to sun
- cognitive changes where the older person may not recognise thirst.

Proactive identification, monitoring and management

This [coronial case](#) highlights the fact that the clinical signs of dehydration are neither reliable nor adequately sensitive to detect dehydration early enough in older people.

We expect providers to proactively identify risk, monitor and manage fluid intake, in line with the older person's preferences and goals of care.

For each older person in their care, providers should:

- discuss and agree on the strategies they will use to monitor and manage fluid intake

- document the strategies in the person's care plan
- regularly review and maintain the care plan and strategies.

Providers must have policies and processes in place to identify older people at higher risk of dehydration on admission to their services and reassess whenever there is a change in clinical status or dehydration is suspected.

Providers must also have policies and processes in place to effectively monitor and manage fluid intake across their services.

When in keeping with the older person's preferences and goals of care, there should be processes to prevent dehydration and escalate concerns when dehydration is suspected. This includes assessment and monitoring to identify older people at higher risk of dehydration, because of changes in behaviour, cognition, function, food and fluid intake, fluid outputs and overall clinical circumstance.

What workers need to know

Aged care workers providing direct care need to:

- know the individual fluid needs of the older people they care for, including when changes in needs occur, and any medical requirements for daily fluid restriction or additional fluid intake. In the absence of a specific medical instruction or individual fluid intake preference, most older people would be recommended to aim to drink at least 1500mls of fluid each day
- make sure fluids are always made available and are always within easy reach across the day. This includes providing support as required by older people to receive and consume fluids, and consulting with relevant health professionals such as occupational therapists to provide assistive equipment when needed
- make sure all food and fluids offered meet an older person's individualised requirements and preferences for texture modified foods, thickened fluids, and fluid restriction. The food and fluids offered should be in line with the older person's right to make informed decisions and exercise choice about where, when and what they eat and drink
- monitor those at an increased risk of dehydration and make an early referral for a medical assessment when increased fluid losses may impact fluid reserves - such as during episodes of acute illness, increased urination, vomiting and diarrhoea, or hot weather
- know the typical volume of fluid held in standard glassware, mugs and bowls, and high fluid content foods to assist accurate recording. This can help you accurately record how much fluid people have had
- develop and regularly review the care plan for an older person that outlines their fluid needs and includes any individualised strategies recommended to prevent and monitor for dehydration.

Responding to dehydration

Late signs of dehydration can include confusion, dizziness, fatigue, falls, low urine output and other signs of deterioration.

Dehydration is a serious clinical concern. If dehydration is strongly suspected or diagnosed in an older person, providers should act immediately to make sure:

- a comprehensive assessment is undertaken in line with the older person's wishes, including consultation with medical practitioners and other relevant health professionals to:
 - support the diagnosis
 - identify contributing factors (what has caused it)
 - discuss treatment options and make plans for early review
- the older person is encouraged to increase their fluid intake, in line with the older person's:
 - food and fluid preferences
 - care needs
 - individual requirements such as texture-modified foods and thickened fluids
- they monitor, document and review the older person's ongoing fluid intake and output to make sure their fluid status improves
- they evaluate the systems and processes within their services to identify, monitor and manage dehydration and make improvements as needed.

Providers should also review factors that contribute to dehydration risk and harm and improve their systems and processes where harm or repeated concerns are identified. This includes:

- using open disclosure - an open and honest discussion with an older person when something's gone wrong that's caused, or could have caused, harm to the older person
- immediately investigating and understanding any contributing systemic factors across all aspects of care
- educating and supporting staff to understand and recognise:
 - the risks, signs and symptoms of dehydration
 - when and how to escalate their concerns for further assessment and intervention
- having effective clinical governance that makes sure policies and processes are aligned with the latest evidence-based practice to support sustained effective prevention and management of dehydration.

Please share this alert with relevant managers and staff at your services.

More information

- [Dehydration standardised care process](#) | Victorian Department of Health
- [Keep your fluids up!](#) | Aged Care Quality and Safety Commission
- [Why meals matter](#) | Aged Care Quality and Safety Commission
- [Summer clinical alert 2025-26 – Preventing heat stress in older people](#) | Aged Care Quality and Safety Commission



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[unsubscribe](#)

s 22 (1)(a)(ii)

From: s 22 (1)(a)(ii) @agedcarequality.gov.au>
Sent: Monday, 20 July 2026 11:26 AM
To: s 22 (1)(a)(ii)
Cc: s 22 (1)(a)(ii)
Subject: Updates to Quality Standards guidance following recommendation 4 of the South Australia coroner's inquest [SEC=OFFICIAL]

OFFICIAL

Hello s 22 (1)(a)(ii)

I wanted to provide an update on Recommendation 4 arising from the South Australia Coroner's Inquest.

As you know, following the inquest, the Coroner recommended amendments to the strengthened Quality Standards relating to monitoring and maintaining hydration for older people receiving aged care services.

s 47C

Summary of actions to address Recommendation four:

- Content was developed in consultation with FNDU, Clinical Unit, and Clinical Education Unit, and underwent a plain language review by Comms.
- The following changes have been published on the website:
 - Major changes to guidance for Outcome 5.5 – Action 5.5.5
 - Minor amendments to Action 5.6.1 / Action 5.6.3 / Outcome 6.1 / Outcome 6.2
- DoHDA have been notified of the changes.
- The CCA issued a clinical alert that addressed the changes and highlighted best practice. We believe it effectively informs providers, workers and others around management of hydration needs - [Preventing and responding to dehydration in older people receiving aged care services](#)
- Comms also issued an electronic message to providers to raise awareness of the updates.

Please let me know if you require any further information.

Kind regards,

s 22 (1)(a)(ii) (She/Her)

Senior Policy Officer
Operational Policy and Support
Knowledge Management and Operational Policy

s 22 (1)(a)(ii) @agedcarequality.gov.au

Melbourne, Woiworung Country

Aged Care Quality and Safety Commission
agedcarequality.gov.au
GPO Box 9819



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Review Article

Hydration Status Assessment in Older Patients

Linda Deißler, Rainer Wirth, Birgit Frilling, Matthias Janneck, Alexander Rösler

Medical Faculty, University of Hamburg, Hamburg, Germany: Linda Deißler, B.Sc.

Marinen Hospital Herne, University Hospital of the Ruhr University Bochum, Herne, Germany: Prof. Dr. med. Rainer Wirth

Albertinen House – Center for Geriatrics and Gerontology, Hamburg, Germany: Dr. med. Birgit Frilling

Albertinen Cardiovascular Center, Hamburg, Germany: Dr. med. Matthias Janneck

Department of Geriatrics, Agaplesion Bethesda Hospital HH-Bergedorf, Hamburg, Germany: PD Dr. med. Alexander Rösler

Summary

Background: Hydration disturbances are common in old age: the reported prevalence of dehydration in elderly patients ranges from 19% to 89%, depending on the definition and the population in question. However, the clinical assessment of patients' hydration status is difficult. In this review, we discuss the diagnostic value of currently used methods that may or may not be suitable for assessing older patients' hydration status.

Methods: We conducted a selective literature search for relevant studies concerning patients aged 65 and above. Of the 355 articles retrieved by the initial search, a multistep selection process yielded 30 that were suitable for inclusion in this review.

Results: 107 different methods for the diagnostic assessment of dehydration in older persons were evaluated on the basis of the reviewed publications. High diagnostic value, especially for the determination of hyperosmolar dehydration, was found for serum osmolality, serum sodium concentration, inferior vena cava ultrasonography, a history (from the patient or another informant) of not drinking between meals, and axillary dryness. On the other hand, a variety of clinical signs such as a positive skin turgor test, sunken eyes, dry mouth, tachycardia, orthostatic dysregulation, and dark urine were found to be of inadequate diagnostic value.

Conclusion: Only five of the 107 methods considered appear to be suitable for determining that a patient is dehydrated. Thus, the available scientific evidence indicates that all clinicians should critically reconsider their own techniques for assessing hydration status in elderly patients. To optimize the clinical assessment of patients' hydration status, there seems to be a need for the rejection of unsuitable methods in favor of either newly developed criteria or of a combination of the best criteria already in use.

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The terms dehydration (hypohydration), euhydration and hyperhydration describe a negative, normal or positive water balance, respectively (e1). For all three states, no standard definitions are in place (e1–e3). Dehydration, which is a common clinical condition, can be further subdivided based on sodium concentration and/or serum osmolality. Hypertonic dehydration is caused by water loss, occasionally related to fever or sweating but in most cases due to insufficient intake of pure water. Hypotonic dehydration (possibly with hyponatremia) is frequently caused by the use of diuretics, heavy sweating with replacement of the fluid loss with low-sodium drinks (for example, drinking water), or losses from the gastrointestinal tract when electrolyte loss exceeds water loss. Isotonic dehydration is frequently secondary to the loss of isotonic fluids such as blood, but may also be associated with vomiting or diarrhea (e2).

The rather vague term volume status is commonly used instead of the broad term hydration, which describes the water content in the entire body.

Especially in the clinical context, volume status describes the intravascular volume. The shift of water and electrolytes is usually in the same direction (hypovolemia/euvolemia/hypervolemia).

Thus, in the following, we use the term hydration status (HS) that includes the intravascular volume status.

Assessment of the hydration status in older patients

Little has changed in recent decades in terms of the challenges associated with assessing the HS of older patients (1, 2). Isotope dilution analysis is considered the gold standard for assessing HS. However, it is not a feasible method in clinical practice, given the significant amount of time and resources required.

Older persons are at an increased risk of developing hydration disorders (e4). This is primarily due to reduced renal function, resulting from decreased renin and aldosterone activity and age-related decline

in thirst in people of older age (e2). In addition, fluid intake may be hampered by functional and cognitive impairments. This may be compounded by the effects of medications, for example diuretics or laxatives (e2).

The prevalence of dehydration in older patients varies widely, depending on the definition used and the population studied. In the context of admission examinations of older patients, 19% of patients were diagnosed with dehydration, based on the blood urea nitrogen to creatinine (BUN/Cr) ratio (3). In nursing home residents, hypertonic dehydration was determined based on elevated serum osmolality in 89% of the residents (4). During the 8-year follow-up, patients with increased plasma osmolality were found to be at an increased relative mortality risk of 1.4 (95% confidence interval: [1.0; 1.9]) compared to patients with normal plasma osmolality, as well as an increased relative risk of 2.3 [1.2; 4.3] for impairments of instrumental activities of daily living (IADL) (e4).

Because of this, and also because of known complications, such as decreased vigilance, falls, urinary tract infections, respiratory tract infections, and renal impairment, a quick and easy assessment of the hydration status of older patients appears to be of critical importance.

The aim of this study is to provide an overview of the diagnostic accuracy of current methods and to propose a procedure that is suitable for use in clinical practice.

Methods

This review is based on pertinent publications retrieved from a selective literature search. The search terms were selected based on the PICO framework and fall into the following three main categories (*eFigure 1*):

- Hydration status
- Patient group
- Diagnostic methods.

All results published in PubMed up to and including September 2021 with full-text articles from medical journals and with a study population aged 65 years or older were included in this analysis.

The resulting 355 articles were subjected to a multi-step selection process with predefined inclusion criteria (*eTable*). This left 24 articles, from whose references a further six articles were selected, using the same procedure (so-called reverse search). This resulted in a total of 30 full-text articles from medical journals being included in the assessment. These comprised 29 individual studies and one meta-analysis.

A detailed description of the methodological approach can be found in the *eMethods* section, supplemented by *eBox*, *eFigure 1*, *eFigure 2*, and *eTable*.

Results

Seventeen individual studies and one meta-analysis addressed the topic of dehydration (2–19); in 12 cases, the directly measured serum osmolality, the calculated

serum osmolality and/or the blood urea nitrogen to creatinine (BUN/Cr) ratio were used as the standard method for diagnosing dehydration (2, 3, 5–14). In the remaining six studies, the diagnosis dehydration was based on the clinical synopsis, various isotope dilution methods or other methods.

Eleven of the reviewed publications investigated the patients' global hydration status (1, 20–29). In five of these studies, an isotope dilution technique was used as the standard method for assessing the hydration status (1, 20–23). Three working groups assessed the hydration status using the clinical synopsis, based on preexisting conditions, systolic blood pressure, general condition, and fluid intake, among other factors (24–26). The remaining studies used laboratory chemistry methods or compared various analyses with each other.

Only one study addressed the diagnosis of hyperhydration in geriatric patients (30). This was a prospective cohort study, reviewing the utility of bioelectrical impedance analysis (BIA) for monitoring diuretic therapy.

Differences in methods, definitions and levels of evidence make it challenging to compare results. The studies included cover 107 different clinical signs as well as various examination methods, including laboratory parameters, urine tests as well as diagnostic devices.

A large number of clinical signs did not show sufficient diagnostic accuracy, especially with regard to the detection of hypertonic dehydration (3, 5, 6, 9, 11, 15–18). These included, among others:

- Reduced skin turgor
- Dryness of the mouth and mucous membranes
- Sunken eyes
- Hemodynamic parameters (for example, Schellong test)
- Urine tests (for example, color of urine).

None of these tests, which are commonly used in clinical practice, achieved a sensitivity of >0.60 and a specificity of >0.75 (5, 6).

We outline below methods that, based on the studies included in this review, may be useful for assessing the hydration status in geriatric patients. In the *Tables 1–4*, the included publications, key statistical figures as well as the reference methods applied in the individual studies are presented.

Laboratory parameters

Serum osmolality and serum sodium

While several studies used directly measured serum osmolality as the standard method to diagnose hyperosmolal dehydration or dehydration due to lack of water, it was shown that the diagnostic quality of calculated serum osmolality was also sufficient to detect hypertonic dehydration (7, 8). Preferably, an age-validated equation by Khajuria and Krahn (2005) should be used for the calculation (31).

Furthermore, Wojzel proposed a serum sodium cut-off level of 140 mmol/L to diagnose hypertonic

TABLE 1

Recommended laboratory methods

Publication	Reference standard	Statistical key figures	Evaluation	Comments/ notes
Method assessed: calculated serum osmolality				
Siervo et al. (2014) (7)	Classification by directly measured S-Osmolality 1. No dehydr. 2.Impending dehydr. (≥ 295 mOsm/kg) 3. Manifest dehydr. (≥ 300 mOsm/kg)	Cut-off value: 295–300 mOsm/L Sens. = 0.79; Spec.= 0.89 PLR: 7.53, NLR = 0.23; OR = 32.4 Cut-off value: ≥ 300 mOsm/L Sens. = 0.64; Spec. = 0.93 PLR* ¹ : 8.85, NLR* ¹ = 0.39; OR = 22.6	If direct measurement of S-Osmolality is not available → use age-validated formula for calculation, cut-off value: 295 mOsm/L	Age-validated formula* ² according to Khajuria & Krahn (2005) (31)
Hooper et al. (2015) (8)		Cut-off value: ≥296 mOsm/L Sens. = 0.80; Spec. = 0.66 PLR* ¹ = 2,36; NLR* ¹ = 0,30		
Method assessed: Serum sodium				
Wojszel (2020) (12)	Calculated S-Osmolarity ≥ 295 mOsm/L	Serum sodium: Cut-off value: 140 mmol/L Sens.= 0.80 (95% CI [0.74; 0.86]) Spec.= 0.83 (95% CI [0.75; 0.88]) PLR* ¹ = 4.58; NLR* ¹ = 0.24	Serum sodium may be used to detect hypertonic dehydr. Cut-off value: 140 mmol/L	
Sanson et al. (2021) (2)		Serum sodium: Correlation with calculated serum osmolality: r = 0.634; p<0.001		

*¹ positive or negative likelihood ratio describes the change in the probability of disease when positive or negative test results occur;

Example: PLR > 1 → Probability of disease increases

*² While the age-validated formula does not include patient age in the calculation, it shows the highest diagnostic quality for a geriatric population:

S-Osmolality [mOsm/L] = $1.86 \times (\text{Na}^+ + \text{K}^+) + 1.15 \times \text{glucose} + \text{urea} + 14$ (all measurements in [mmol/L])

Dehydr., dehydration; NLR, negative likelihood ratio; OR, odds ratio; PLR, positive likelihood ratio; S-Osmol, serum osmolality; Sens., sensitivity;

Spec., specificity; 95% CI, 95% confidence interval

dehydration (defined by a calculated serum osmolality ≥ 295 mOsm/L) (12). Table 1 provides an overview of key statistical figures.

Medial history clues and clinical examination

Missed drinks between meals and expressing fatigue

A meta-analysis published in 2015 evaluated the use of clinical and low-tech methods for their utility to diagnose hypertonic dehydration (defined by increased calculated serum osmolality or directly measured serum osmolality). It was found that both a history of missing some drinks between meals (stated by the patient or a third party) and expressing fatigue have high sensitivity and specificity (Table 2) (5).

Axillary moisture

Several studies analyzed the palpation of axillary moisture (3, 5, 6, 10, 11, 13), the measurement of axillary skin moisture using a skin moisture meter (10) or the measurement of axillary sweat by placing tissue paper in the axilla (13). Here, axillary dryness scored high in specificity (Table 3).

Technology-based diagnostic assessment

Ultrasonography of the inferior vena cava

Orso et al. assessed the feasibility of using ultrasound of the inferior vena cava to diagnose dehydration (defined by a BUN/Cr > 20). A high diagnostic accuracy was found for both the parameters of expiratory diameter of the inferior vena cava with a cut-off of 1.55 cm

and of the caval index with a cut-off of 0.48 (Table 4) (14).

Bioelectrical impedance analysis

The utility of bioelectrical impedance analysis (BIA) for determining the hydration status was evaluated in several studies (1, 5, 21–26, 29, 30). The use of calculated parameters, such as “total body water” (TBW), “extracellular water” (ECW) and others, was not convincing in any of these studies. However, there is evidence that directly measured resistance (R) (5) and the use of calculated parameters are of utility for intraindividual follow-up measurements (1, 30) (Table 4).

Discussion

Our review shows that many clinical signs used to assess the hydration status in older patients are not reliable. This includes clinical signs, such as positive skin turgor test, dry mucous membranes, sunken eyes, peripheral venous filling status, as well as pulse and blood pressure. Consequently, a clinical synopsis based on these criteria is of questionable utility, despite its frequent use in studies. Rosi et al. evaluated in 2022 a diagnostic approach based on the Geriatric Dehydration Screening Tool (GDST-M) which includes a questionnaire on drinking behavior, pain and mobility and also enables the assessment of various clinical signs, such as axillary dryness, body mass index (BMI) and dry mouth. In comparison with calculated serum osmolality, this tool showed a sensitivity of 0.62 and a

TABLE 2

Potential diagnostic utility of (third-party) medical history clues

Publication	Reference standard	Statistical key figures	Evaluation	Comments/ notes	
Method assessed: Missed drinks between meals					
Hooper et al. (2015) (5)	Kajii et al. (2006)*	Impending hypertonic dehydr.: S-Osmol ≥ 295 mOsmol/kg	Sens. = 1.00 (95% CI [0.59;1.00]) Spec. = 0.77 (95% CI [0.64; 0.86]) PPV = 0.32; NPV = 1.00	In our opinion, potential benefit; further evaluation needed; difficult to obtain information	So far, data obtained only by one working group
		Overt hypertonic dehydr.: S-Osmol. ≥ 300 mOsmol/kg	Sens. = 1,00 (95% CI [0.16;1.00]) Spec. = 0.71 (95% CI [0.59; 0.81]) PPV = 0.09; NPV = 1.00		
Method assessed: Self-reported fatigue					
Hooper et al. (2015) (5)	Kajii et al. (2006)* Sjöstrand, (2013)* Sjöstrand Healthy (2013)*	S-Osmol ≥ 295 mOsmol/kg	Sens. = 0.30–0.71 Spec. = 0.75–1.00 PPV = 0.24–1.00 NPV = 0.21–0.96	Wide dispersion of key statistical figures; "some potential" in meta- analysis; in our opinion not suitable for frail old patients (Fried frailty criteria, including weakness and self-reported exhaustion)	

* The studies mentioned are included in the meta-analysis by Hooper et al. (2015) (5). The raw data of the mentioned working groups were obtained and re-analyzed according to the research question of Hooper et al. The data analyzed are based on both previously published studies and unpublished data from various working groups.
Dehydr., dehydration; NPV, negative predictive value; PPV, positive predictive value; s-Osmol, serum osmolality; Sens., sensitivity; Spec., specificity; 95% CI, 95% confidence interval

specificity of 0.47 (32). While this tool offers a higher diagnostic quality than any single method, this development does not seem to provide a breakthrough in the difficult assessment of the hydration status.

Furthermore, it becomes apparent that the absence of a gold standard, inconsistent definitions, and different reference methods not only affect the comparability of research results, but also make it difficult to translate them into practical recommendations for everyday clinical practice.

In many studies, directly measured serum osmolality is used as the reference method to diagnose hypertonic dehydration and this method is also recommended in the current ESPEN guideline on monitoring of the hydration status in geriatric patients (33). If this test is not available, calculated serum osmolality or serum sodium levels can be used (7, 8), in which case care should be taken that an age-validated formula (by Khajuria & Krahn, 2005 [31]) and potentially reduced cut-off values (12) are applied.

In everyday clinical practice, easy-to-use, non-invasive methods are needed. The described (third-party) history of missing some drinks between meals can be easily obtained in patients without cognitive deficits. For this parameter, a negative predictive value of 1.00 was reported (5). However, data on this parameter are only available from one working group. Another study provides an argument for paying attention to drinking behavior. It showed that geriatric patients with a lower fluid intake also reported a less intense feeling of thirst; consequently, they were more likely to have elevated serum sodium levels (19).

Axillary moisture is a parameter that was investigated in numerous studies. Axillary dryness seems to

indicate (hypertonic) dehydration with high specificity. In case of mere palpation-based findings, moisture quantification appears to be problematic.

To our surprise, one meta-analysis mentioned incident fatigue as a useful diagnostic criterion (5). It is noticeable in the cited studies that there is a large spread in the statistical values. Furthermore, weakness and exhaustion are classical criteria of frailty and difficult to quantify; thus, our team of authors does not believe it is appropriate to apply this criterion to geriatric patients.

The use of inferior vena cava (IVC) ultrasonography to assess the hydration status is an established method; however, only few studies on the geriatric population are available.

In our literature selection, Orso et al. proposed to diagnose dehydration (defined as an increased BUN/Cr ratio) by determining both the expiratory IVC diameter with a cut-off value of 1.55 cm and the caval index with a cut-off value of 48%, because of the high diagnostic accuracy achieved with this approach (14). Diederich and Burkhardt recommend to diagnose dehydration based on an inspiratory diameter of $\leq$ 0.4 cm, with a specificity of 0.80 (34). Boccardi et al. categorized the hydration status of geriatric patients based on the BUN/Cr ratio. They were unable to detect any differences between dehydrated, normally hydrated and hyperhydrated patients based on IVC ultrasound findings. However, this needs to be qualified by noting that rather unusual cut-off values were applied for the classification based on the BUN/Cr ratio (35).

One must not forget that the ability of IVC ultrasound to provide information about volume status is limited in patients with pulmonary hypertension and/

TABLE 3

Potential diagnostic utility of clinical examination

Publication		Reference standard	Key statistical figures	Evaluation	Comments/ notes
Method assessed: Incident axillary dryness					
Bunn & Hooper (2019) (6)		S-Osmol ≥ 295 mOsmol/kg	Sens. = 0.32 (95% CI [0.17; 0.48]) Spec. = 0.73 (95% CI [0.66; 0.81]) OR: 1.33 (95% CI [0.61; 2.90])	"some potential" to diagnose hyperosmolal dehydration (4)	Axillary mois- ture, palpated manually
Hooper et al. (2015) (5)	Eaton et al. (1994)* ¹		Sens. = 0.50 (95% CI [0.27; 0.73]) Spec. = 0.82 (95% CI [0.70; 0.90])		
	Shimizu et al. (2012)* ¹		Sens. = 0.36 (95% CI [0.11; 0.69]) Spec. = 0.83 (95% CI [0.59; 0.96])		
Eaton et. al (1994)* ² (13)		BUN/Cr ≥ 1:10 plasma osmolality ≥ 295 mOsmol/kg	Sens. = 0.50 (10/20 subjects) Spec. = 0.82 (54/66 subjects) PPV = 0.45; NPV =0.84	High NPV & good reproducibility support the use of this method.	
Fortes et al. (2014) (3)		normal hydr., WDD (S-Osmol ≥ 295 mOsmol/kg) and WEDD (BUN/Cr ≥ 20 & normal S-Osmol)	Both types of dehydration OR = 1.4 (95% CI [0.7; 3.0]) WDD: OR = 1.3 (95% CI [0.5; 3.1]) WEDD: OR = 1.7 (95% CI [0.7; 4.2])	Dry axilla increases the chance of diagnosing dehydration.	
Gross et al. (1992) (15)		Assessed normal hydr. (= 0) to severely dehydr. (= +3) (RR, S-Na & S-Osmol, BUN/Cr)	Kendall's Tau correlation = 0.19 p ≥ 0.05 (n = 53)	Small study population (n = 53)	
Shimizu et al. (2012)* ³ (11)		Calculated S-Osmolarity ≥ 295 mOsmol/L	Sens. = 0.44 Spec. = 0.89 OR = 4.0	Axillary dryness as potential sign of dehydration	Device-based measurement of skin moisture with skin moist- ure meter
Kinoshita et al. (2013) (10)			Cut-off <30% skin moisture: Sens. = 0.12; Spec. = 0.91 Cut-off 40% skin moisture Sens. = 0.59; Spec. = 0.09	Axillary dryness useful to confirm suspected diagnosis of dehydration	

*¹ The studies mentioned are included in the meta-analysis by Hooper et al. (2015) (5). The raw data of the mentioned working groups were obtained and re-analyzed according to the research question of Hooper, L. et al. The data analyzed are based on both previously published studies and unpublished data from various working groups. Due to this re-analysis, some of the results of the individual studies differ from those of the meta-analysis.

*² Results of the individual study by Eaton, D. et al. (1994) (13)

*³ Results of the individual study by Shimizu, M. et al. (2012) (11)

BUN/Cr, blood urea nitrogen to creatinine ratio; dehydr., dehydrated; hydr., hydrated; OR, odds ratio; S-Osmol, serum osmolality; S-Na, serum sodium; WDD, water-deficiency dehydration; WEDD, water- and electrolyte-deficiency dehydration.; Sens., sensitivity; Spec., specificity; 95% CI, 95% confidence interval

or severe tricuspid regurgitation. The prevalence of pulmonary hypertension in persons aged 65 years and older is reported to be 5% to 10% (36).

According to our literature search, studies on other modalities, such as chest X-ray, measurement of central venous pressure, measurement of pulmonary artery occlusion pressure, and thermolulution or pulse contour measurements, are not available for older patients.

The role of bioelectrical impedance analysis in the assessment of HS in old age remains undetermined; the ESPEN guideline recommends against using this method (33).

It is possible that electrolyte concentrations are decisive for the result of total body water measurements using bioelectrical impedance analysis: In a study by Berneis et al., the natural water loss in young healthy subjects was replaced by infusion of hypertonic saline solution. Consequently, the actual TBW remained unchanged and plasma sodium levels increased from 142 to 148 mmol/L. As the result,

bioelectrical impedance analysis showed an increase in TBW by 6.8% (37). However, studies comparing bioelectrical impedance analysis with isotope dilution methods come to more positive conclusions. This also applies to studies involving intra-individual controls (1, 21, 22); thus, it is currently not possible to predict the future significance of BIA.

Based on the analyzed literature, we currently consider the following parameters to be best supported by evidence with regard to the diagnosis of dehydration in older patients: directly measured serum osmolality, calculated serum osmolality and serum sodium levels, as well as inferior vena cava ultrasound. To a lesser extent, a (third-party) history of missing some drinks between meals as well as axillary dryness can contribute to the diagnosis.

Before this paper went to press, we re-applied the developed search string. Other working groups confirmed that the existing diagnostic tools are inadequate for diagnosing dehydration in older age (38). Combining conventional methods also failed to

TABLE 4

Potential diagnostic utility of technology-based methods

Publication	Reference standard	Key statistical figures	Evaluation	Comments/notes
Method assessed: Ultrasonography of the inferior vena cava				
Orso et al. (2016) (14)	BUN/Cr ratio ≥ 20	Exsp. IVC diameter: Cut-off value: 1.55 cm Sens. = 0.86 (95% CI [0.79; 0.90]) Spec. = 1.00 (95% CI [0.97; 1.00]) PPV = 1.00; NPV = 0.83 Caval index: Cut-off value: 0.48 Sens. = 0.99 (95% CI [0.96; 0.99]) Spec. = 1.00 (95% CI [0.97; 1.00]) PPV = 1.00; NPV = 0.99	Exceptional diagnostic quality of ultrasound → Re-evaluation advised, using populations with different definitions of dehydration	Caval index = [(maximum diameter – minimum diameter)/maximum diameter]
Method assessed: BIA resistance at 50 kHz (cut-off: 550 kOhm)				
Hooper et al. (2015) (5)	Allison et al. (2005)* Kafri et al. (2013)* Powers et al. (2012)* Stookey et al. (2005)*	S-Osmol ≥ 295 mOsmol/kg S-Osmol. ≥ 300 mOsmol/kg	Sens. = 0.18–0.80 Spec. = 0.61–1.00 PPW = 0.03–1.00 NPW = 0.26–0.96 Sens. = 0.17–1.00 Spec. = 0.61–0.91 PPV = 0.00–0.75 NPV = 0.56–1.00	Wide dispersion of sensitivity and specificity data for resistance upon re-analysis of the data in this meta-analysis
				Data from small individual studies → BIA better for intra-individual monitoring than for interindividual comparison

* The studies mentioned are included in the meta-analysis by Hooper et al. (2015) (5). The raw data of the mentioned working groups were obtained and re-analyzed according to the research question of Hooper et al. The data analyzed are based on both previously published studies and unpublished data from various working groups. Due to this re-analysis, some of the results of the individual studies differ from those of the meta-analysis.
BIA, bioelectrical impedance analysis; BUN/Cr, blood urea nitrogen to creatinine ratio; exsp., expiratory; IVC, inferior vena cava; NPV, negative predictive value; PPV, positive predictive value; S-Osmol, serum osmolality; Sens., sensitivity; Spec., specificity

achieve a significant improvement in diagnostic accuracy (32). This could be remedied by introducing innovative technology. Rodin et al. used a dehydration body monitor device—a polymer film-based photoplethysmographic device affixed to the case back-glass of a smartwatch—to measure the fluid loss in younger participants during a period of physical exercise. An advancement of this technology so that it can be used in geriatric patients is conceivable (39). Further technological innovations, such as smart containers or camera-based observations of the surrounding, could improve compliance with recommended fluid intake (40).

The available data indicate that all clinicians should critically reconsider their own approach for assessing the hydration status in older patients. To optimize the clinical assessment of patients' hydration status, there seems to be a need for the rejection of unsuitable methods in favor of either newly developed criteria or of a combination of the best criteria already in use. In everyday clinical practice, the combination of the above four criteria could be a start. It has to be prospectively evaluated in future studies.

Conflict of interest statement

RW is Member of the Board of the German Geriatric Society (DGG).

The remaining authors declare that no conflict of interest exists.

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► Supplementary material

eReferences, eMethods, eTable, eBox, eFigures:
www.aerzteblatt.de/m2023.0182

Supplementary material to:

Hydration Status Assessment in Older Patients

by Linda Deißler, Rainer Wirth, Birgit Frilling, Matthias Janneck, and Alexander Rösler

Dtsch Arztebl Int 2023; 120: 663–9. DOI: 10.3238/arztebl.m2023.0182

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eMETHODS

The methodological approach for the selective search of the literature

A selective search of the literature was performed, for which the search vocabulary was defined according to the PICO framework and divided into three main categories: hydration status, patient group and diagnostic methods. Keywords were selected using available MeSH terms and the PubMed keyword database. All keywords were linked to form a search string, using a Venn diagram (*eFigure 1*). All results published in PubMed up to and including September 2021 with full-text articles from medical journals were included in the analysis.

Using the search string, the database search yielded 355 articles that were subjected to a multistep selection process (*eFigure 2*), employing inclusion criteria previously defined by the author group (*eBox*). According to the criteria of the German Society for Geriatrics (DGG) (e5), we searched for data of patients aged 65 years and older, or, in the absence of age information, for existing need for nursing care, treatment in a geriatric facility, frailty or multimorbidity.

This left 24 articles, from whose references a further six articles were selected by reverse search, using the same procedure. This involved reviewing the references of the studies already included for suitability, using the selection process described above. In this step, six additional studies were included. A total of 30 full-text articles from medical journals were included in the analysis—29 individual studies and one meta-analysis.

First, we arranged the studies retrieved in a summary table (*eTable*) and then discussed the utility and clinical applicability of the described diagnostic procedures with all co-authors in two consecutive conferences. This positive selection was presented in smaller tables (*Tables 1–4*).

eTABLE

Overview of all studies included in our analysis

Reference method for determining HS	Publications/ study design	Study setting and study population	N	Methods assessed	Key messages
Hydration status: Hyperosmolar dehydration					
Directly measured serum osmolality, calculated serum osmolality, or rapid weight loss over a period of 7 days	Hooper et al. (2015) (5) meta-analysis	Hospital patients, residents of nursing facilities, persons living independently → Age: ≥ 65 years	3412	67 different clinical signs/symptoms, hemodynamic parameters, lab tests, BIA; among others: skin turgor; dryness of mouth, mucous membranes, axilla; systolic blood pressure, Schellong test, urine color, U-stix, BIA resistance, and more.	3 of the 67 methods studied were assessed as suitable: "Missed drinks between meals", expressing fatigue, BIA resistance at 50 Hz; potentially suitable: axillary dryness, among others.
Directly measured serum osmolality	Bunn & Hooper (2019) (6) Cross-sectional study	Long-term residents of nursing facilities: nursing homes, assisted living, special facilities for dementia patients → Age: ≥ 65 years → DRIE cohort	188	49 different clinical methods, incl. skin turgor, dry mouth, axillary moisture, capillary refill time, peripheral vein filling, among others.	There is a complete lack of diagnostic quality for determining dehydration.
	Siervo et al. (2014) (7) Cross-sectional study		186	36 equations for calculating serum osmolality	One formula (Khajuria & Krahn [2005] [31] Clin Biochem) was found to have utility in a geriatric population.
	Hooper et al. (2015) (8) Cross-sectional study	Hospitalized and non-hospitalized persons 5 different cohort studies → Age: ≥ 65 years → DRIE, NU-AGE and potentially Fortes, Sjöstrand, and Pfortmüller cohorts	595		Recommendation to use directly measured serum osmolality or a formula adjusted to the population.
	Hooper et al. (2016) (9) Cross-sectional study			13 different urine parameters, including urine color, urine specific gravity, volume, urinalysis, urine osmolality	Urine color, urine specific gravity and osmolality show only low diagnostic quality for identifying hypertonic dehydration.
Calculated serum osmolality	Kinoshita et al. (2013) (10) Cross-sectional study	Patients of an acute care hospital → age ≥ 65 years	29	Four clinical signs of dehydration: reduced skin turgor, sunken eyes, axillary dryness, device-based measurement of skin moisture in axilla (stated in %)	Axillary moisture levels > 50% can virtually rule out dehydration.. Axillary moisture of <30% is suggestive of hypertonic dehydr. (Spec. = 0.91; Sens. = 0.12).
	Shimizu et al. (2012) (11) Cross-sectional study		27	Six clinical signs of dehydration: impaired consciousness, dryness of axilla, mucous membranes and mouth, sunken eyes, skin turgor, capillary refill time, laboratory parameters	Incident dry axilla (Sens. = 0.44; Spec. = 0.89) shows high specificity in detecting hyperosmolar dehydration.
	Wojzel (2020) (12) Cross-sectional study		358	Serum parameters: sodium, potassium, urea, glucose	Best results (ROC analysis) for sodium with a cut-off value of 140 mmol/L sensitivity 0.80; specificity 0.83.
	Sanson et al. (2021) (2) Retrospective cohort study		4613	Serum and urine parameters: Serum sodium, potassium, urea, creatinine; BUN/Cr, hematocrit, urine specific gravity	Only serum sodium and urea showed a significant progressive increase with an increase in serum osmolality.

Hydration status: hyperosmolal and iso-osmolal dehydration					
Directly measured serum osmolality and BUN/Cr	Fortes et al. (2015) (3) Cross-sectional study	Patients of an acute care hospital → Age: ≥ 60 years	178	7 clinical and hemodynamic signs of dehydration: tachycardia, systolic blood pressure < 100 mm Hg, dryness of mucous membranes and axilla, skin turgor, capillary refill time, sunken eyes	All clinical signs were found to have low sensitivity (0.0–0.44). Salivary osmolality had a sensitivity of 0.7 and a specificity of 0.68 to diagnose both types of dehydration.
	Eaton et al. (1994) (13) Cross-sectional study	Geriatric acute patients → Age: ≥ 70 years	100	Axillary moisture: manually palpated sweat excretion and sweat excretion measured by placing tissue paper in the axilla	Palpation of a moist axilla was found to have a high negative predictive value (84%). Potential utility as an exclusion criterion.
Hydration status: dehydration					
BUN/Cr	Orso et al. (2016) (14) Cross-sectional study	Patients in emergency department → Age: ≥ 70 years	270	Ultrasonography of inferior vena cava: absolute expiratory diameter, caval index, shock index, among others	Significantly lower values of expiratory diameters in dehydrated patients (1.3±0.5 cm vs. 1.7±0.4 cm; p<0.001); higher caval index in dehydrated patients (75 vs. 40%; p = 0.01); caval index with cut-off values of 48%: Sens.= 0.993, Spec.= 1.0 for diagnosing dehydration; cut-off value of 1.55 cm for the expiratory diameter: Sens.= 0.855, Spec.= 1.00.
Clinical synopsis based on systolic blood pressure, serum sodium, BUN/Cr, serum osmolality	Gross et al. (1992) (15) Cross-sectional study	Acute patients in an emergency department → Age: ≥ 60 years	55	38 clinical signs: vigilance, sunken eyes, skin turgor, mucosal dryness, axillary moisture, and more.	Some methods showed a significant correlation with patient age (e.g., skin turgor) but not with hydration status.
Clinical synopsis: Medical history, physical examination, fluid intake, weight changes	Vivanti et al. (2008) (17) Cross-sectional study	Inpatients in a geriatric rehabilitation facility → Age: ≥ 60 years	43	Hematological and urine parameter, hemodynamic measurements, clinical signs: oral mucosal dryness, skin turgor.	No statistically significant differences in urine parameters, hematological and serological parameters between patients classified as dehydrated or euhydrated.
	Vivanti et al. (2013) (16) Cross-sectional study		10	Hourly weight fluctuations within 9 h for three consecutive days.	Weight fluctuations between 0.3% and 2.8% observed in euhydrated patients. Weight fluctuations < 3% should not be used as an indicator of dehydration.
Serum uric acid	Yoshihara et al. (2007) (18) Cross-sectional study	Outpatients of a national screening program → Age: 76 years	403	Salivary samples: salivary flow rate, salivary spinnability	A statistically significant difference in salivary spinnability between subjects with uric acid concentrations ≥/ < 7 mg/dL was found.
None	Johnson & Hahn (2018) (4) Cross-sectional study	Nursing home residents → Age: 64–103	60	Correlation between hematological parameters, urine parameters (for example: FRI = urine specific gravity, urine osmolality, urine creatinine and urine color), clinical signs, hemodynamic parameters, sense of thirst, medical history	No statistically significant correlation between FRI and measured serum osmolality or serum sodium; patients with increased FRI reported a less pronounced sense of thirst; clinical examinations did not correlate with other markers of dehydration.
	Ekman, L. et al. (2020) (219) Cross-sectional study	Patients of a geriatric rehabilitation facility with status post hip fracture → Age: ≥ 65 years	38		Low fluid intake correlated strongly with increased urine specific gravity. Patients with low fluid intake reported a less pronounced sense of thirst. Patients with a fluid intake of < 800 mL/d were found to have more concentrated urine and had lost weight in the previous month. Urine specific gravity proposed as a potential marker of low-intake dehydration.

Hydration status: global HS

TBW, ECW using isotope dilution methods	Olde Rikkert et al. (1997) (1) Prospective observational study	Geriatric hospital inpatients → Age: ≥ 70 years	53	MF-BIA, weight changes	Utility of individual BIA measurements for diagnostic purposes questionable; serial measurements useful for evaluation of treatment response.
	Olde Rikkert et al. (1998) (20) Prospective observational study			Hematological parameters: serum sodium, potassium, urea, creatinine, hematocrit; BUN/Cr; observation for 16 months	In euvoletic patients, the median of all serially measured laboratory parameters was within the population-based normal ranges. One-time testing of the parameters showed high interindividual variability; intraindividual variability much less pronounced.
	Powers et al. (2009) (21) Cohort study	Patients of an acute care hospital → Age ≥ 65 years	32	TBW estimation using BIA, anthropometric measurements	BIA measurements did not differ significantly when compared to the isotope dilution analysis.
	Ritz (2001) (22) Cohort study		169		TBW using BIA (50 kHz): Difference of 0.48 ± 2.3 L compared to isotope dilution analysis; BIA measurement are useful for monitoring patients with shifts in fluid and volume status.
	Hoyle et al. (2011) (23) Cohort study	Geriatric hospital inpatients with hyponatremia → Age: ≥ 65 years	22	BIA measurements: TBW, ECW Clinical examination: mucosal dryness, axillary dryness, skin turgor, peripheral edema, among others	Clinical assessment showed only moderate inter-individual agreement ($\kappa = 0.59$; $p < 0.001$). BIA-TBW showed a clear linear relationship with TBW measurements by isotope dilution ($r = 0.69$; $p < 0.001$).

Clinical assessment of HS based on weight, HR, sunken eyes, mucosal dryness, skin turgor, peripheral venous filling, among others	Rosher & Robinson (2004) (24) Uncontrolled, non-randomized interventional study	Nursing home residents → Age: ≥ 70 years	51	Intervention: 9-week hydration program with minimum intake of 470 mL in addition to previous oral fluid intake. Measurements: BIA, physical examination	Stat. significant increase in TBW, measured using BIA at the end of the program; improvement in filling of veins on the dorsum of the foot; no effect on other clinical signs
	Rösler et al. (2009) (25) Cohort study	Geriatric hospital inpatients → Age: ≥ 65 years	103	BIA: resistance, reactance, vector analysis, anthropometric measurements.	Agreement of expert assessment with BIA measurements in 40/60 cases in euvoletic patients, but no agreement with regard to diagnosis of dehydration or hyperhydration (0/43)
	Cumming et al. (2014) (26) Cohort study	Hyponatremic inpatients with fragility fractures → Age: ≥ 70 years	125	BIA measurements & obtaining clinical signs, e.g. skin turgor, dry mouth, among others	BIA measurements have the potential to improve the assessment of volume status. In 23 of 33 cases with hyponatremia, the expert assessment of HS was consistent with the classification based on BIA measurements.
None	Wakefield et al. (2002) (27) Cohort study	Nursing home residents → Age: ≥ 65 years	89	Correlations between various parameters, including urine color, osmolality, specific gravity, and hematological parameters	Significant correlations between urine color and urine specific gravity ($r = 0.57$; $p < 0.001$) and urine osmolality ($r = 0.57$; $p < 0.001$); sign. correlations between urine osmolality and serum osmolality ($r = 0.37$; $p < 0.01$) and BUN/Cr ratio ($r = 0.39$; $p < 0.01$); no correlation between urine color and hematological & serological parameters
	Mentes et al. (2006) (28) Cohort study	Geriatric hospital inpatients → Age: ≥ 65 years	92	Correlation between urine specific gravity and urine color.	Correlations between urine color and urine specific gravity range from $r = 0.3$ to $r = 0.7$, depending on patient subgroup.
	Powers et al. (2012) (29) Cohort study	Hospital outpatients and inpatients → Age: ≥ 65 years	63	Correlation between various BIA (TBW, ECW) and urine parameters	No statistically significant correlations
Hydration status: Hyperhydration					
Clinical synopsis based on peripheral edema, pulmonary congestion, jugular venous congestion etc.	Coodley et al. (1995) (30) prospective cohort study	Patients with congestive heart failure and IV diuretic therapy → Age: ≥ 65 years	12	BIA resistance, reactance, TBW	Single measurements using BIA seem to have limited usefulness for monitoring diuretic therapy; consecutive measurements for intraindividual assessment may be considered.

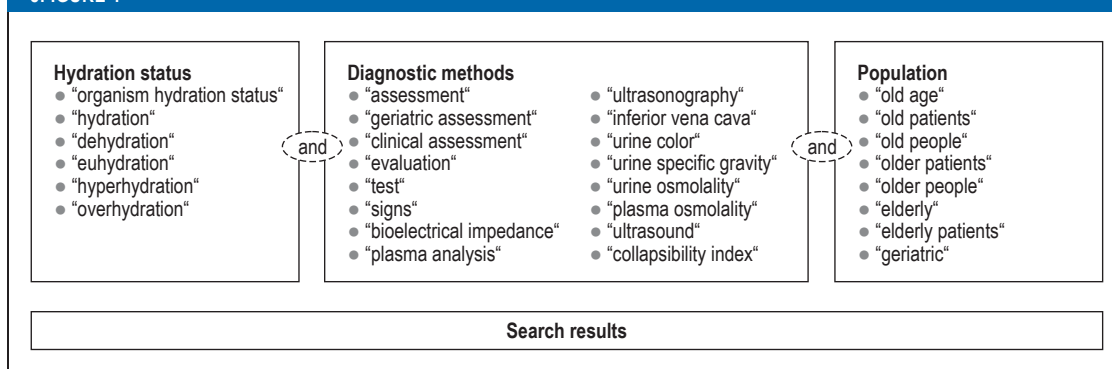
BIA, bioelectrical impedance analysis; BUN/Cr: blood urea nitrogen to creatinine ratio; ECW, extracellular water; FRI, Fluid Retention Index; HS, hydration status; IV, intravenous; MF-BIA, multi-frequency bioelectrical impedance analysis; pts, patients; CRT, capillary refill time; ROC analysis, receiver operating characteristic analysis; Sens., sensitivity; Spec., specificity; TBW, total body water

eBOX

Inclusion criteria of the screening process

- **Language**
 - English
 - German
- **Methods**
 - Primary literature and meta-analyses
 - Studies on diagnostic quality
 - Studies comparing methods for hydration status assessment with each other or with a reference method
- **Study population**
 - Patients aged 65 years or older
 - Groups of persons who, because of their frailty, represent a geriatric population (e.g. nursing facility residents, multimorbidity, frailty, nursing care needs)

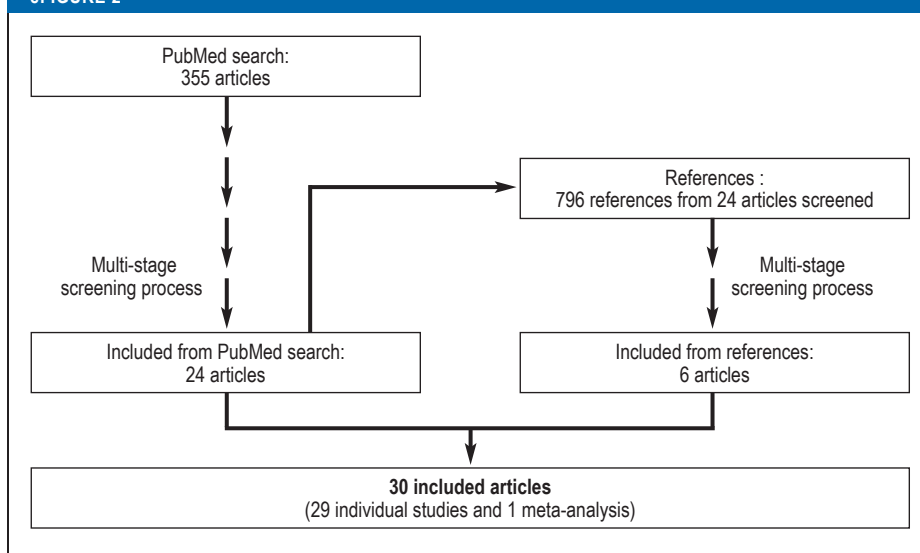
eFIGURE 1



Literature search according to the PICO framework

PICO, patient, intervention, comparison, outcome

eFIGURE 2



Literature selection process

s 22 (1)(a)(ii)

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s 22 (1)(a)(ii)
Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]
Attachments: Strengthened Quality Standards recommendations - Coroner Court of SA Inq... (3.12 MB)

OFFICIAL

Thanks s 22 (1)(a)(ii)

s 22 (1)(a)(ii) from OP&S has engaged with the FNDU to review and provide SME on the Coroner's recommendations for the Commission's guidance re: outcome 5.5 and examples of key tasks providers can take (Action 5.5.5) regarding the implementation of processes to maintain an individual's nutrition and hydration. The team also advised that the Department has stated that they will commit to include these recommendations in the first 5-year periodic review of the Quality Standards (due 2030).

Recommended changes to the Commission's provider guidance is advised to be scheduled for July 2026. I have also requested the correction to the current reference to actions as outcomes under Standard 5.

The FNDU and campaign team have previously published QB articles on the importance of hydration and person-centred strategies to encourage adequate intake (including thickened fluid considerations), but I agree with the approach of a dedicated resource, or clinical alert addressing this issue and would be happy to support.

I have also engaged the support of our clinical and clinical education units to review resources highlighted within the Commission's repository of guidance and determine if there are any others we can review and consider promoting in line with usual processes and requirements.

Please let me know if I can be of any further assistance in responding to the matter in addition to current support being provided.

Kind regards,

s 22 (1)(a)(ii) BSc MDietSt GradDipPH APD
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s 22 (1)(a)(ii)



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Subject: RE: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Just bringing in s 22 (1)(a)(ii) s 22 (1)(a)(ii) and s 22 (1)(a)(ii) as well

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake d. Responding to inadequate fluid intake

- For Rec 4 regarding changes to the standards, the dept is the policy holder so we would take any requests to them. There is also a question of where in the standards to adjust, ie the outcomes (compliance obligations) or actions (guidance published as a notifiable instrument). The third option which is more in our direct control is to adjust our guidance and promote any more specified practice.

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
 - That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

For Recs 5 and 6 – do we agree with updates recommended? Any risks?

Are there any plans under the current FNDU program to address hydration – perhaps the coroners rec's are a chance to do a clinical alert or Quality Bulletin article on it? Be good to get ^{s 22(1)(a)(ii)} thoughts here too

Kind Regards, ^{s 22(1)(a)(ii)}

^{1)(a)(ii)} (she/her)

Assistant Commissioner, Regulatory Strategy and Partnerships
Aged Care Quality and Safety Commission

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I live and work on Gadigal Country, land of the Eora Nation



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Subject: Re: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hello

s 47F

Recommendations 5 and 6 seems reasonable

Recommendation 4 could be addressed through our FNDU RBM and/or outreach work

I have seen this sort of scenario play out before

People with Lewy body dementia often experience periods (up to a week or less) of drowsiness which is usually self limiting. This is one of the Lewy Body diagnostic criteria along with cognitive impairment, parkinsonism and visual hallucinations

s47F(1)

s 22 (1)(a)(ii)

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Kaurna Country

#Everyone you meet is fighting a battle you know nothing about - be kind always



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Subject: FW: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi s 22 (1)(a)(ii)

Below is the email thread that originally arrived with Government Relations that made its way to the Coroner team. The original attachments are the PDF that came through from the SA Minister (not directly from the SA Coroner). The attached email is advice from DCSCRS that they replied to the minister acknowledging receipt. As discussed with you this week, the Coronial team will develop a procedure and log for when these types of recommendations come through to us. This includes supporting senior executive decision-making on whether to implement the recommendation, and a process for overseeing its implementation via the SRPC.

The recommendations to the Commission are at the end of the coroner's report, the PDF labelled Attachment 1. I've pasted them below.

Recommendations to the Commission:

Rec 4

- I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:
 - That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):
 - The provider implements processes to maintain an older person's hydration by:
 - a. Measuring the daily fluid intake of residents who are clinically dehydrated
 - b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s
 - c. Recognising inadequate fluid intake
 - d. Responding to inadequate fluid intake

Rec 5 & 6

- I make the following recommendations to the Aged Care Quality and Safety Commissioner:
 - That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
 - That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

s 22 (1)(a)(ii)



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 47E(d) SCRS <DeputyCommissionerSCRS@agedcarequality.gov.au>
Sent: Tuesday, 24 March 2026 10:09 AM
To: Coroner Inquiries <CoronerInquiries@agedcarequality.gov.au>
Cc: s 47E(d) SCRS <DeputyCommissionerSCRS@agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Subject: For Action: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi Team,

Please see attached Commissioner correspondence from the South Australian Minister for Health and Wellbeing, providing a copy of the Deputy State Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) Page 35 of the report lists recommendations for the Commission. Kindly for your review and action as appropriate.

@s 22 (1)(a)(ii) I believe the OOC were drafting a response from the Commissioner – I will follow up where this is at and confirm.

@s 22 (1)(a)(ii) Copying you in for visibility as some of the recommendations relate to Commission posters and educational resources.

Kind regards,

s 22 (1)(a)(ii) (She/Her)
Executive Officer to s 22 (1)(a)(ii) Deputy Commissioner
Sector Capability and Regulatory Strategy Division
E | s 22 (1)(a)(ii) agedcarequality.gov.au T | s 22 (1)(a)(ii)

Deputy Commissioner SCRS

Deputy Commissioner, Sector Capability & Regulatory Strategy

Aged Care Quality and Safety Commission

E s 47E(d) agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



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From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>

Sent: Monday, 23 March 2026 3:53 PM

To: s 47E(d) <s 47E(d) [@agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>

Subject: FW: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Yes, this can go to the coronial team etc. Can they draft a response for s 22 (1)(a)(ii) to send to the SA Minister?

Kind regards

s 22 (1)(a)(ii)



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From: s 47E(d) <s 47E(d) agedcarequality.gov.au>

Sent: Friday, 6 March 2026 4:57 PM

To: Office of the Commissioner <s 47E(d) [agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Cc: s 47E(d) <s 47E(d) [agedcarequality.gov.au](mailto:s 47E(d)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Subject: FOR ACTION: Letter from the SA Minister for Health and Wellbeing re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii) [SEC=OFFICIAL]

OFFICIAL

Hi ^{s 22 (1)(a)} (and ^{s 22 (1)(a)(ii)} absence next week)

See attached a letter from the South Australian Minister for Health and Wellbeing, the Hon Chris Picton MP to addressed to you providing a copy of the Deputy State Coroner's Inquest Findings into the death of ^{s 22 (1)(a)(ii)} There are several recommendations that have been directed to the Commission within.

Please let us know if you require assistance preparing a response to the Minister. Otherwise, we will leave with your office to action as appropriate.

Kind regards

^{s 22 (1)(a)(ii)}

^{s 22 (1)(a)(ii)}

Assistant Director, Parliamentary Services
Engagement, Education and Communication

Aged Care Quality and Safety Commission

E ^{s 22 (1)(a)(ii)} @agedcarequality.gov.au | W www.agedcarequality.gov.au

^{s 22 (1)(a)(ii)}

GPO Box 9819, Sydney 2001

I work part time and do not work on Tuesdays.



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s 22 (1)(a)(ii)

From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Tuesday, 7 April 2026 2:45 PM
To: s 22 (1)(a)(ii)
Cc: s 22 (1)(a)(ii); s 22 (1)(a)(ii); s 22 (1)(a)(ii)
Subject: Strengthened Quality Standards recommendations - Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL]
Attachments: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest int... (1.04 MB); RE: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest int... (1.84 MB)

OFFICIAL

Hi s 22 (1)(a)(ii)

I hope you are well.

I am reaching out as Sector Ed and the Department has alerted us to the Coroner's Court of SA's inquest into the death of an aged care resident in 2020 s47F(1)

These included the following recommendations for the Commission to action:

Strengthened Quality Standards

194 I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:

Four That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):

The provider implements processes to maintain an older person's hydration by:

- a. Measuring the daily fluid intake of residents who are clinically dehydrated*
- b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s*
- c. Recognising inadequate fluid intake*
- d. Responding to inadequate fluid intake*

While the Department has stated that they will commit to include these recommendations in the first 5 year periodic review of the Quality Standards (due 2030), they have suggested working with the

Commission to consider if/how the guidance supporting [Outcome 5.5/Action 5.5.5](#) can incorporate the suggestions included in the above recommendation, to further support the sector's understanding of the importance of hydration in the delivery of aged care services.

We have undertaken an analysis of the current SQS guidance (see attached) and found that while the provider guidance addresses hydration/dehydration recommendations in part or at a broader level, there is opportunity to strengthen the guidance to address these recommendations more specifically. We are looking to update these changes as part of continuous improvement processes.

We have made a start with some minor track changes to the provider guidance for Outcome 5.5/Action 5.5.5, and are now welcoming your consultation and expertise on how we can better revise these suggestions in line with best practice – [SQS Guidance updates for 5.5.5 24032026 DRAFT.docx](#)

We are keen to hear your insights and any further suggestions you may have.

.....

Commission posters/educational content

195 I make the following recommendations to the Aged Care Quality and Safety Commissioner:

- Five* That the poster “Preventing Urinary Tract Infections - Recognise Dehydration”, published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
- Six* That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

The inquest also made recommendations to amend the [Preventing Urinary Tract Infections: Recognising dehydration](#) poster – I am not sure if this had already been forwarded to your team for consideration.

We also found Commission web content that would benefit from your review: [Keep your fluids up!](#)

.....

Please reach out if you have any questions – happy to offer a discussion to talk through this in more detail if you would like.

Kind Regards,

s 22 (1)(a)(ii) (she/her/hers)
A/Assistant Director
Operational Policy and Support
Knowledge Management and Operational Policy

Aged Care Quality and Safety Commission

ES 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

ES 22 (1)(a)(ii)

GPO Box 9819, Sydney NSW 2001

Dharug Country



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s 22 (1)(a)(ii)

CORONERS COURT OF SOUTH AUSTRALIA

DISCLAIMER - Every effort has been made to comply with suppression orders or statutory provisions prohibiting publication that may apply to this judgment. The onus remains on any person using material in the judgment to ensure that the intended use of that material does not breach any such order or provision. Further enquiries may be directed to the Registry of the Court in which it was generated.

INQUEST INTO THE DEATH OF ADELINA D'ANGELO

[2026] SACC 1

Inquest Findings of her Honour Deputy State Coroner Kereru

12 February 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a woman living with dementia who experienced severe dehydration, leading to acute kidney injury, while under the care of staff at a residential aged care facility. The Inquest explored the circumstances leading to severe dehydration, whether there was a failure to recognise the developing condition and whether steps could have been taken to avoid reaching that state.

Held:

1. Adelina D'Angelo, aged 88 years of Campbelltown, died at the Royal Adelaide Hospital on 9 October 2020 as a result of acute on chronic renal failure due to dehydration on a background of Lewy body dementia, Parkinson's disease and congestive cardiac failure.
2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MS E ROPER

Interested Party: NORTH EASTERN COMMUNITY HOSPITAL INC

Counsel: MR R BÖNIG - Solicitor: FINLAYSONS LAWYERS

Witness: DR M GIORDANO & DR R KONOK

Counsel: MS S GILES - Solicitor: WALLMANS LAWYERS

Hearing Date/s: 28/05/2025-31/05/2025, 08/07/2025, 10/07/2025, 12/07/2025 & 31/07/2025

Inquest No: 30/2024

File No/s: 2046/2020

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**INQUEST INTO THE DEATH OF
ADELINA D'ANGELO
[2026] SACC 1**

Introduction

- 1 Mrs Adelina D'Angelo was born in Italy on 16 September 1932. She died on 9 October 2020, having recently turned 88-years-old.
- 2 Mrs D'Angelo suffered from a number of medical conditions including Lewy body dementia, congestive cardiac failure, myocardial infarction, Parkinson's disease, chronic kidney disease, fractured neck of femur (surgically repaired), hypothyroidism, urinary tract infection, hypertension and excision of squamous cell carcinoma.
- 3 In 2017, when Mrs D'Angelo was 84-years-old, she underwent an Aged Care Assessment and was placed into respite at the North Eastern Community Hospital Aged Care Facility (NECH) in Campbelltown, South Australia.
- 4 Mrs D'Angelo began respite for a four-week period from 22 June 2017 at NECH, after which she became a resident on a permanent basis.
- 5 Mrs D'Angelo's long term general practitioner (GP) was Dr Mario Giordano. Once she became a resident of NECH, Dr Giordano continued to visit her there for regular check-ups.
- 6 On 19 September 2020, Mrs D'Angelo was picked up and taken to the house of her daughter, Toni, for her planned birthday celebration with extended family and friends. She was observed to enjoy the day, including eating and drinking as usual.
- 7 On 26 September 2020, Mrs D'Angelo's daughter, Anna, visited her at NECH. Mrs D'Angelo was observed to be bright and her normal self, much as she was on her birthday the week before.
- 8 On 3 October 2020, Anna received a call from NECH advising that her mother's food and fluid intake had reduced in the last few days. She was further advised that a locum doctor had examined her, that her vitals were 'ok' and a urine sample was to be collected.
- 9 The locum doctor, Dr Raunak Konok, queried whether Mrs D'Angelo had suffered a stroke but did not order any specific medical intervention, with the nurse recording in the clinical notes that there was '*nothing to be done*'.
- 10 On 4 October 2020, Mrs D'Angelo was observed to be less responsive. Following a phone call with a family member, Toni, who insisted that an ambulance be called, Mrs D'Angelo was conveyed and then admitted to the Royal Adelaide Hospital (RAH).
- 11 On admission to the RAH, Mrs D'Angelo was noted to be sleeping but responding to voice. Her vital signs were abnormal, and she was found to be dehydrated with a high sodium level of 163 mmol/L, high creatinine level of 210 μ mol/L and high urea level of 39.7 mg/dL. She was diagnosed with dehydration and presumed pre-renal acute on chronic kidney injury due to her poor oral intake. Despite intravenous fluid resuscitation she deteriorated and became hypotensive, bradycardic and less responsive.

- 12 Following a family discussion, Mrs D'Angelo was commenced on palliative care and pronounced life extinct on 9 October 2020.

Reason for report of death and cause of death

- 13 A Medical Report of Death was received by the Coroners Court of South Australia following Mrs D'Angelo's death. The report was made due to concerns raised by the D'Angelo family to RAH clinicians about her care at NECH. The opinion of the reporting medical officer as to her cause of death was '*severe dehydration*'.
- 14 Following receipt of the Medical Report of Death, a coronial investigation was commenced and an autopsy on Mrs D'Angelo's remains was directed. Associate Professor (A/P) Neil Langlois, forensic pathologist at Forensic Science SA, undertook the post-mortem examination. On 29 April 2021, A/P Langlois furnished his post-mortem report.
- 15 A/P Langlois' opinion was that Mrs D'Angelo's death was a result of *pneumonia complicating inanition with dehydration and urinary tract infection on a background of Parkinson's disease and Lewy body dementia*.¹
- 16 During the course of the coronial investigation, an expert report was obtained from Professor Craig Whitehead, consultant geriatrician. In his report, he opined that Mrs D'Angelo appeared to have died of *dehydration precipitating acute kidney injury and renal failure*.² Professor Whitehead explained that he did not believe that significant urosepsis was involved in her death.
- 17 A/P Langlois was asked to comment on this opinion in a supplementary post-mortem report. He observed that while he and Professor Whitehead did differ in their placing of significance on factors contributing to death, they were in agreement on what they considered to be the main elements of death; dementia and dehydration. A/P Langlois opined:

I consider the dementia to be the underlying process that has led to her death with dehydration being the precipitant of her death at the time. The contribution of other factors could be debated, but their inclusion or not in the cause of death would remain matters of individual opinion that I feel are peripheral to the key issues being considered in this case.³

- 18 For reasons that I have set out in detail below, I find Mrs D'Angelo's cause of death to be:

Acute on chronic renal failure due to dehydration on a background of Lewy body dementia, Parkinson's disease and congestive cardiac failure.

¹ Exhibit C2a

² Exhibit C15, page 4

³ Exhibit C2b

Evidence at Inquest

- 19 The documentary evidence at Inquest comprised 43 exhibits.
- 20 In addition to the documentary evidence, oral evidence was heard from:
- Associate Professor Neil Langlois, Forensic Pathologist, Forensic Science SA
 - Dr Mario Giordano, General Practitioner
 - Dr Raunak Konok, General Practitioner/Locum Medical Practitioner
 - Ms Vivian Ebhodaghe, Registered Nurse, North Eastern Community Hospital
 - Ms Cara Miller, Chief Executive Officer (CEO), North Eastern Community Hospital
 - Professor Craig Whitehead, Expert Geriatrician
- 21 In these findings I will not summarise all the evidence tendered or heard at the Inquest but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

Hindsight bias

- 22 I warn myself concerning a vital consideration in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias.
- 23 A description of ‘hindsight bias’ is given in the Australasian Coroners Manual, namely:
- The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person’s reputation ...
- Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.
- 24 As I have said, I am very mindful of this warning when considering the evidence in this Inquest.

Adelina D'Angelo

- 25 In the affidavits provided by her family, Mrs D'Angelo was described as a caring and generous daughter, wife, mother and grandmother. She had an active social life, dominated by family events such as weddings, birthdays, Catholic feasts and dances. She would often ‘*cook up a storm*’ and ring her children to come and collect food. This generosity also extended to her neighbours. She was described as instilling important values in her children such as respect, humility and consideration for others.
- 26 By way of background, Mrs D'Angelo was born in 1932 in Italy. She met her husband, Giorgio while living in Italy. Mr D'Angelo migrated to South Australia in late 1956 with

Mrs D'Angelo following in early 1957. They married on 5 February 1958. Mrs D'Angelo worked at Penfolds Wines before they started a family. They had four children; Anna, Antonia (known as Toni), Donata and Mario.

- 27 The D'Angelo family lived on a 2,000 square metre property in Magill. The family lived in a small house there. Mrs D'Angelo's daughter Anna remembered a large vegetable garden and a number of chickens in their backyard.
- 28 When her youngest child started school, Mrs D'Angelo re-entered the work force, taking up employment in bakeries. She often worked the late and early morning shifts, allowing her to continue to look after her family and their home during the day.
- 29 In 1968, the D'Angelo family built a new home on their land in front of the existing house. Once moving into the newly built home, they rented their former home to a single parent with two children.
- 30 Around 1976, Mrs D'Angelo's mother moved into the granny flat at the family home. She remained there until her death in 1994. Mrs D'Angelo took a very active grandparent role, so her children were able to work full time. Anna described being a grandmother as bringing Mrs D'Angelo much joy.
- 31 When her husband's health declined, Mrs D'Angelo cared for him until his death in 2012. With the prospect of being alone in the house and the four children now grown up with their own families, a decision was made to ensure that Mrs D'Angelo was cared for. That included a family member moving in with Mrs D'Angelo, and her children regularly visiting and spending time at the house.
- 32 When Mrs D'Angelo was 84-years-old she underwent an Aged Care Assessment after a hospital admission where she was diagnosed with delirium on a background of functional decline. With much consideration and some agonising from her children, it was agreed that Mrs D'Angelo would spend time at an aged care facility for respite in June 2017. This aged care facility was NECH. As often occurs with respite arrangements for the elderly, Mrs D'Angelo's respite stay was transitioned into a permanent residency at the same facility.

Dr Mario Giordano

- 33 Dr Mario Giordano gave evidence at the Inquest. He had been Mrs D'Angelo's treating GP for more than 20 years. The clinical records of consultations with Mrs D'Angelo produced to the Court commenced on 14 September 2000.
- 34 Dr Giordano received his Bachelor of Medicine and Surgery from the University of Adelaide in 1978. He undertook his internship at the RAH and then at the Modbury Hospital in 1978. He then worked as a Resident Medical Officer at the Women's and Children's Hospital (named the Children's Hospital at the time) and the Queen Victoria Hospital where he furthered his studies in obstetrics, obtaining a diploma in obstetrics at the Royal Australian College of Obstetricians and Gynaecologists. In 1980, he began practice as a general practitioner.
- 35 Following Mrs D'Angelo entering NECH, Dr Giordano visited her at the facility and continued to consult with her there. These consultations were every 4-6 weeks in addition

to any specific request by nursing staff for a particular ailment. The frequency of these visits decreased during the COVID-19 pandemic as entry restrictions were placed on nursing homes. Dr Giordano gave evidence that he was immunocompromised due to cancer treatment, and in July 2020 he had stopped attending aged care facilities.

- 36 Dr Giordano had very little independent memory of the events relating to Mrs D'Angelo. He relied on a combination of his clinical records and his usual practice to assist while giving evidence.
- 37 The relevance of Dr Giordano's involvement in the events leading up to Mrs D'Angelo's death related to his treatment of Mrs D'Angelo's pre-existing medical conditions, and the medications that he prescribed for them. Most importantly however were the results of routine biochemistry testing on 26 June 2020 which revealed a level of hypernatremia, or high sodium levels. This was the subject of considerable evidence and will be detailed below.

Dr Raunak Rahat Konok

- 38 Dr Raunak Konok completed her Bachelor of Medicine and Surgery in 1996 at the Bangladesh Medical College and moved to Australia to practice in 2004. Upon arrival, she passed exams and undertook a year as an intern and then a year as a registered medical officer in psychiatry and a year in paediatrics at the Women's and Children's Hospital. In 2013, Dr Konok commenced working as a locum, including work at the Salisbury Super Clinic in 2016. In 2020, Dr Konok was employed as a GP at Surrey Downs Medical Centre as well as continuing as a locum doctor.
- 39 Dr Konok's only involvement with Mrs D'Angelo was on 3 October 2020, when she was called, in her capacity as a locum, to attend NECH to assess Mrs D'Angelo due to concerns that she was lethargic and was excessively sleeping.⁴ Her observations and assessment were the subject of oral evidence because Dr Konok did not initiate any active treatment for Mrs D'Angelo despite her suspecting that she had suffered a life threatening condition (stroke). This approach was against the expressed end of life wishes in Mrs D'Angelo's Palliative Care Plan.⁵

Professor Craig Whitehead

- 40 Professor Craig Whitehead is a senior consultant geriatrician who has been in consultant practice for 30 years. He is currently appointed as the Regional Clinical Director of Rehabilitation, Aged and Palliative Care in the Southern Adelaide Local Health Network. He is also a professor with Flinders University and is on the board of directors of the aged care provider Helping Hand. In his routine clinical practice, he sees residents in residential aged care and has experience with managing general medical problems in this frail, elderly population. Professor Whitehead carries out his clinical work at the Repatriation General Hospital, Flinders Medical Centre, Noarlunga Health Service and also at Victor Harbor.

⁴ Exhibit C7a

⁵ Exhibit C6a, page 32.

- 41 Professor Whitehead prepared an expert overview of Mrs D'Angelo's care at NECH and gave extensive oral evidence at the Inquest.
- 42 It is important to note that Professor Whitehead gave expert evidence in this Inquest about the care provided to Mrs D'Angelo by general practitioners, registered and enrolled nurses and personal care assistants. In his evidence he frequently acknowledged that his training and experience placed his opinions at a level that he would not apply to other clinical staff. I have taken this into account when reaching certain findings in this matter.

Dehydration vs renal impairment – The cause and effect

- 43 A/P Langlois was called to give oral evidence at the Inquest. His opinion about the cause of death and that suggested by Professor Whitehead was the subject of cross-examination. A/P Langlois explained that in forming his conclusion that Mrs D'Angelo was dehydrated, he relied on the blood tests results, the hospital diagnosis and the changes he observed to the kidneys, which would support the possibility of dehydration as a cause of acute kidney injury. When considering the blood test results from the sample taken at 12:35 on 4 October 2020, he stated that the pattern he could see, of a very high urea and moderately but not dramatically high creatinine, was the pattern he associated with dehydration causing renal failure. While he noted that dehydration would not necessarily be the only cause of acute renal injury, it was his evidence that he could not see any other definite cause for the kidney injury he observed.⁶ His observations were based on the macroscopic and microscopic findings of the kidneys during the post-mortem examination which were set out in some detail in his report.⁷
- 44 When asked if he would review the cause of death he had given in his original report, A/P Langlois suggested that the cause could be rephrased as 'dehydration complicating dementia' or 'dementia complicated by dehydration'.⁸ He did not advocate for the inclusion of the reference to a urinary tract infection in the cause of death, noting that he initially included it as a possible reason why Mrs D'Angelo may have stopped eating and drinking, as such an infection is known to cause changes in behaviour in older persons. As to whether any infection was clinically significant, he stated that he would defer to Professor Whitehead, who opined that Mrs D'Angelo did not have a clinically significant urinary tract infection and that this issue was irrelevant to the cause of death.⁹
- 45 As to other possible causes or contributing factors to Mrs D'Angelo's death, A/P Langlois was cross-examined extensively. The primary alternative hypothesis put to him was that kidney failure may have caused Mrs D'Angelo to experience difficulty swallowing, eating and drinking, and that this caused her to become dehydrated, rather than a lack of fluids being provided. Once again, A/P Langlois deferred to Professor Whitehead's opinion as a clinician. However, he stated that he could see no reason why acute renal impairment may have started and then led to the problems described.¹⁰ He did however acknowledge the nexus between renal impairment creating a change in behaviour, such as a decrease in fluid intake.

⁶ Transcript, page 35 and 42

⁷ Exhibit C2a, page 8

⁸ Transcript, page 75

⁹ Transcript, page 520

¹⁰ Transcript, page 59

- 46 Importantly, A/P Langlois cautioned that drawing inferences from post-mortem examination of the kidneys is problematic, as they are very active organs during life and it is difficult to tell even under the microscope whether the damage seen occurred during life or as a consequence of death. He explained *'You cannot always extrapolate backwards.'*¹¹
- 47 A/P Langlois agreed that when taken at face value, prior blood test results from 11 July 2018 and 25 June 2020 indicated a degree of renal impairment. The caveat given by A/P Langlois in relation to his assessment of renal function based on these test results was that it was his understanding that the eGFR was a controversial method of assessing renal function. This was a matter on which Professor Whitehead later agreed in his oral evidence and had also given evidence about in a previous Inquest.¹² Given that controversy was addressed in detail in that Inquest, I will not discuss it in detail here.
- 48 The most persuasive evidence from the pathological perspective was A/P Langlois' finding of pitting of the renal cortical surface and cortical atrophy at autopsy. These changes, as he explained further in his oral evidence, were indicative of chronic renal impairment.¹³
- 49 It was suggested to A/P Langlois that Mrs D'Angelo's failure to improve when administered intravenous fluids in hospital supported the hypothesis that renal impairment caused the dehydration, rather than the other way around. On this topic, A/P Langlois again stated that he would defer to Professor Whitehead, however he did suggest that by the time Mrs D'Angelo presented to hospital, there had been further renal impairment due to the dehydration, and she was now in a situation that was in his words *'irreversible'*.
- 50 Professor Whitehead was not asked to address the suggestion that Mrs D'Angelo's failure to improve when administered fluids indicated that dehydration was the consequence of renal failure, rather than the reverse. He did however explain that he would not have expected the administration of fluids to have reversed the dehydration, as in his experience, such a process takes several days.¹⁴ While he queried the initial choice of normal saline administered at the hospital, it was his view that this decision did not make a huge difference to the outcome.¹⁵ I understood that A/P Langlois and Professor Whitehead were very much in agreement on this issue.
- 51 The hypothesis of renal failure causing dehydration was put to Professor Whitehead. He explained that high output renal failure or a renal obstruction can cause dehydration, however he opined that it was extremely unlikely as there was no evidence of renal obstruction.¹⁶ Accordingly, it was his evidence that it was extremely unlikely that renal failure caused dehydration.

¹¹ Transcript, page 52

¹² *Inquest into the death of Millicent Glenn* [2025] SACC 24

¹³ Transcript, page 56-57

¹⁴ Transcript, page 545

¹⁵ Transcript, page 546

¹⁶ Transcript, page 617

- 52 Further, Professor Whitehead expressed the view that Mrs D'Angelo almost certainly had a degree of chronic kidney disease and that this made her more prone to developing acute kidney injury.¹⁷ As explained by A/P Langlois, *'when a kidney has been damaged and then you put another insult on top of it, you make a person dehydrated, then of course that can lead to kidney failure.'*¹⁸
- 53 I am satisfied that with the combined evidence of A/P Langlois, Professor Whitehead and also Dr Giordano, it is open on the evidence to find that Mrs D'Angelo had a degree of chronic renal impairment before her deterioration in September 2020 and I am satisfied that I should make that finding. However, the acute kidney injury detected at autopsy was caused by dehydration.
- 54 There is no evidence to support a finding that Mrs D'Angelo's chronic renal impairment was the cause of her severe dehydration, which was diagnosed upon her admission to hospital on 4 October 2020. It may well have exacerbated the detrimental effect of dehydration on her kidneys, but there is no evidence that renal failure suddenly caused Mrs D'Angelo to refuse food and fluid in September 2020.
- 55 The possibility of a cardiac cause of death was also explored during the inquest. A/P Langlois expressed the view that he did not consider the condition of the heart to be a significant factor in Mrs D'Angelo's death.¹⁹
- 56 That opinion was supported by the report of cardiologist Dr Garry Helprin.²⁰ Dr Helprin opined that Mrs D'Angelo did not experience a myocardial infarction, and that the troponin rise seen in the blood test results of 4 October 2020 was simply due to dehydration and renal impairment.²¹ This evidence has informed me in coming to the conclusion I set out at the beginning of these findings; that the provoking cause of Mrs D'Angelo's death was acute on chronic renal failure caused by dehydration. Underlying this was Lewy body dementia, Parkinson's disease and congestive cardiac failure (the latter for which she was prescribed frusemide and spironolactone).

Dehydration – A broader issue

- 57 While this inquest explored several possible missed opportunities to prevent the death of Mrs D'Angelo, an issue of significant and national concern emerged during the evidence of Professor Whitehead.
- 58 As explained by Professor Whitehead, the natural history of dementia (part of ageing itself) is to lose the sensation of thirst. As people develop cognitive impairment not only do they fail to be thirsty, but they lack the faculties to seek and find food and fluids to maintain hydration.²²
- 59 It was his evidence that the hospitalisation of severely dehydrated aged care residents is very common in his experience. He explained that he sees a procession of elderly patients

¹⁷ Transcript, page 547

¹⁸ Transcript, page 34

¹⁹ Transcript, page 26

²⁰ Exhibit C21

²¹ Exhibit C21, page 5

²² Exhibit C15, page 2

coming into the hospital with dehydration. In fact, he told the court that the weekend before he attended to give evidence, three people were admitted in exactly the same advanced dehydration condition as Mrs D'Angelo.

- 60 What is clear from the evidence is that dehydration is an underappreciated problem for older Australians living in residential care. As lamented by Professor Whitehead, the failure to address hydration in a meaningful way can lead to potentially preventable deaths. While the aged care industry is highly regulated, those regulations appear to be naive to the issue of hydration. Meaning that there is no specific aged care quality standard exclusively directed to dehydration. While there are mentions of hydration within the nutrition standard, those are not sufficiently individualised. There is no mandated minimum fluid prescription for residents, even those deemed to be at high risk of dehydration. The Aged Care Quality Standards were under review during the Inquest, with the draft standards received into evidence.²³ The draft standards proposed the following actions:

Nutrition and hydration

5.5.5 The provider implements processes to maintain an older person's nutrition and hydration by:

- a) conducting regular malnutrition screening
- b) minimising the impact of chronic conditions
- c) responding to the risk of malnutrition and when an older person is malnourished or has unplanned weight loss or gain.

...

6.1.2 The provider implements a system to monitor and continuously improve the food service in response to:

- a) the satisfaction of older people with the food, drink and the dining experience
- b) older people's intake of food and drink to ensure it meets their nutritional needs (including review of identified unplanned weight loss and malnutrition identified in Standard 5)
- c) the impact of food and drink on the health outcomes of older people
- d) contemporary, evidence-based practice regarding food and drink.

...

6.2.1 As part of assessment and planning, the provider assesses and regularly reassesses each older person's nutrition, hydration and dining needs and preferences. The assessment considers:

- a) the specific nutritional needs of older people, including a focus on protein and calcium rich foods
- b) the older person's dining needs
- c) what the older person likes to eat and drink
- d) when the older person likes to eat and drink
- e) what makes a positive dining experience for the older person
- f) clinical and other physical issues identified that impact the older person's ability to eat and drink.

²³ Exhibit C12a

Note: 'Clinical and other physical issues' may include consideration of a person's oral health, ability to chew and swallow, the impact of medications on appetite, seating and positioning requirements for eating and drinking, dexterity, physical assistance needed to eat and drink, etc.

- 61 Following the conclusion of the inquest, I received into evidence the final Strengthened Aged Care Quality Standards that took effect on 1 November 2025.²⁴ They include the same deficiency. The final text reads:

Nutrition and hydration

5.5.5 The provider implements processes to maintain an individual's nutrition and hydration by:

- a) conducting regular malnutrition screening
- b) minimising the impact of chronic conditions
- c) responding to the risk of malnutrition and when an individual is malnourished or has unplanned weight loss or gain.

...

6.1.2 The provider implements a system to monitor and continuously improve the food and drinks service in response to:

- a) the satisfaction of individuals with the food, drink and the dining experience
- b) individuals' intake of food and drink to ensure it meets their nutritional needs (including review of identified unplanned weight loss and malnutrition identified in Standard 5)
- c) the impact of food and drink on the health outcomes of individuals
- d) contemporary, evidence-based practice regarding food and drink.

...

6.2.1 As part of assessment and planning, the provider assesses and regularly reassesses each individual's nutrition, hydration and dining needs and preferences. The assessment considers:

- a) the specific nutritional needs of individuals, including a focus on protein and calcium rich foods
- b) the individual's dining needs
- c) what the individual likes to eat and drink
- d) when the individual likes to eat and drink
- e) what makes a positive dining experience for the individual
- f) clinical and other physical issues identified that impact the individual's ability to eat and drink.

- 62 This Inquest has therefore illuminated a critical gap in the oversight and management of aged care facilities. It was plain from the evidence of current Chief Executive Officer of the North Eastern Community Hospital Incorporated, Cara Miller, that there would be little utility in suggesting that aged care facilities voluntarily commence the monitoring of minimum fluid prescription for residents. She indicated that in some facilities, there is no funding available for these extra care requirements. Ms Miller explained:

Yeah, I think - so at the moment the funding that exists for the delivery of services under the eight standards that are currently legislated and monitored by the commission a requirement for documenting regular fluid intake is not as prescriptive as what I'm suggesting you're saying. In that regard if there was to be a change that then has a flow

²⁴ Exhibit C22b

on effect to the staffing to be able to deliver and document that. At this stage I think it's very widely reported that there's a lot of pressure on the aged care systems. A significant number of providers are not profitable and to have extra care and nursing requirements that would need to be delivered for that greater oversight, not just in review of monitoring but recording, that would I would suggest need to be something that would need to be stipulated by the Commonwealth and the commission as a set of standards in the proposed new standards. That would need to have a requirement around what we're currently hearing and monitoring about care and nursing minutes per resident per day. So if there's a greater expectation around that that would then have to flow into a funding model that would meet the requirements for those staff members to be available to execute that greater monitoring and compliance if that was to be set as a standard.²⁵

- 63 While some facilities may recognise the urgent need to prioritise this issue, others may not or simply do not have the resources, resulting in a lack of consistency in the care provided to older Australians.

The diagnosis of dehydration in the elderly – A misconception

- 64 Underpinning the broader issue above, and a contributing factor to the failure to detect Mrs D'Angelo's dehydration at an earlier time, was the widespread misunderstanding in relation to how dehydration in older persons can be detected. It is a common misconception that dehydration will manifest in clinical features in the aged. Dr Giordano, Dr Konok, RN Ebhodaghe and Ms Miller all gave evidence that their understanding of the generic signs of dehydration was that it could be detected with certain clinical features. Professor Whitehead explained that this is not the case in the elderly.
- 65 It was the uncontested evidence of Professor Whitehead that there are no reliable physical signs of dehydration in older adults, and the only way it can be reliably detected is by measuring the concentration of the blood.
- 66 He told the Court that there had been significant studies over the years indicating that the physical signs of dehydration are unreliable in older adults. This information is contained within most of the text books in the area of geriatric medicine. Professor Whitehead explained that dehydration is technically and accurately defined as being hyper-concentrated. However, in his experience, doctors typically confuse dehydration with hypovolaemia, or low blood volume. While the concepts are related, he explained that a person must be very concentrated in order to become hypovolaemic.²⁶
- 67 Further, the external signs of being dehydrated, or hyper-concentrated, are actually very unreliable. Professor Whitehead explained that a common misconception exists that you can tell a person is dehydrated from the end of the bed.²⁷ This is the precise misconception that was borne out in the evidence of Dr Giordano, Dr Konok, Ms Miller and RN Ebhodaghe.

²⁵ Transcript, page 692-693

²⁶ Transcript, page 524

²⁷ Transcript, page 532

- 68 Dr Giordano told the Court that he believed a patient who was dehydrated would have dry lips, a low thready pulse, low urine output and a suggestion of low blood pressure.²⁸
- 69 Dr Konok said that if she were looking for signs of dehydration, she would look at the lips and the mouth, check for capillary refill, look at skin turgor, which she described as being ‘quite reliable’ and said she expected blood pressure would be low.²⁹
- 70 Ms Ebhodaghe deposed in her affidavit that in her training to become a nurse she was taught to look for generic signs of dehydration, such as cracked lips, dry skin, low urine output, signs of thirst and a dry tongue.³⁰
- 71 Ms Miller also expressed the firm belief that her staff could tell what the signs of dehydration were, and that dehydration could be detected by conducting routine observations.
- 72 A Fact Sheet published by the Aged Care Quality and Safety Commission was received into evidence and set out the physical signs of dehydration:³¹

Preventing Urinary Tract Infections

Recognise dehydration

Urine colour chart

	Good
	Good
	Fair
	Dehydrated
	Dehydrated
	Very dehydrated
	Severely dehydrated

Signs of dehydration
Top-to-toe

- Headache
- Dry mouth or lips
- Feeling of thirst
- Sunken eyes
- Tiredness
- Dark/smelly urine
- Urinating less than 4 x a day
- Cold hands

Prevent dehydration
Encourage residents to drink 1 – 2 litres of fluids every day (unless advised not to by GP)

Encourage regular bladder emptying and mobilise as much as able

Act quickly to resolve constipation and continence problems

Please speak to the aged care home manager if you have any questions.
Adapted from NHS Nottinghamshire County Council 'To Dip or Not to Dip' project and Dr Annie Joseph's work.
Version 1 (September 2021)

²⁸ Transcript, page 160

²⁹ Transcript, page 247

³⁰ Exhibit C19, paragraph 7

³¹ Exhibit C22

- 73 It was Professor Whitehead's evidence, which I have accepted in its entirety, that this advice is misleading for those caring for elderly people. He explained:

This idea of a minimum fluid prescription being part of standards of care [I] absolutely support that. I mean this seems to have been put in the context of preventing urinary tract infections. Again, the evidence that keeping someone hydrated prevents urinary tract infections, I've never actually seen a study that supports that fact. In theory it might. But the signs of dehydration - I mean if you had all of those, to be honest, you might be moribund. It's not really very helpful.³²

- 74 As seen in the clinical records, a locum doctor saw Mrs D'Angelo on 25 August 2020 due to a level of agitation and recorded the observation that her hydration at that time was 'fair'.³³ The events that followed casts doubt on this assessment. No bloods were requested to confirm this assessment and so this misunderstanding appears to have had an impact on Mrs D'Angelo's course of treatment.
- 75 I will return to this issue at the end of these findings when considering recommendations.

Circumstances leading up to Mrs D'Angelo's death

Incidents of concern raised by the D'Angelo family

- 76 In a detailed letter written by the D'Angelo family to the Coroners Court on 28 August 2021 a number of concerns were outlined in respect of the care provided to Mrs D'Angelo by the staff at NECH. This was subsequently converted into an affidavit sworn by Anna D'Angelo.³⁴
- 77 In particular, there was an occasion in June 2020 where Mrs D'Angelo's daughter identified a skin lesion on her mother's face when visiting. This had not previously been detected by staff. It required removal and was ultimately found to be a squamous cell carcinoma.³⁵ There were also frequent falls documented between 22 December 2017 and 20 August 2020 (16 in total)³⁶ one of which led to Mrs D'Angelo fracturing her left neck of femur.³⁷
- 78 Oral evidence was not heard about these particular incidents; however, documentary evidence was received (including the clinical records) which supported the family's concerns that these incidents did occur. While not directly relevant to her cause of death, it did give rise to a concern of sub-optimal care in the aged care facility.
- 79 In June 2018, the D'Angelo family received a letter from the Department of Health notifying them of a review conducted by the Australian Aged Care Quality Agency (the Quality Agency) on 22 June 2018 and found that NECH was not providing an appropriate

³² Transcript, page 638

³³ Exhibit C11, page 75

³⁴ Exhibit C3, C3a

³⁵ Exhibit C8, pages 4-7

³⁶ Exhibit C12, pages 28, 86, 87, 97, 121, 125, 137, 138, 140, 145, 151, 153, 159, 163, 174, 237 and 239

³⁷ Exhibit C12, page 28

standard of care to residents. In response, sanctions were imposed on the aged care facility with a meeting organised for residents, relatives and representatives to attend.³⁸

- 80 The meeting was held the next day and Toni D'Angelo attended along with a number of other residents' families. Concerns were raised at the meeting about behavioural issues, physical assaults, multiple falls and inadequate staff to assist with meals for residents who could not feed themselves.³⁹
- 81 Details of the Audit Report were received into evidence, revealing that there were five (of 44) requirements that did not meet expected outcomes, including '*behaviour management, skin care and living environment*'.⁴⁰
- 82 In October 2018, a further site visit and audit was conducted with NECH meeting all 44 accreditation standards.⁴¹
- 83 While these incidents were of concern individually, when viewed collectively it gave rise to a concerning pattern of events which understandably created distress and anxiety for the D'Angelo family. Without their involvement and advocacy on behalf of their mother, the events that were the subject of this Inquest may not have come to light.

North Eastern Community Hospital Aged Care Facility

- 84 From 24 May 2020, Registered Nurse (RN) Vivian Ebhodaghe worked at NECH and cared for Mrs D'Angelo and other residents. As touched on above, she gave oral evidence during the Inquest and provided an affidavit.
- 85 Ms Ebhodaghe explained that there were approximately 84 residents at the time she was employed at the facility.⁴² Ms Ebhodaghe typically worked an afternoon shift (3 pm to 11 pm) and described that during her shift the composition of staff would be one RN and three Enrolled Nurses (EN). The EN's were the primary carers for the residents and would be responsible for between 28 to 30 residents each. The EN was responsible for administering medications, attending to minor wounds and would seek assistance from the RN on duty when necessary. There were also typically two Personal Care Workers (PCA) for each EN on a shift. A PCA was responsible for attending to the resident's daily needs such as attending to meals and hydration, toileting and assistance with mobility.
- 86 There were no doctors at the NECH aged care facility. The usual aged care arrangement, as explained in more detail by Dr Giordano, was that the resident would be under the care of their general practitioner (GP) from the community. If their GP was not available, the resident would be seen by a locum doctor or transferred to a hospital by ambulance, depending on the severity of the incident.⁴³

³⁸ Exhibit C3a,

³⁹ Exhibit C3a, pages 1-2 – Contemporaneous notes (taken by Toni) annexed to Ms Anna D'Angelo's affidavit

⁴⁰ Exhibit C12, Annexure CEM-C, pages 275-276

⁴¹ Exhibit C12, Annexure CEM-D, pages 300-326

⁴² Chief Executive Officer Cara Miller confirmed there to be 84 beds at NECH (Exhibit C12, paragraph 3)

⁴³ Exhibit C19, para 14

- 87 Mrs Ebhodaghe was involved in Mrs D'Angelo's day to day care, but more specifically her care plan review following the June 2020 blood results. She was also on shift when Dr Konok assessed Mrs D'Angelo on 3 October 2020, just before being transferred to hospital in acute kidney failure.

When did Mrs D'Angelo become dehydrated?

- 88 Mrs D'Angelo suffered from a number of co-morbidities as may be expected in someone in their advanced years. The diagnosis of Lewy body dementia was particularly relevant to her risk of dehydration. This was for two reasons; firstly, her cognitive issues impacted on her ability to feel thirsty, and secondly, her motor function was affected (parkinsonism symptoms).
- 89 There were numerous entries in the clinical records from the aged care facility acknowledging that Mrs D'Angelo required prompting and assistance with meals and fluids due to her diagnosis of dementia. This was therefore a known and recognised risk factor. The care plan set out: *'She requires a special set up due to cognitive impairment, positioning to eat, toileting prior to meal times ... She requires her drinks to be poured, a cup to be placed in her hand and verbal prompts to drink ... For supervision she requires staff to standby to provide verbal prompts and physical assistance to eat ... 1:1 assist with feeding'*.⁴⁴
- 90 Mrs D'Angelo's daughter Anna also observed that following her admission to NECH, her ability to walk unaided declined quickly, as did her cognitive function. In response to the COVID-19 pandemic, restrictions at the facility saw residents served meals in their rooms rather than in the dining area. Anna explained:

In the months before my mother's death she was not able to feed herself. On multiple occasions I went to visit my mother and her food tray had not been touched and was still positioned at the foot of her bed which she was unable to reach. Our mother required assistance with feeding and drinking.'

She was able to place her own food into her mouth but she would have to be given the utensil with the food on it. She would not be able to or would not initiate taking the food off the plate for herself.

Similarly, she had to be prompted and directed with her drinking. She was able to hold and use a cup or straw but had to be presented the drink. She would not reach for or move to her drink across the table and certainly if it were not close or out of reach, she would not drink. It would be entirely up to staff at the home to ensure that she had enough fluid intake. Something I feel they did not do.⁴⁵

- 91 As touched on above, on 6 June 2020 what appeared to be a skin lesion or boil near Mrs D'Angelo's ear was brought to the attention of aged care staff by her family. A locum was called to attend NECH on the same day and upon doing so, queried whether the boil was a skin cancer.⁴⁶ Dr Giordano was notified, and he referred Mrs D'Angelo for a dermatology review on 10 June 2020. It was recorded in the clinical notes that Anna

⁴⁴ Exhibit C6a, pages 316-317

⁴⁵ Exhibit C3, paragraphs 10-12

⁴⁶ Exhibit C12, page 221 and Exhibit C11, page 86

D'Angelo was concerned that the lesion had not been detected and acted upon earlier by the aged care staff at NECH.⁴⁷

- 92 On 22 June 2020, Dr Giordano saw Mrs D'Angelo at NECH and ordered that a set of routine general chemistry bloods be taken. He then contacted Anna to discuss the upcoming dermatology review. It was recorded in his entry that he considered the 'boil' may be a basal cell carcinoma.⁴⁸
- 93 The results from the blood test were sent to Dr Giordano by facsimile on 26 June 2020. These results were the subject of much oral evidence as Professor Whitehead, in his expert report, commented that the results revealed a level of dehydration as her results revealed a sodium level of 149 mmol/L, where the normal range is between 135 to 145 mmol/L. In addition to this was a slightly elevated chloride level of 111 mmol/L, with a normal range being 95 to 110 mmol/L.⁴⁹ This was concerning to Professor Whitehead as Mrs D'Angelo was also taking diuretic medications⁵⁰ for the condition of congestive cardiac failure, which heightened her risk of dehydration and meant that subtle signs were serious.
- 94 While Professor Whitehead emphasised that the results were only mildly abnormal, he described this as a red flag to have considered Mrs D'Angelo's hydration status and the potential cessation of her diuretic medication. Professor Whitehead opined '*[p]atients will be significantly dehydrated by the time their sodium creeps outside the normal range*'.⁵¹
- 95 There were three questions that arose from Professor Whitehead's opinion about the blood results. Firstly, did Dr Giordano consider Mrs D'Angelo's results to be reflective of a level of dehydration? Secondly, if he did, should he have acted upon it by reviewing (and potentially ceasing) her diuretic medication and/or repeating the test? Lastly, was this result causally linked to the severely deranged blood results upon Mrs D'Angelo's admission to hospital just prior to her death?
- 96 It is important to highlight that that Mrs D'Angelo suffered congestive cardiac failure which required diuretic treatment. There was extensive evidence before the Court, both documentary and by way of oral evidence, that this condition was actively managed in accordance with her symptoms by Dr Giordano and the specialists to whom Mrs D'Angelo was referred.⁵² I am satisfied, particularly based on the expert evidence of Professor Whitehead on this topic,⁵³ that the prescription of diuretic medication for Mrs D'Angelo's condition of congestive cardiac failure was indicated and appropriate.
- 97 Another observation was that Mrs D'Angelo had been taking diuretics for a number of years and there were two prior occasions when Mrs D'Angelo's diuretics were paused during inpatient admission in hospital. Dr Giordano was notified of this by way of

⁴⁷ Exhibit C12, page 223

⁴⁸ Exhibit C12, page 227

⁴⁹ Exhibit C15, page 4

⁵⁰ Spironolactone and furosemide

⁵¹ Exhibit C15, page 4

⁵² Transcript, page 623, 624

⁵³ Transcript, pages 620-624

discharge summary.⁵⁴ Following improvement on each occasion, Mrs D'Angelo was then recommenced on diuretics. Blood results for 30 September 2019⁵⁵ did not reveal any concerns for Mrs D'Angelo's hydration status. The September 2019 blood results were therefore an important baseline for the change in Mrs D'Angelo's condition in the year that followed. The cessation of diuretic therapy in hospital in response to adverse symptoms was also relevant, in that Dr Giordano was made aware that from time to time, Mrs D'Angelo's diuretic medication was reviewed and paused.

- 98 Following the abnormal blood results in June 2020, Professor Whitehead gave oral evidence that he was comfortable that Mrs D'Angelo's diuretic medications were not changed. The issue, as will be addressed below, was not that the medication should have been changed, rather that there should have been consideration of Mrs D'Angelo's elevated risk of dehydration in the context of her blood results and the medication she was prescribed and that it be recorded in the clinical records.⁵⁶

Episode of hypernatraemia

- 99 Dr Giordano had no independent memory of reviewing the June 2020 blood results. He did however accept in his oral evidence that he must have done so as they had reached Mrs D'Angelo's clinical file, and that they revealed a mild level of hypernatraemia.⁵⁷ Dr Giordano could not recall if he took any action in relation to the results.⁵⁸
- 100 No direct action was recorded in response to the mild hypernatraemia in either Dr Giordano's or NECH's clinical records. The NECH clinical records simply reflected that the results had been received and faxed to Dr Giordano, from whom they were awaiting a response.⁵⁹ Following this entry, there was no further mention of the blood results or any action required. It was essentially left to Dr Giordano to consider and address.
- 101 Dr Giordano did however conduct a face-to-face consultation with Mrs D'Angelo at NECH on 10 July 2020. This was 14 days after the blood results were sent to him. The entry in the NECH clinical records was as follows:

MEDICAL REVIEW
OBS STABLE
CHEST CLEAR
CVS STABLE
RIGHT FACIAL LESION NOTES ?SCC ?BCC
AWAIT DERMATOLOGY REVIEW
DR MARIO GIORDANO FRACGP⁶⁰

- 102 Dr Giordano gave evidence that consistent with his general practice he would have arrived at the facility, obtained information from staff members about whether there were

⁵⁴ Exhibit C5, pages 26-27 – Discharge summary sent to Dr Giordano (frusemide was ceased); 29 September at Calvary (furosemide was ceased)

⁵⁵ Exhibit C11, page 30

⁵⁶ Transcript, page 641

⁵⁷ Exhibit C2a, page 83

⁵⁸ Transcript, page 149

⁵⁹ Exhibit C12, page 228

⁶⁰ Exhibit C12, page 231

any concerns and then visited Mrs D'Angelo.⁶¹ His clinical notes informed him that he would have checked Mrs D'Angelo's blood pressure, heart, listened to her lungs and checked for ankle oedema.

- 103 In the absence of an independent recollection, Dr Giordano asserted that he would have observed Mrs D'Angelo's general appearance to see if there were any signs of dehydration; such as a sunken face and/or dry lips.⁶² He explained that dehydration would also manifest in a low volume thready pulse, low urine output and potentially low blood pressure.⁶³
- 104 Hypothesising as to why a repeat general chemistry blood test was not ordered, Dr Giordano gave the following evidence:
- A. In retrospect, one could argue that one may have repeated the blood test, but there was nothing there on clinical examination which made me concerned that her hydration had not been corrected.
 - Q. So when you refer to clinical examination are you referring to clinical examination that happened after this date.
 - A. Yes.
 - Q. So I just want to focus on the results and looking at those results, considering just the results that you can see there, do you think that those results call for any follow-up testing.
 - A. Clinical follow-up yes, biochemical follow-up no, unless she did not respond to clinical management.⁶⁴
- 105 In light of Professor Whitehead's evidence, it is difficult to see how an improvement could be detected without blood testing.
- 106 Three days after this consultation, Mrs D'Angelo's care plan was reviewed, and a three-day food and fluid chart was commenced. A submission was made that this care plan review was consistent with Dr Giordano's general practice of discussing a patient's fluid intake with nursing staff after an abnormal blood result,⁶⁵ and that a finding could be made accordingly.
- 107 The difficulty with that submission was that Dr Giordano had no memory of reviewing the blood results on 26 June 2020, the consultation on 10 July 2020⁶⁶ or speaking to the nursing staff about any concerns. As detailed above, he retrospectively relied upon Mrs D'Angelo's observations being normal (as recorded in his consultation on 10 July 2020) for not repeating the bloods. Therefore, the obvious question arose: why would a three-day food and fluid chart be necessary?

⁶¹ Transcript, page 158

⁶² Transcript, page 160

⁶³ Transcript, page 160

⁶⁴ Transcript, pages 152-153

⁶⁵ Written submissions on behalf of Dr Giordano, paragraph 45 (f)

⁶⁶ Transcript, page 369-370

- 108 Professor Whitehead opined that following the mildly hypernatraemic status, the gold standard of practice would be to order a repeat test. He gave the following evidence:

I suppose - there are degrees of practice failure, for want of a better term. You know, there's gold standard and there's - at [one] end, to truly egregious at the other. I think it's generally good practice if you've got an abnormal blood test to repeat it, to make sure that it normalises, and I think that probably should have been done in this case. The reality is, of course, that it was a minor abnormality, and may well have resolved by itself, and therefore for - in terms of - because this is putting into context that we know subsequently she becomes much more dehydrated - it's really in saying did Dr Giordano miss an opportunity to prevent the eventual outcome, and I don't believe he did, because I don't think it would be reasonable to expect him to have gone 'Aha, I need to really intervene now because I know in a few months' time Mrs ...D'Angelo will end up severely dehydrated and in hospital'. I think that's an unreasonable thing to expect Dr Giordano to predict that based on what, you know - turning up and seeing this blood test, because of the minor level of the abnormalities. Having said that, in the spectrum of practice, I think if you've got an abnormal blood test, you should probably repeat it, and it's quite possible if it was repeated it would have been normal.⁶⁷

- 109 The issue therefore was whether Dr Giordano had turned his mind to Mrs D'Angelo's hydration status. In the absence of his memory⁶⁸, the clinical records (other than the commencement of food and fluid chart) did not support that contention.
- 110 While of some concern in isolation, I understood Professor Whitehead's evidence to be that no causal relationship existed between Mrs D'Angelo's mildly hypernatraemic state in June 2020 and her severely dehydrated state a few months later. Events that occurred in the intervening months were supportive of Mrs D'Angelo remaining well.
- 111 Accordingly, I am not critical of Dr Giordano for not ordering a follow up test. However, there was simply no evidence to support the contention that Dr Giordano specifically turned his mind to Mrs D'Angelo's elevated risk of dehydration following the blood results on 26 June 2020. If he had turned his mind to that risk, reference to her mildly hypernatraemic state should have been recorded in the NECH clinical records for the benefit of nursing staff (and locum doctors), particularly given Mrs D'Angelo's elevated risk due to her dementia as well as the diuretic medications she was taking.
- 112 What it did demonstrate was the missed opportunity to have provided clear instructions to nursing staff for the monitoring of Mrs D'Angelo's fluid intake, quite separately from the three-day food and fluid chart which might have assisted her to stay out of concerning territory later. This was therefore a missed opportunity to place those responsible for the day-to-day care of Mrs D'Angelo on notice that they needed to carefully monitor her fluid intake and ensure it was adequate.

The three-day food and fluid chart⁶⁹

- 113 While serendipitous in its timing, occurring three days after Dr Giordano saw Mrs D'Angelo, there was evidence to suggest that the commencement of the three-day food and fluid chart was simply part of the six-monthly care plan review process. An

⁶⁷ Transcript, page 627

⁶⁸ Transcript, page 370

⁶⁹ Exhibit C6A, pages 115-117

entry made in the NECH clinical records by an EN dated 13 July 2020 noted that a six-monthly care plan review was to commence on 13 July until 15 July 2020.⁷⁰ These were the very dates of the three-day food and fluid chart. There was no mention at all that the plan was instituted due to concerns about Mrs D'Angelo's hydration levels.

- 114 It was also the evidence of Ms Ebhodaghe that if fluid balance charts were recommended by a doctor, the request would then be escalated to the clinical nurse specialist, who would then discuss that request with a care manager. A dietician would then be organised to attend the review and assess the resident's care needs to determine if they had changed.⁷¹ There was no evidence that this process was activated.
- 115 Some comfort was placed on the commencement of the food and fluid chart by both staff at NECH and Dr Giordano during the oral evidence. In particular, that it was said to be both an indication that Mrs D'Angelo's food and fluid was being monitored regularly and it showed her eating and drinking adequately. While it was demonstrative of the aged care facility having semi-regular processes to monitor food and fluid in place, Professor Whitehead raised concerns about the unreliability of measuring fluid in such a chart, as well as the inadequacy of Mrs D'Angelo's fluid intake on two of the three charted days.
- 116 Professor Whitehead undertook his own calculation and observed that on 14 and 15 July 2020, the amounts recorded were inadequate, with only 600-700 mL ingested.⁷² Despite what Professor Whitehead saw as insufficient fluid intake recorded, there was no acknowledgement noted on the document that this was an inadequate amount or any adjustment made to the care plan to increase Mrs D'Angelo's fluid in response. This was despite an area at the bottom of the chart allowing for daily totals and daily balance.
- 117 A later entry in the clinical records revealed that in fact no concerns were held in relation to the amount of fluid Mrs D'Angelo was drinking. On 22 August 2020, when the care plan review was discussed with Anna, Mrs D'Angelo's nutrition and hydration were recorded as *'Eats and drinks well. nil significant weight loss. same management and [sic] current.'*⁷³
- 118 The lack of awareness may have been as a result of the change in procedures at NECH prior to 2020. It was apparent from the clinical records that up until early 2020, nursing staff were required to enter a tally into the Care Review Tool of the average fluid intake over a 24-hour period from the food and fluid chart completed prior to the review. It was also evident that this particular form included a prompt to implement strategies to improve fluid intake if the average intake over a 24-hour period was less than 1,500 mL. The portion of Care Review Tool relating to fluid in-take is extracted below:

⁷⁰ Exhibit C12, page 232

⁷¹ Transcript, page 463

⁷² Transcript, page 645-646

⁷³ Exhibit C12, page 240

Refer to Speech Pathologist.

- What is the average 24hr fluid in-take - 1330 - 1460 mls. Refer to food and fluid charts completed prior to this review. If less than 1500 mls in 24 hours strategies to improve fluid intake have been implemented (unless require restricted fluids) offer supper at night.
- No ☐ (Reason): _____
- Yes ☐ Specify strategies ↗ _____

- 119 It is important to note that the extract above from a care review plan in July 2019 revealed Mrs D'Angelo was averaging 1330 – 1460 mLs of fluid in a 24-hour period. This was roughly double that recorded in the 3-day Food and Fluid Chart for 14 and 15 July 2020. Notwithstanding, it still fell below the 1500 ml benchmark amount, and the specific strategy was to 'offer supper at night'.
- 120 In contrast, the care review checklist⁷⁴ completed by Ms Ebhodaghe in late July 2020, following the three-day food and fluid chart, did not quantify the average 24-hour amount of fluid Mrs D'Angelo had been consuming. It did not include a prompt to implement strategies for inadequate fluid intake. The checklist was also in a different format to the previous document.⁷⁵
- 121 In her affidavit, Ms Cara Miller the CEO of NECH, explained that the method of recording the six-monthly reviews changed with the introduction of an electronic record system, MANAD. This system was rolled out over time in modules and saw a change in the care review format coincidentally in July 2020. Ms Miller was asked about the change in this document where it related to the lack of quantifying fluid, specifically, what she knew about the philosophy behind the change. Ms Miller was not able to provide any information on why it had changed, having commenced her role in December 2022, but agreed that the previous format was preferable in measuring how much fluid was ingested with prompting to address an inadequate amount.⁷⁶
- 122 As I have observed, the previous care review tool had specified what appeared to be the benchmark of an adequate amount of fluid (1,500 mL) and a mechanism to address hydration if the amount fell below that. It could therefore not be reasonably suggested that the aged care facility had no awareness of a safe target amount of fluid an elderly resident required (particularly one who was reliant on staff to eat and drink). This was notwithstanding the aged care industry's lack of a mandated minimum fluid prescription. It will remain a mystery as to why the format changed in the way it did, other than as part of a more general electronic system conversion.
- 123 The lack of documented concern held for the risk of mild hypernatraemia, or the potential for the increased risk with diuretic medications (by Dr Giordano) and a documented fluid chart which did not require a total 24-hour fluid calculation (by the aged care facility), was support for the contention that there was a lack of appropriate focus on Mrs D'Angelo's hydration status.

⁷⁴ Now called 'checklist' and not 'tool'

⁷⁵ Exhibit C6a, pages 107-110

⁷⁶ Transcript, page 714

- 124 I am satisfied on balance that the three-day food and fluid chart was instituted as part of routine six monthly care plan review and not due to any concerns raised by Dr Giordano following the blood results on 26 June 2020. I further find that the food and fluids recorded over this three-day period, if correctly interpreted and considered, was another indicator that Mrs D'Angelo was not ingesting adequate fluid. However there was no appreciation that this was the case.
- 125 15 July 2020 was also the last occasion when Mrs D'Angelo's daily fluid intake was measured. The scene was therefore set for the unfortunate events that followed.

Removal of lesion

- 126 Mrs D'Angelo attended the Lyell McEwin Hospital on 2 September 2020 to have the 'boil' removed from her face. She returned to NECH in the evening, and it was recorded that she ate '*part of her meal and much fluid orally*'.⁷⁷ The following day the discharge summary that was returned with Mrs D'Angelo was faxed to Dr Giordano. This informed him that Mrs D'Angelo had undergone an excision of a right pre-auricular lesion plus flap with a follow up appointment for pathology results on 11 September 2020.⁷⁸
- 127 A surgical pathology report, verified on 4 September 2020, revealed that the lesion was indeed cancerous, reported as an invasive squamous cell carcinoma with keratoacanthoma type features.⁷⁹

Mrs D'Angelo's birthday

- 128 On 19 September 2020 Mrs D'Angelo was taken out of the NECH facility for her birthday celebrations, held at her daughter's home. The D'Angelo family and friends gathered at the house for celebrations which were described by her daughter Anna as a happy day for them all. Mrs D'Angelo was in good spirits, enjoying herself and was able to eat and drink.⁸⁰
- 129 Anna also visited her mother at NECH on 26 September 2020 and observed her to be her usual bright self, much as she was on her birthday the week before.
- 130 Following that, there were few entries in the clinical records to suggest that there were any concerns held for Mrs D'Angelo's health before 3 October 2020.
- 131 It was suggested by counsel for NECH, Mr Ralph Bönig, in his cross-examination of Professor Whitehead, that because there was no documented evidence in the notes of clinical dehydration during this time frame, it was not open to criticise any oversight of dehydration by aged care facility staff.
- 132 Professor Whitehead agreed that there were likely no clinical signs of dehydration manifesting in Mrs D'Angelo for aged care staff to detect. However, his criticism was not directed at individuals. Professor Whitehead's concern with Mrs D'Angelo's care was that there was no regular monitoring of Mrs D'Angelo's fluid intake at an aged care

⁷⁷ Exhibit C12, page 249

⁷⁸ Exhibit C11, pages 66-72

⁷⁹ Exhibit C9, page 53 and Exhibit C8, pages 4,5 and 7

⁸⁰ Exhibit C3, paragraph 40

facility level, and no regulation of an adequate fluid amount at an industry level. He gave the following evidence:

Q. But isn't the point you're making that in any event, leaving aside all of those facts, your main criticism in this matter, in Mrs D'Angelo's death, is that her fluid intake was not being monitored adequately.

A. Correct, yes.

Q. That's the bottom line, essentially, as I understand from your evidence today.

A. And that it - yes, that the only way she could have got from A to B is by not drinking and it was not being assessed, not measured, and not noted.

Q. So, leaving aside the clinical signs or the inability to detect the clinical signs. Even leaving aside the blood tests. If she was not drinking between 1 to 2 litres per day, or at a minimum 1 litre per day, and that being monitored and documented, then there should have been concern.

A. There should have been concern raised, yes.

Q. But the other factor in this is that there ...was no policy at the time and that seems to be an across the board phenomena to dictate what the level fluids should be for a patient with the risk factors like Mrs D'Angelo.

A. Correct. But there's no mandated minimum fluid prescription for a resident who's at high risk of dehydration. And that is not part of the standards, as I say, the focus is very much on weight loss, which actually - I mean obviously you can lose weight when you dehydrate, because we're mostly water, but that's - the weight loss is perceived as a loss of nutrition, not a loss of fluid, although the two are related. And I think that is the problem, that as you've said, the open question is what's the best way and the most fair way for an aged care provider to do that monitoring in a way that's sustainable and meaningful in aged care as it is in the 21st century. And that, to my mind, is a fundamental point here, that there is no debate about it. We talk about weight loss but we don't talk about a minimum fluid prescription. And really, that's not a big ask, I don't think.

Q. And now, even in 2024, your evidence is that there is still not an adequate guideline or policy in place to dictate the amount of hydration a dementia patient has.

A. I don't believe so, no.⁸¹

133 There were however signs of a potential decline in Mrs D'Angelo from 27 September 2020, as reflected in the clinical records. Enrolled nurse, Ms Puttnins recorded Mrs D'Angelo's daily progress to be as follows:

P: Sleepy/lethargic

I: Adelina had been very sleepy since beginning of shift, hardly had her breakfast and refused her morning tablets. She was awake and alert after her wash but became more sleepy again and remained so at lunchtime. Had minimal food and oral intake,

⁸¹ Transcript, page 677

could not tolerate her medication as well. Medication discarded. Obs stable. [Team leader] notified.

E: Currently sleeping in bed, appears comfortable, no signs of pain.⁸²

134 While Mrs D'Angelo was recorded as being alert the following morning with her observations all within normal limits, the next day there was only reference to her bowels not being open and no observations of her alertness or otherwise. There were no entries made on 30 September 2020 at all. On 1 and 2 October 2020, there were two entries recording skin tears.⁸³

135 Later, on 2 October 2020, Ms Puttnins made the following clinical note:

P: Difficulty in eating

I: Adelina was observed to be struggling with eating her meals and was refusing to eat. Currently she is on regular cut up meals, which she's not tolerating. [Team leader] notified.

E: She managed to eat her dessert and had good amount of fluid.⁸⁴

136 The following morning at 11:27 am, a similar entry was made by the same enrolled nurse, recording that Mrs D'Angelo had been sleepy again but rousable, would occasionally moan, was refusing her breakfast and not tolerating fluid. She was not given her medications as she was not swallowing. They were again discarded. As she had done the day before, Ms Puttnins notified the team leader.

137 A little later in the day (2:13 pm) an RN checked on Mrs D'Angelo's poor oral intake. It was recorded in this entry that her vital signs were within normal limits, but a locum was contacted to review Mrs D'Angelo for sleepiness/tiredness.⁸⁵ Despite the entry reflecting the plan for a telehealth consultation due to the unavailability of the locum service for an in-person visit, Dr Konok attended at NECH in person a few hours later.

Dr Konok's consultation

138 I turn now to the attendance of Dr Konok at NECH on 3 October in 2020. Dr Konok explained that she was called to the aged care facility in the capacity as a locum doctor after receiving information from the National Home Doctor Service application relating to Mrs D'Angelo. A document was received into evidence which reflected the information available to Dr Konok prior to attending.⁸⁶

139 The clinical symptoms listed on the document were '*lethargy, excessive sleeping, not eating*'. It also indicated that the consult occurred sometime between 5:29 pm and 6:19 pm.

⁸² Exhibit C12, page 257

⁸³ Exhibit C12, page 259

⁸⁴ Exhibit C12, page 259

⁸⁵ Exhibit C12, page 260

⁸⁶ Exhibit C7A

- 140 Dr Konok explained her usual practice when visiting aged care facilities. This included speaking with a nurse when she arrived to assess why she had been called and to determine whether there was anything significant in the patient's observations. During her consult, Dr Konok would make handwritten notes which she would then later use to write up her clinical report on the iPad. The completed report would then be sent to the GP and the nursing home.
- 141 Dr Konok had not seen Mrs D'Angelo before this occasion. She explained in evidence that she did however have some memory of the consult. Dr Konok remembered seeing Mrs D'Angelo in her bed and that she was not responding to her name. She also remembered that a female nurse accompanied her to Mrs D'Angelo's bedside.⁸⁷ Dr Konok later added that she thought Mrs D'Angelo was not opening her eyes but recalled that she did respond to pain stimulus.⁸⁸
- 142 Dr Konok thought that the person who accompanied her was either the nurse looking after the patient (EN) or an RN. She recalled the nurse stating to her something to the effect of *'This had happened before, but this time is worse and going on for longer.'* Dr Konok explained that this statement was imprinted in her memory, but she could not recall whether it was a reference to Mrs D'Angelo not eating and drinking or being unresponsive.
- 143 Dr Konok said it was part of her general practice to ask the nurse whether the patient was for active management. She described the term 'active management' to mean *'Whether the patient is for hospitalisation, further investigation and all management that's offered to the patient for the diagnosis.'*⁸⁹
- 144 A large focus of Dr Konok's evidence was the entry in her notes, *'not for resuscitation/active management'*. The relevance of this was two fold; firstly, it dictated what Dr Konok did and did not do following her examination of Mrs D'Angelo, and secondly, it was not in accordance with Mrs D'Angelo's recorded wishes.
- 145 Relying on her general practice in aged care facilities, Dr Konok explained that she would generally ask nursing staff what the patient's wishes were and if the nurse didn't know they would be asked to retrieve the relevant documentation.⁹⁰ In the absence of her memory of how this information was elicited, Dr Konok formed the view that she must have been provided with this information by the nurse who accompanied her.⁹¹
- 146 On the National Home Doctor Service Report prepared by Dr Konok after her consult with Mrs D'Angelo, she recorded her observations of blood pressure, pulse, respirations and oxygen saturation levels which were all within normal limits. Following that Dr Konok recorded her examination and diagnosis, as extracted below:

Examination:	Patient is in bed
	Shallow breathing noted
	GCS 13

⁸⁷ Transcript, page 217

⁸⁸ Transcript, page 257

⁸⁹ Transcript, page 219

⁹⁰ Transcript, page 220

⁹¹ Transcript, page 219-220

Hear dual, regular
Chest NAD
Abdomen soft
Increased tone toned in right arm
Diagnosis: ? CVA⁹²

- 147 Dr Konok explained that CVA was an acronym for cerebrovascular accident, old terminology for a stroke. She considered this to be a possibility.⁹³ To come to this differential diagnosis, Dr Konok observed increased tone in Mrs D'Angelo's right arm. Her evidence was that Parkinson's disease will not cause a change on one side of the body, the difference would be seen on both sides. She explained:

I know that she had Parkinson's disease but on the right side there was more resistance compared to the left...⁹⁴ I was more relying on the increased tone on the right side compared to the left side....so she had Parkinson's. That will give her increased tone, but I remember on the right side it was – the tone was increased compared to the left.⁹⁵

- 148 Dr Konok did not consider dehydration despite the information bringing her to the aged care facility was that Mrs D'Angelo was lethargic, excessively sleepy and not eating. She explained, '*[t]o be honest, I was not concerned about dehydration when I saw her.*'⁹⁶ It is acknowledged that there was nothing in the clinical notes from Dr Giordano, had Dr Konok looked at them, to alert her to Mrs D'Angelo's heightened dehydration risk.
- 149 As it was Dr Konok's understanding that Mrs D'Angelo was not for active management, she did not continue with the diagnostic process. She explained that to her, this meant that Mrs D'Angelo was '*going the palliative way*'.⁹⁷ Dr Konok did order a blood glucose test and a urine dipstick to be done. She understood that these tests could be done on site and were sometimes requested by families notwithstanding palliation. Dr Konok could not recall what she reported back to the nursing staff after her consultation with Mrs D'Angelo, but suspecting as she did that Mrs D'Angelo had suffered something as serious as a stroke, her evidence was she must have reported this to the nurse.⁹⁸ Relying on her usual practice, Dr Konok also explained that she would have requested nursing staff to contact family and advise them of the outcome of her visit. The record of her consultation did include the direction to '*inform family*'.
- 150 Dr Konok was asked what she would have done differently had she been aware that Mrs D'Angelo was for active management upon considering that she had suffered a condition as life threatening as a stroke. She very candidly explained that she would have contacted an ambulance for transfer to hospital and contacted Mrs D'Angelo's family.⁹⁹ She therefore acknowledged that her incorrect understanding of Mrs D'Angelo's advanced care wishes impacted on emergency intervention.

⁹² Exhibit C7

⁹³ Transcript, page 235

⁹⁴ Transcript, page 234

⁹⁵ Transcript, page 262

⁹⁶ Transcript, page 247

⁹⁷ Transcript, page 245

⁹⁸ Transcript, page 242

⁹⁹ Transcript, pages 237-238

- 151 Dr Konok's evidence that she was provided with information that Mrs D'Angelo was not for active management was unchallenged. She clearly did not read the document and I accept she was likely advised this or misheard. What was less clear was who provided that information to her. In an attempt to ascertain how it was that Dr Konok formed this erroneous belief, the court heard evidence from Ms Ebhodaghe.
- 152 Ms Ebhodaghe made the entry in the clinical records of Dr Konok's visit.¹⁰⁰ Unfortunately, she was unable to recall whether she was the nurse that was present with Dr Konok during the consult.¹⁰¹ The note recorded:¹⁰²
- P: Locum doctors visit
- I: Locum doctor visited and stated there is not much to be done, but UA to be collected, vital signs are within normal range, repositioned on regular bases, refused dinner but had few sips of water, BGL taken and was 5.9mmol. NOK notified of the locum doctors
- E: Requires close monitoring
- 153 Ms Ebhodaghe said she did not recall having a conversation with the locum doctor or if she led the locum doctor to see Mrs D'Angelo. She was, however, adamant that she would not have told Dr Konok what Mrs D'Angelo's palliative care plan was, even if she had been asked, and she would not have used the phrase 'active management'. If she had been asked what Mrs D'Angelo's end of life wishes were, she said she would've obtained the relevant documentation for the doctor from the resident's folder.
- 154 In support of this evidence, it was also Ms Ebhodaghe who had completed Mrs D'Angelo's care plan review in July 2020. That review included a review of the palliative care plan that was signed by Dr Giordano. Ms Ebhodaghe was shown the plan and asked how she'd interpret it. She told the court that in her view, this document meant that Mrs D'Angelo was for hospital transfer.¹⁰³
- 155 It was also Ms Ebhodaghe's evidence that she knew Mrs D'Angelo was not on palliative care at any time while she was at the facility.¹⁰⁴ Accordingly, it was highly improbable that Ms Ebhodaghe told Dr Konok that Mrs D'Angelo was not for active measures. These were not words that Ms Ebhodaghe says she used; they were not familiar words to her, and she would have known them to be incorrect.
- 156 The other possibility was that it was a different member of staff who provided this information to Dr Konok. Ms Ebhodaghe told the court that on 3 October 2020 there would have been three ENs on duty. If she was present and available, she said she would have accompanied the doctor to the patient.¹⁰⁵ She was certain that this would not have been the role of a PCA, but she could not recall whether an EN would undertake that task. This leaves open the possibility that one of the three enrolled nurses present accompanied

¹⁰⁰ Exhibit C12, page 261

¹⁰¹ Transcript, page 465

¹⁰² Exhibit C19

¹⁰³ Transcript, page 480

¹⁰⁴ Transcript, page 487

¹⁰⁵ Transcript, page 456

Dr Konok and provided her with misinformation about Mrs D'Angelo's end of life wishes.

- 157 To further address that possibility, Ms Ebhodaghe was asked several times in her oral evidence whether there was any significance to the fact that she had made the note of the locum doctor's visit. She was asked whether her recording the information in the note meant that she was the person who had a conversation with the locum doctor, or whether someone else had the conversation and she made the note. Her response was:

If I'm the one who document it - I think I did. I don't know, but yeah, I still can't recall all of this, yeah. I still can't recall all of this, sincerely.

- 158 She was then asked:

So you don't know, even looking at that note, whether you had a conversation with the locum doctor or not.

- 159 She responded:

For me to have written all of this, should be - yeah, I'm just - I don't know, but I don't want to just assume. I can't remember.¹⁰⁶

- 160 Returning to the subject for a third time in her evidence, Ms Ebhodaghe was asked this question:

Q. And just looking at that note now, you're unable to assist the court with whether you spoke to the locum or whether somebody else has given you that information.

A. I'm sure I did, yeah. I'm sure I did. I can't actually recall all the incident, everything that happened, yeah, but for me to have documented this, yeah - I know this is what I could have documented, yes.¹⁰⁷

- 161 She then said again that she was not 100% sure.

- 162 Ms Ebhodaghe had no recollection of speaking with the family, but it was her evidence that if she was told there was not much to be done, she would have told the family that. She also stated that if she was told that by a locum, she would've asked what the diagnosis was, in anticipation of having to call the family and explain what had transpired with the locum.

- 163 This evidence was consistent with Mrs D'Angelo's daughter Anna's evidence that she was contacted by NECH on 3 October 2020 and informed that a locum had visited her mother as she had not been eating or drinking *much* for a few days. No mention was made that she was refusing or unable to take anything by way of mouth.¹⁰⁸ She was informed Mrs D'Angelo's vital signs were 'ok' and that a urine sample was to be collected. Anna passed this information onto her brother, Mario, as she was not in

¹⁰⁶ Transcript, page 466-467

¹⁰⁷ Transcript, page 467

¹⁰⁸ Exhibit C3, paragraph 43

Adelaide at the time of the phone call. He attended the nursing home in the afternoon and was given the same information by the staff.

- 164 Importantly, Ms Ebhodaghe said that if she was told the diagnosis was stroke, she would have conveyed that to the family. Further, she explained that a resident suffering from a stroke is not a common occurrence, so she would have escalated care if that had been communicated to her.¹⁰⁹ She then would have consulted the folder for Mrs D'Angelo's palliative care plan to determine her wishes. She also said that even if it was not her that the doctor spoke with, that she would expect that whoever did speak with the doctor would have escalated it.
- 165 Ms Ebhodaghe emphasised the importance of contacting the family with such information as regardless of what was on an Advance Care Directive, the decision about what to do next would be up to the family.¹¹⁰
- 166 As explained by Ms Ebhodaghe, *'someone having a stroke means prompt intervention'*. It is highly improbable in my view that if Dr Konok had told an EN that she suspected stroke, this nurse would not have informed the family of that fact or escalated the matter to the RN on duty who was Ms Ebhodaghe. I accept that if this was advised directly to Ms Ebhodaghe, she would have acted differently, in the way she described.
- 167 Based on the evidence as a whole, it is open to find that it was Ms Ebhodaghe who accompanied Dr Konok to Mrs D'Angelo's bedside. I further find that Dr Konok only conveyed to Ms Ebhodaghe that there was *'not much more to be done'*, asked her to obtain a urine sample and blood glucose reading, and did not articulate her suspicions that Mrs D'Angelo had suffered a stroke.
- 168 I am satisfied that Ms Ebhodaghe did not inform Dr Konok that Mrs D'Angelo was for palliative care or not for active management. It will remain unclear why Dr Konok formed the view that Mrs D'Angelo was not for active management. It may be that she was told this information by some unidentified member of staff, or perhaps she simply misheard or assumed it. I can make no conclusive finding about that.
- 169 Turning now to Professor Whitehead's review of Dr Konok's involvement. He was critical of her assessment of Mrs D'Angelo for a number of reasons. In his expert report he commented that the assessment by Dr Konok was *'fairly perfunctory'*. He further noted that no blood tests were ordered and that subcutaneous fluids could have been administered at that time to treat dehydration.¹¹¹
- 170 Professor Whitehead was also critical of the probable diagnosis of stroke. It was his evidence that Dr Konok was incorrect in placing emphasis on the one-sided rigidity that she detected. He explained that the sign of an acute stroke is actually flaccid paralysis and not rigidity. In his view, this was *'pretty basic information'* that he hoped most GPs would know.¹¹²

¹⁰⁹ Transcript, page 471

¹¹⁰ Transcript, page 479

¹¹¹ Exhibit C5, page 4

¹¹² Transcript, page 655

- 171 Professor Whitehead explained that in his view, in deciding not to actively treat, a medical practitioner should always sight the relevant document for themselves, but that the key thing is to pick up the phone. He opined *'I think it's inappropriate just to leave someone who you think has a stroke without checking with the family about actually what they want to have done.'*¹¹³ Professor Whitehead explained that if Dr Konok did not feel comfortable to have that conversation (as she indicated in her evidence, due to her role as a locum), she was obliged to arrange for her transfer to hospital so that conversation could occur.
- 172 In this case, a telephone call to the D'Angelo family would have undoubtedly corrected any misinformation or misunderstanding that Dr Konok had received in relation to Mrs D'Angelo's end of life wishes. However, it was the evidence of Professor Whitehead that intervention by Dr Konok at this late stage probably would not have changed the outcome for Mrs D'Angelo.
- 173 Accordingly, after pausing to make *Briginshaw* considerations, I find that Dr Konok's assessment of Mrs D'Angelo was inadequate in several respects. She did not consider dehydration, despite being provided with information that Mrs D'Angelo was lethargic and not eating. Further, her differential diagnosis of stroke was not medically sound, and she failed to consider other possibilities. Those issues were compounded by her misunderstanding in relation to Mrs D'Angelo's end of life wishes, and her failure to contact the D'Angelo family that evening.
- 174 Dr Konok accepted that the criticism of Professor Whitehead was warranted.¹¹⁴ She agreed that she should have viewed Mrs D'Angelo's documented wishes herself. Further, Dr Konok reflected upon her treatment of Mrs D'Angelo and offered an apology in court to the family. Dr Konok said she was terribly sorry and acknowledged *'I know it's your mother and I can feel it. If I am given the chance, I would go back.'*¹¹⁵
- 175 I observed Dr Konok to give her evidence truthfully and genuinely. Her apology to the D'Angelo family was heartfelt. It was apparent that she was deeply affected by her mistake, leading to changes in her practice; to always check documentation rather than relying on information provided by others.

Transfer to hospital

- 176 The consequence of Dr Konok not initiating active treatment for Mrs D'Angelo was that she remained at NECH for a further 18 hours. Mrs D'Angelo was monitored with only one entry made in the clinical notes at 10:12 pm on 3 October 2020, and four entries made on 4 October 2020 at 7:30 am,¹¹⁶ 10:28 am, 10:30 am and 11:17 am. All entries raised a level of concern as to Mrs D'Angelo's condition. A urinary tract infection (UTI) was diagnosed on 4 October 2020.
- 177 Anna D'Angelo received a phone call on the morning of 4 October from staff at NECH advising of the UTI as well as informing her (for the first time) that Mrs D'Angelo had

¹¹³ Transcript, page 590

¹¹⁴ Transcript, page 252

¹¹⁵ Transcript, page 253

¹¹⁶ This entry was made retrospectively on 5 October 2020 and recorded carers asking an EN to review Mrs D'Angelo due to her being slow to respond (Exhibit C12, page 262)

not taken any prescription medication for a few days. The staff member expressed concern for Mrs D'Angelo, telling Anna that she had not seen her mother physically look this way before.¹¹⁷ Anna was informed that a locum doctor would be called.

178 Anna contacted her sister, Toni, who in turn immediately rang the facility and insisted that an ambulance be called. The South Australian Ambulance Service Patient Clinical Record reflected that the tasking was received at 11:02 am with paramedics arriving at the facility at 11:08 am. Mrs D'Angelo was taken to the RAH.

179 As outlined at the beginning of the finding, upon her arrival at the RAH, Mrs D'Angelo was noted to be sleeping but responded to voice. Her vital signs were within normal limits however she was found to be severely dehydrated with an acute on chronic kidney injury. No clear underlying cause was found. Efforts were made to resuscitate Mrs D'Angelo with intravenous fluids. She did not respond and continued to decline. Ultimately, her family agreed to a palliative approach.

180 Mrs D'Angelo died on 9 October 2020.

Preventability

181 In light of my findings above, it is important to consider the question of preventability. The *Coroners Act 2003* directs my attention to considering recommendations which might prevent a recurrence of the same circumstances. My duty in that regard would be amplified if preventing those circumstances would have prevented death. In many cases, the question is a difficult one, requiring the weighing up of various possibilities and potential effects of actions not taken. A finding that a death could have been prevented is a finding of substantial weight to the community and, in this case, to the aged care sector. It must be approached with care. If I was uncertain about the potential effect of particular actions, I would refrain from making a finding about preventability. However, in this case, carefully considering all of the evidence I heard together, I am satisfied that a finding that Mrs D'Angelo's death was preventable is open and should be made. There are several aspects.

Systemically guarding against dehydration

182 At a systemic level, if there had been a mechanism to monitor fluid intake, Mrs D'Angelo's death from the effects of dehydration would have been prevented. I have formed this view based on the expert opinion of Professor Whitehead and what I have found Mrs D'Angelo's cause of death to be. Professor Whitehead described this lack of systemic monitoring as the 'greatest missed opportunity'.¹¹⁸ I consider that there are likely two issues I heard evidence about which collide to give rise to this systemic issue; the first is the apparent general misunderstanding in the aged care community that dehydration in the elderly can be detected without blood testing, and, secondly, a lack of realisation of the potential seriousness of subtle signs in blood tests and the potential seriousness of developing dehydration.

183 I find that greater awareness is needed of dehydration in the elderly and the necessity for early detection by blood testing. If there had been greater awareness at the time of these

¹¹⁷ Exhibit C3, paragraph 48

¹¹⁸ Transcript, page 569

events, I consider it likely that concerns could have been raised by any number of nurses and carers.

Action by Dr Giordano

- 184 Professor Whitehead said that the blood test revealed that Mrs D'Angelo was 'vulnerable'.¹¹⁹ He described metaphorically that, at some unknown point following the test, she dropped 'off the cliff'.
- 185 If Dr Giordano had turned his mind to Mrs D'Angelo's elevated risk of dehydration in the context of the mild hypernatraemia revealed in June 2020, and made a record of this in the clinical notes for the aged care staff to monitor, her death would likely have been prevented. It is trite to observe that a condition like dehydration, which can develop undetected as it seems to have done in Mrs D'Angelo's case, would not develop with early preventative measures. I find that to be particularly so where there was a very simple mechanism to address potential dehydration; conscious consideration and documentation of fluid intake.
- 186 I note that in his evidence, Professor Whitehead allowed for the *possibility* that Mrs D'Angelo's dementia had advanced to such a degree that her dehydration might not have been reversible.¹²⁰ Factored against that possibility is the evidence of Mrs D'Angelo's family about her behaviour at her birthday celebration. She was happy, alert and, importantly, taking in food and fluid. I note that this celebration was about three months after the blood test was taken, which in the context of these circumstances is a particularly meaningful timeframe, particularly where Professor Whitehead opined, with some equivocation, that Mrs D'Angelo's clinical dehydration likely started in September.¹²¹ I am satisfied that a recorded acknowledgement of the results three months before her birthday could have prevented the dehydration developing to the dangerous level that it did and that this would have prevented her death.
- 187 I also note that Professor Whitehead was eager to record that he did not consider that Dr Giordano should be expected to have predicted the outcome some months later based on the blood test result.¹²² I accept that to be so, however that is not quite the question that properly arises. The true question is whether the blood test result should have prompted some different action than was taken and whether that different action might have prevented what ultimately occurred. In that sense, Dr Giordano's ability to predict the future is not relevant and I remain satisfied that the evidence established the conclusion I have reached. That is, while the metaphorical cliff was not there to be seen, the vulnerability to dehydration had presented itself in the test and the surrounding circumstances.

Calculating the result of the three-day food and fluid chart

- 188 If the format of the Care Review Tool had not been altered to remove the 24-hour calculation which served to draw attention to trends, it would likely have been realised that on two of the three days of the food and fluid chart, Mrs D'Angelo had taken in an

¹¹⁹ Transcript, page 573

¹²⁰ Transcript, page 585

¹²¹ Transcript, page 649

¹²² Transcript, page 627

inadequate amount of fluid. This would have prompted a remedial mechanism of some kind and, at the very least, closer attention to her ongoing intake. It may be that concern being raised would have led to the earlier blood test being checked and a further blood test being ordered. If that had occurred, the issue of vulnerability to dehydration would again likely have been readily apparent with the same mechanisms available to address it. This was also likely to have prevented Mrs D'Angelo's death.

Action by Dr Konok

- 189 If Dr Konok had requested to see Mrs D'Angelo's Advance Care Directive herself on 3 October 2020, as she accepted she should have, she would have initiated emergency treatment. It is likely that this would have led to blood testing and the administration of fluids which are common and basic interventions. These would have been positive interventions and should have occurred at an earlier time. Notwithstanding that, given the expert evidence, I reach the conclusion that Mrs D'Angelo's condition by this time was advanced to a degree that I cannot say that this intervention would, more likely than not, have prevented her death.

Treatment at the Royal Adelaide Hospital

- 190 I heard some evidence about the particular treatments chosen while Mrs D'Angelo was at the RAH. Consistent with Professor Whitehead's evidence,¹²³ I do not consider that anything that occurred at the RAH was inappropriate or contributed to the issue of dehydration. As I have indicated, by the time Mrs D'Angelo presented at the hospital, the opportunities to prevent her death were gone.

Conclusions

- 191 The findings I have made are set out in accordance with the issues above. I have come to these conclusions on the basis that I am comfortably satisfied each of them were established on the evidence.
1. Mrs D'Angelo died from acute on chronic renal failure caused by severe dehydration, on a background of Lewy body dementia, Parkinson's disease, and congestive cardiac failure.
 2. There was no regular, meaningful monitoring of her daily fluid intake, particularly in the weeks before her deterioration.
 3. As a result, Mrs D'Angelo's dehydration developed to a critical point which was unable to be reversed.
 4. The only reliable way to detect dehydration in older adults is through blood tests, not physical signs, yet this was not adequately understood by multiple clinicians and staff involved in her care.
 5. The June 2020 blood tests showed mild hypernatraemia, a biochemical marker of dehydration. Although not critically abnormal, this result should have prompted:
 - i. Explicit recognition of increased dehydration risk,

¹²³ Transcript, pages 661-662

- ii. Clear instructions to nursing staff, and
- iii. Ongoing monitoring of fluid intake.

These actions would likely have prevented Mrs D'Angelo's death.

6. A three-day food and fluid chart completed shortly afterwards as part of her care plan review showed inadequate intake, but this was neither recognised nor acted upon. This was a further opportunity to identify and address a risk of dehydration which would likely have prevented Mrs D'Angelo's death. After July 2020, there was no further quantification of daily fluid intake.
7. Changes in documentation systems removed prompts for staff to calculate total daily fluid intake or respond to inadequate volumes.
8. Dr Konok's assessment on 3 October 2020 was inadequate. Dehydration was not considered, despite clear reports of lethargy and poor oral intake. A suspected diagnosis of stroke was medically unsound and not communicated to nursing staff or the family.
9. Dr Konok mistakenly believed Mrs D'Angelo was not for active treatment, contrary to her documented wishes, and failed to verify this directly or contact the family. As a result, Mrs D'Angelo was not transferred to hospital that evening, delaying emergency treatment.
10. Intervention on 3 October 2020 would not have altered the final outcome.

Recommendations

- 192 Pursuant to section 25(2) of the *Coroners Act 2003* I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 193 I make the following recommendations directed to the Minister for Health and Wellbeing and the Minister for Seniors and Ageing Well:

- One* That a copy of this finding is forwarded to the Commonwealth Minister for Health, Disability and Ageing with a request to consider the concerning prevalence of dehydration in older persons living within aged care facilities, particularly those with risk factors such as dementia, chronic renal disease and the use of diuretic medications.
- Two* That the Medical Research Future Fund consider providing a grant opportunity to enable the development of an evidence-based dehydration intervention pathway for older Australians living within aged care facilities.
- Three* That a copy of this finding is forwarded to the Commonwealth Aged Care Quality and Safety Commissioner and the Commonwealth Inspector-General of Aged Care with a request to consider implementation of the recommendations directed toward them.

194 I make the following recommendation to the Aged Care Quality and Safety Commissioner, the Inspector-General of Aged Care and the Minister for Health, Disability and Ageing:

Four That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):

The provider implements processes to maintain an older person's hydration by:

- a. Measuring the daily fluid intake of residents who are clinically dehydrated*
- b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s*
- c. Recognising inadequate fluid intake*
- d. Responding to inadequate fluid intake*

195 I make the following recommendations to the Aged Care Quality and Safety Commissioner:

Five That the poster "Preventing Urinary Tract Infections - Recognise Dehydration", published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.

Six That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

196 I make the following recommendation to the Nursing and Midwifery Board of Australia:

Seven That nurses working within the aged care environment receive specialised training in relation to maintaining hydration in older persons, including:

- a. The recommended daily minimum fluid intake*
- b. The unreliability of traditional assessment methods in detecting dehydration*
- c. Medical conditions or treatments which increase the risk of dehydration, and*
- d. Strategies to encourage adequate fluid intake.*

197 I make the following recommendations to the Royal Australasian College of General Practitioners:

Eight That further education be provided as a matter of urgency to redress the widespread use of unreliable assessment methods to detect dehydration in older persons by General Practitioners.

Nine That General Practitioners working within the aged care environment provide advice to Aged Care Facilities regarding the hydration needs of their patient/s, including the recommended daily minimum fluid intake for that patient, and what steps are to be taken in the event of inadequate fluid intake.

Acknowledgments

- 198 I acknowledge the valuable assistance of all counsel in the Inquest.
- 199 I would like to convey my sincere condolences to the family and loved ones of Mrs D'Angelo who experienced her death as unexpected and upsetting.

Keywords: Aged Care; Dehydration; Dementia

Publicly Available

s 22 (1)(a)(ii)

From: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au>
Sent: Thursday, 26 March 2026 4:31 PM
To: s 22 (1)(a)(ii)
Cc: s 22 (1)(a)(ii)
Subject: RE: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL:Sensitive, ACCESS=Personal-Privacy]

OFFICIAL: Sensitive (Personal privacy)

Hi s 22 (1)(a)(ii)

I have undertaken an analysis of the existing [provider guidance](#) for Outcome 5.5 (and a bit further across other outcomes, for context) against Recommendation 4 of the Coroner Court of SA Inquest.

While I do think there is current provider guidance that addresses these recommendations in part, I think there is opportunity to strengthen the guidance to address more specifically.

I have provided my response in 4 parts, for your review and consideration:

- A. Suggested updates for 5.5.5 – refer to [Part A](#) below
- B. Other areas of the provider guidance that is relevant to the recommendation – refer to [Part B](#) below
- C. Additional opportunities for amendments to the provider guidance – refer to [Part C](#) below
- D. Suggestion to provide recommendation 5 and 6 to the Chief Clinical Advisor Division – refer to [Part D](#) below

For context:

Recommendation 4 of the Coroner Court of SA Inquest

Four That consideration be given to amending the final Strengthened Aged Care Quality Standards to include the following requirements (potentially within standard 5.5.5):

The provider implements processes to maintain an older person's hydration by:

- a. Measuring the daily fluid intake of residents who are clinically dehydrated*
- b. Measuring the daily fluid intake of residents assessed as being at risk of dehydration, including all residents living with dementia and residents being administered diuretic medication/s*
- c. Recognising inadequate fluid intake*
- d. Responding to inadequate fluid intake*

s 47C

Part A – Suggested updates for 5.5.5

Please see suggested edits to guidance for 5.5.5 in track changes here: [w !\[\]\(2b17f17ebbacc911bb0ff784ab641779_img.jpg\) SQS Guidance updates for 5.5.5 24032026 DRAFT.docx](#)

Please note:

- Green highlighted text in the word doc shows where current provider guidance already addresses aspects of recommendation 4.
- Comments added for EL1 review.

Context:

From [Safety of clinical care services | Aged Care Quality and Safety Commission](#)

5.5.5 *Nutrition and hydration*

The provider implements processes to maintain an individual's nutrition and hydration by:

1. conducting regular malnutrition screening
2. minimising the impact of chronic conditions
3. responding to the risk of malnutrition and when an individual is malnourished or has unplanned weight loss or gain.

Part B – Other areas of the provider guidance that is relevant to the recommendation.

While guidance for 5.5.5: *Nutrition and hydration* is specifically related to hydration, there are other areas of the provider guidance that include either direct reference to hydration, or are relevant more broadly (ie: assessment/responding to risks/deterioration etc), that is already in place to help support the recommendations.

s 47C

Outcome 6.1: Partnering with individuals on food and drinks

Note: The Coroner's Inquest refers to action 6.1.2 in section 60 and 61.

To make sure you're meeting older people's food, drink and dining preferences, include processes to monitor:

- how satisfied they are with food, drinks and the dining experience This can include food satisfaction surveys, feedback forums and other monitoring strategies such as considering plate wastage (served food that remains uneaten).
- that they're consuming enough food and drink to meet their nutritional needs (Outcomes 5.4, 5.5 and 6.3).

Make sure workers are in line with, understand and provide appropriate assistance when:

- partnering with older people on their food, nutrition and dining needs
- delivering and improving food, nutrition and hydration services
- recognising clinical change that impacts food intake and nutrition (Outcome 5.5)
- supporting older people with modified diets and thickened fluids (Outcome 6.4)
- helping older people with eating and drinking
- using the communication system (Outcome 3.3) to:
 - make sure nutrition and hydration information is up-to-date
 - escalate any risks, changes, deterioration or incidents affecting the older person's nutrition, hydration or ability to eat and drink

Outcome 6.2 Assessment of nutritional needs and preferences

Note: The Coroner's Inquest refers to action 6.2.1 in section 60 and 61.

Relevant to their role, make sure workers understand how to:

- assess each older person's nutrition, hydration and dining needs and preferences as a part of their care and services plan (Outcome 3.1)

Assess older people's nutrition, hydration and dining needs and preferences as part of your assessment and planning processes.

Assess each older person's individual nutrition, hydration and dining needs and preferences. Do this regularly and in partnership with the older person (Outcome 2.1) and include anyone else the older person wants to involve (Outcome 3.1). For example, their supporters, family, carers, registered health practitioners and allied health professionals.

Put in place strategies to manage deterioration or changes in the older person that relate to them eating and drinking (Outcome 5.4). For example, when deterioration and changes affect the older person's ability to:

- eat, drink and swallow
- meet their specific nutritional needs
- meet their hydration needs
- access food and drink when they want it (Outcome 3.2).

Relevant to their role, make sure workers understand how to:

- assess each older person's nutrition, hydration and dining needs and preferences as a part of their care and services plan (Outcome 3.1)
- use this information to plan and provide satisfactory food, drink and dining experiences each older person enjoys
- refer to appropriate registered health practitioners and allied health professionals for specialist advice and reviews. For example, a speech pathologist for an eating, drinking and swallowing assessment (Outcome 5.4).
- undertake relevant screening using validated assessment tools (Outcome 5.5).

Outcome 3.1: Assessment and planning

In the context of creating care and services plans:

- are comprehensive (Outcome 5.4). Consider each older person's:
 - individual needs and preferences (Outcome 1.1)
 - goals of care in collaboration with their supporters, registered health practitioners, allied health professionals and others they want to involve in their care (Outcome 5.4)
 - choices so that you can support them in optimising their quality of life, reablement and maintenance of function
 - clinical needs and risks. For example, individual nutrition, hydration and dining needs and preferences (Outcome 6.2).

Outcome 3.2: Delivery of funded aged care services

Note: Not specific to processes about dehydration directly, but relevant more broadly.

Put in place strategies to support workers to deliver quality and safe care and services.

You need to develop these strategies to meet the requirements of your risk management system (Outcome 2.4).

These strategies need to support workers to:

- recognise risks or concerns about an older person's health, safety and wellbeing
- identify deterioration, changes to an older person's physical, mental and cognitive functions, or changes in their ability to perform activities of daily living. This includes changes to an older person's circumstances, needs, goals and preferences (Outcome

Outcome 5.4: Comprehensive care

Note: Not specific to processes about dehydration directly, but relevant more broadly.

Put in place processes for comprehensive clinical assessment.

- You need to have robust systems for person-centred care (Outcome 1.1), assessment and planning and reablement (Outcome 3.1). Put in place evidenced-based clinical assessment processes that:
 - identify and address how complex the older person's clinical conditions, issues and risks are. The older person's care and services plan needs to include strategies to prevent, mitigate and escalate:
 - acute conditions
 - exacerbations of chronic conditions
 - clinical risks of harm.

Part C – Additional opportunities for amendments to the provider guidance s 47C

Guidance for action 5.6.1

s 47C

- Put in place processes for ongoing monitoring and response to:
 - changing clinical care needs which could include changes in behaviour, changes to medication
 - changing communication needs
 - changing daily care needs such as personal hygiene and dietary requirements.
 - need for additional care minutes from registered health practitioners and allied health professionals and workers.

Guidance for action 5.6.3

s 47C

- Put in place assessment processes to respond to changed behaviours that include:
 - making sure the immediate safety of the older person and others is maintained
 - identifying factors that could cause changes, including unmet needs, environmental, malnutrition, delirium, pain, eating, drinking, swallowing and medication changes
 - identifying each older person's psychosocial and support needs
 - involving supporters, carers and family, or others who know the person (when relevant)
 - referring to behavioural support specialists/ services and allied health professionals when needed for aged care services delivered in a residential care home, home or community setting, as outlined in Action 7.2.3.

Guidance for **outcome 6.1**

Note: The Coroner's Inquest refers to action 6.1.2 in section 60 and 61.

s 47C

Make sure workers are in line with, understand and provide appropriate assistance when:

- partnering with older people on their food, nutrition and dining needs
- delivering and improving food, nutrition and hydration services
- recognising clinical change that impacts food intake and nutrition (Outcome 5.5)
- supporting older people with modified diets and thickened fluids (Outcome 6.4)
- helping older people with eating and drinking

Guidance for **Outcome 6.2 Assessment of nutritional needs and preferences**

Note: The Coroner's Inquest refers to action 6.2.1 in section 60 and 61.

s 47C

- clinical, physical and cognitive issues that may affect the older person's ability to eat, drink and swallow. For example, poor oral health or the effects of medication on appetite.

Part D – Suggestion to provide recommendation 5 and 6 to the Chief Clinical Advisor Division

I am not sure whether Recommendation 5 and 6 have been provided to the Chief Clinical Advisor Division for consideration.

Coroner's Inquest sections 72-73 include more context related to the poster/fact sheet (noting there may be other references to that guidance in the Coroner's Inquest).

For reference:

- Poster link: [Preventing Urinary Tract Infections: Recognising dehydration](#)
- Commission web content: [Keep your fluids up!](#)

I make the following recommendations to the Aged Care Quality and Safety Commissioner:

- Five* That the poster “Preventing Urinary Tract Infections - Recognise Dehydration”, published in the resource library section of the Aged Care Quality and Safety Commission website, be amended to reflect that caution must be exercised in the identification of dehydration in older persons based on observable signs as it may only be reliably identified by a blood test.
- Six* That the Commissioner provide educational resources to aged care providers regarding the prevalence of dehydration in older persons, and the unreliability of traditional assessment methods in detecting dehydration.

Happy to chat about any of the above – many thanks!

Kind regards

s 22 (1)(a)(ii) (She/Her/Hers)
Senior Policy Officer
Operational Policy and Support
Regulatory Strategy and Policy (RSP) Group

Aged Care Quality and Safety Commission
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Adelaide, Kurna Country
I work Monday, Tuesday, Thursday, Friday



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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To: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au>

Cc: s 22 (1)(a)(ii) @agedcarequality.gov.au>

Subject: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii)
[SEC=OFFICIAL:Sensitive, ACCESS=Personal-Privacy]

OFFICIAL: Sensitive (Personal privacy)

Hi s 22 (1)(a)(ii)

As discussed, could you please undertake an analysis of the existing provider guidance for Outcome 5.5 (specifically Action 5.5.5) and compare against Recommendation 4 of the Coroner Court of SA Inquest (see attached) to see if there's any gaps that warrant an update to the guidance material?

We can then look at the risk involved as to whether we action these updates now or hold for future SQS enhancements as part of CI processes.

<https://www.agedcarequality.gov.au/strengthened-quality-standards>

s 22 (1)(a)(ii) sharing for your awareness as discussed.

Kind Regards,

s 22 (1)(a)(ii) (she/her/hers)

A/Assistant Director

Operational Policy and Support

Knowledge Management and Operational Policy

Aged Care Quality and Safety Commission

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From: s 22 (1)(a)(ii) s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

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To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>; s 22 (1)(a)(ii) <s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: s 22 (1)(a)(ii) [@agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)
Subject: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii)
[SEC=OFFICIAL:Sensitive]

OFFICIAL: Sensitive

Hi s 22 (1)(a)(ii),

s 22 (1)(a)(ii) a contact from the Department, reached out to me today to discuss the SA Coroner's findings re the inquest into the death of an aged care resident in 2020. DHDA has requested we update the guidance material (standard 5, outcome 5.5.5) to include recommendations relating hydration/dehydration for residential aged care providers.

I suspect that is information that could be included here, in the digital guidance.

5.5.5 *Nutrition and hydration*

The provider implements processes to maintain an individual's nutrition and hydration by:

1. conducting regular malnutrition screening
2. minimising the impact of chronic conditions
3. responding to the risk of malnutrition and when an individual is malnourished or has unplanned weight loss or gain.

Noting the request relates to guidance material, are you happy to manage this at your end and follow up with s 22 (1)(a)(ii) (email in the trail below)? Please let me know if there's anything I can do support this.

Cheers,

s 22 (1)

s 22 (1)(a)(ii)

Assistant Director

Sector Education

Engagement, Education and Communications

Aged Care Quality and Safety Commission

E: s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Canberra ACT 2601

Ngunnawal Country



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Sent: Monday, 23 March 2026 2:57 PM
To: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au>
Cc: Quality Aged Care <qualityagedcare@health.gov.au>; s 22 (1)(a)(ii) @Health.gov.au>
Subject: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii)
[SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

Hi s 22 (1)(a)(ii) – great to chat just now.

As discussed, we are sharing some Ministerial correspondence from SA's Minister for Health and Wellbeing (Minister Picton) from 5 March 2026 who forwarded the [SA Coroner's findings](#) re the inquest into the death of an aged care resident in 2020.

There are recommendations (page 34) relating hydration/dehydration guidance for residential aged care providers for the strengthened Quality Standards (sQS).

We've confirmed with Minister Picton's office that similar letters were also sent to the ACQS Commissioner and IGAC, forwarding them copies of the inquest findings, noting recommendations relating to their respective areas of responsibility.

We have drafted a reply for Minister Butler which refers to the Department working with the Commission to consider if/how the sQS guidance supporting Outcome 5.5 / Action 5.5.5 can incorporate the suggestions included in Recommendation Four relating to hydration/dehydration, to further support the sector's understanding of the importance of hydration in the delivery of aged care services.

I will forward you the final Minister Butler reply to Minister Picton when signed, but wanted to give you heads up ahead of that.

We have not undertaken to make any changes to sQS at Action 5.5.5 or Standard 6, but have committed to include these hydration/dehydration recommendations in the mix for the first 5 year periodic review of the Quality Standards (due 2030).

Thanks again for the chat and for undertaking to share with appropriate policy leads at your end to progress.

Look forward to hearing back re progress.

Regards,

s 22 (1)(a)(ii)

s 22 (1)(a)(ii) (he/him)

Assistant Director – Quality Standards and Star Ratings Section

Choice and Transparency Branch | Quality and Assurance Division | Ageing and Aged Care Group

This email comes to you from Turrbal / Kabi Kabi Country

OFFICIAL:Sensitive

OFFICIAL:Sensitive

From: s 47E(d) @Health.gov.au>
Sent: Tuesday, 10 March 2026 7:07 PM
To: MPS s 47E(d) .gov.au>
Cc: s 47E(d) @Health.gov.au>
Subject: MC26-004925 - FW: Letter to Hon Mark Butler MP [SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

MC26-004925

Hi MPS,
Could we please seek an M response to the attached?
For Quality and Assurance Division
Thanks

s 22 (1)(a)(ii)
Departmental Liaison Officer

Office of the Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme
s 22 (1)(a)(ii) health.gov.au
s 47E(d) u
21 Commercial Road, Port Adelaide SA 5015
Suite MG.51 | PO Box 6022, Parliament House, Canberra ACT 2600

OFFICIAL:Sensitive

From: Minister Butler <Minister.Butler@Health.gov.au>
Sent: Tuesday, 10 March 2026 7:07 AM
To: s 47E(d) @Health.gov.au>
Subject: FW: Letter to Hon Mark Butler MP [SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

For s 22 (1)(a)(ii)

s 22 (1)(a)(ii)
Departmental Liaison Officer

Office of the Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

Suite MG.51 | PO Box 6022, Parliament House, Canberra ACT 2600

The Department of Health, Disability and Ageing acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

OFFICIAL:Sensitive

From: Health:Minister for Health <ministerforhealth@sa.gov.au>
Sent: Thursday, 5 March 2026 3:34 PM
To: Minister Butler <Minister.Butler@Health.gov.au>
Subject: Letter to Hon Mark Butler MP

OFFICIAL:Sensitive

OFFICIAL: Sensitive

Our ref: MHW-H26-0932

Good afternoon,

Please find attached signed letter from Hon Chris Picton MP, Minister for Health and Wellbeing.

Kind regards

Office of the Hon Chris Picton MP
Minister for Health and Wellbeing

Level 9, Citi Centre Building, 11 Hindmarsh Square | GPO Box 2555 Adelaide SA 5001
T: (08) 7117 6500 E: ministerforhealth@sa.gov.au | W: www.sahealth.sa.gov.au



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s 22 (1)(a)(ii)

From: s 47E(d) SCRS <DeputyCommissionerSCRS@agedcarequality.gov.au>
Sent: Friday, 26 June 2026 2:39 PM
To: Coroner Inquiries
Cc: s 47E(d) SCRS
Subject: Info: Correspondence re Coroner's Inquest Findings into the death of s 22 (1)(a)(ii)
[SEC=OFFICIAL]

OFFICIAL

Hi Team,

Sharing the below correspondence for your visibility.

Thanks,

s 22 (1)(a)(ii)

Deputy Commissioner SCRS

Deputy Commissioner, Sector Capability & Regulatory Strategy

Aged Care Quality and Safety Commission

E s 47E(d) @agedcarequality.gov.au | W www.agedcarequality.gov.au

GPO Box 9819 in your capital city



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 22 (1)(a)(ii) @sa.gov.au>
Sent: Friday, 26 June 2026 1:33 PM
To: Office of the Commissioner <s 47E(d) agedcarequality.gov.au>
Cc: s 47E(d) @sa.gov.au>; Health:Minister for Health <ministerforhealth@sa.gov.au>
Subject: RE: Correspondence [SEC=OFFICIAL]

OFFICIAL

Good afternoon, s 22 (1)(a)(ii)

Thank you for the correspondence from Commissioner s 22 (1)(a)(ii) acknowledging the Coronial recommendations in relation to the death of s 22 (1)(a)(ii) directed to the Aged Care Quality and Safety Commission (Commission).

The Commission's response to the recommendations, including work being progressed in collaboration with the Department of Health, Disability and Ageing (the Department) is noted and will be provided to the South Australian Deputy State Coroner.

Thank you for considering and implementing the recommendations, and supporting continuous improvement in the quality and safety of Commonwealth funded aged care.

Kind regards

s 22 (1)(a)(ii)

Director Safety & Quality

Clinical System Support & Improvement

Department for Health & Wellbeing | SA Health

Mobile: s 22 (1)(a)(ii) @sa.gov.au

Website: www.health.sa.gov.au

she/her

Read the

Reconciliation Action Plan

May 2026 – April 2029



I acknowledge I am working on Kaurna Country

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From: Office of the Commissioner <s 47E(d) agedcarequality.gov.au>

Sent: Friday, 5 June 2026 10:33 AM

To: Health:Minister for Health <MinisterforHealth@sa.gov.au>

Cc: Office of the Commissioner <s 47E(d) agedcarequality.gov.au>

Subject: Correspondence [SEC=OFFICIAL]

You don't often get email from s 47E(d) agedcarequality.gov.au. [Learn why this is important](#)

OFFICIAL

Good morning

Please see attached correspondence to Minister Boyer from Commissioner s 22 (1)(a)(ii)

With thanks

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Executive Officer to s 22 (1)(a)(ii) Commissioner
Aged Care Quality and Safety Commission

s 22 (1)(a)(ii) @agedcarequality.gov.au | www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Canberra ACT 2601



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Joshua Pelizzari

From: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Thursday, 16 April 2026 7:09 AM
To: Coroner Inquiries
Cc: s 22 (1)(a)(ii)
Subject: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL:Sensitive, ACCESS=Personal-Privacy]

Follow Up Flag: Flag for follow up
Flag Status: Flagged

OFFICIAL: Sensitive (Personal privacy)

Hi s 22 (1)(a)(ii)

FYI

s 22 (1)(a)(ii)
Assistant Director
Sector Risk and Partnerships Section
Regulatory Strategy and Partnerships Branch
Sector Capability and Regulatory Strategy Division

Aged Care Quality and Safety Commission
E s 22 (1)(a)(ii)@agedcarequality.gov.au | W www.agedcarequality.gov.au
s 22 (1)(a)(ii)
GPO Box 9819, Melbourne VIC 3001
Woiworung Country



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 22 (1)(a)(ii) s 22 (1)(a)(ii)@agedcarequality.gov.au>
Sent: Wednesday, 15 April 2026 11:38 AM
To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii)@agedcarequality.gov.au>
Subject: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii) [SEC=OFFICIAL:Sensitive, ACCESS=Personal-Privacy]

OFFICIAL: Sensitive (Personal privacy)

FYI

s 22 (1)(a)(ii) Hayes

Assistant Director

Sector Education

Engagement, Education and Communications

Aged Care Quality and Safety Commission

s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Canberra ACT 2601

Ngunnawal Country



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: **s 22 (1)(a)(ii)** <**s 22 (1)(a)(ii)** [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Sent: Friday, 27 March 2026 5:25 PM

To: **s 22 (1)(a)(ii)** **s 22 (1)(a)(ii)** [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Cc: **s 22 (1)(a)(ii)** [@agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au); **s 22 (1)(a)(ii)**

<**s 22 (1)(a)(ii)** [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>; **s 22 (1)(a)(ii)** **s 22 (1)(a)(ii)** [agedcarequality.gov.au](mailto:s22(1)(a)(ii)@agedcarequality.gov.au)>

Subject: RE: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of **s 22 (1)(a)(ii)**

[SEC=OFFICIAL:Sensitive, ACCESS=Personal-Privacy]

OFFICIAL: Sensitive (Personal privacy)

Hi **s 22 (1)(a)(ii)**

Thanks for sending this over to us – just wanting to update you that we're currently analysing what we already have included in the guidance to inform what updates we need to make to address the recommendations in the Coroner Inquest and timings for this.

We can take over the request from here and follow-up with s 22 (1)(a)(ii) directly, but happy to loop you in on our progress.

Kind Regards,

s 22 (1)(a)(ii) (she/her/hers)

A/Assistant Director

Operational Policy and Support

Knowledge Management and Operational Policy

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au) | W www.agedcarequality.gov.au

T s 22 (1)(a)(ii)

GPO Box 9819, Sydney NSW 2001

Dharug Country



In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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From: s 22 (1)(a)(ii) s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Sent: Monday, 23 March 2026 16:35

To: s 22 (1)(a)(ii) <s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>; s 22 (1)(a)(ii)

<s 22 (1)(a)(ii) [agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Cc: s 22 (1)(a)(ii) [@agedcarequality.gov.au](mailto:s 22 (1)(a)(ii)@agedcarequality.gov.au)>

Subject: FW: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii)

[SEC=OFFICIAL:Sensitive]

OFFICIAL: Sensitive

Hi s 22 (1)(a)(ii) ,

s 22 (1)(a)(ii) a contact from the Department, reached out to me today to discuss the SA Coroner's findings re the inquest into the death of an aged care resident in 2020. DHDA has requested we update the guidance material (standard 5, outcome 5.5.5) to include recommendations relating hydration/dehydration for residential aged care providers.

I suspect that is information that could be included here, in the digital guidance.

5.5.5 *Nutrition and hydration*

The provider implements processes to maintain an individual's nutrition and hydration by:

1. conducting regular malnutrition screening
2. minimising the impact of chronic conditions
3. responding to the risk of malnutrition and when an individual is malnourished or has unplanned weight loss or gain.

Noting the request relates to guidance material, are you happy to manage this at your end and follow up with s 22 (1)(a)(ii) (email in the trail below)? Please let me know if there's anything I can do support this.

Cheers,

s 22 (1)

s 22 (1)(a)(ii) Hayes

Assistant Director

Sector Education

Engagement, Education and Communications

Aged Care Quality and Safety Commission

E s 22 (1)(a)(ii) agedcarequality.gov.au | W www.agedcarequality.gov.au

s 22 (1)(a)(ii)

GPO Box 9819, Canberra ACT 2601

Ngunnawal Country



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From: s 22 (1)(a)(ii) @Health.gov.au

Sent: Monday, 23 March 2026 2:57 PM

To: s 22 (1)(a)(ii) s 22 (1)(a)(ii) agedcarequality.gov.au

Cc: Quality Aged Care <qualityagedcare@health.gov.au>; s 22 (1)(a)(ii) @Health.gov.au

Subject: sQS Guidance - re Action 5.5.5 - RE: Coroner Court of SA Inquest into death of s 22 (1)(a)(ii)

[SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

Hi ^{s 22 (1)} – great to chat just now.

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There are recommendations (page 34) relating hydration/dehydration guidance for residential aged care providers for the strengthened Quality Standards (sQS).

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We have not undertaken to make any changes to sQS at Action 5.5.5 or Standard 6, but have committed to include these hydration/dehydration recommendations in the mix for the first 5 year periodic review of the Quality Standards (due 2030).

Thanks again for the chat and for undertaking to share with appropriate policy leads at your end to progress.

Look forward to hearing back re progress.

Regards,

^{s 22 (1)(a)(ii)}

^{s 22 (1)(a)(ii)} (he/him)

Assistant Director – Quality Standards and Star Ratings Section

Choice and Transparency Branch | Quality and Assurance Division | Ageing and Aged Care Group

T: ^{s 22 (1)(a)(ii)} [@health.gov.au](mailto: @health.gov.au) | Location: Brisbane (1hr behind ACT)

This email comes to you from Turrbal / Kabi Kabi Country

OFFICIAL:Sensitive

OFFICIAL:Sensitive

From: ^{s 47E(d)} [@health.gov.au](mailto: @health.gov.au)>

Sent: Tuesday, 10 March 2026 7:07 PM

To: MPS ^{s 47E(d)} [@health.gov.au](mailto: @health.gov.au)>

Cc: Minister Butler DLO ^{s 47E(d)} [@Health.gov.au](mailto: @Health.gov.au)>

Subject: MC26-004925 - FW: Letter to Hon Mark Butler MP [SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

MC26-004925

Hi MPS,
Could we please seek an M response to the attached?
For Quality and Assurance Division
Thanks

s 22 (1)(a)(ii)

Departmental Liaison Officer

Office of the Hon Mark Butler MP

Minister for Health and Ageing

Minister for Disability and the National Disability Insurance Scheme

s 22 (1)(a)(ii) [@health.gov.au](mailto:health.gov.au) | s 22 (1)(a)(ii) [.health.gov.au](mailto:health.gov.au)

s 47E(d)

21 Commercial Road, Port Adelaide SA 5015

Suite MG.51 | PO Box 6022, Parliament House, Canberra ACT 2600

OFFICIAL:Sensitive

From: Minister Butler <Minister.Butler@Health.gov.au>
Sent: Tuesday, 10 March 2026 7:07 AM
To: s 47E(d) [@Health.gov.au](mailto:health.gov.au)>
Subject: FW: Letter to Hon Mark Butler MP [SEC=OFFICIAL:Sensitive]

OFFICIAL:Sensitive

For s 22 (1)(a)(ii)

s 22 (1)(a)(ii)

Departmental Liaison Officer

Office of the Hon Mark Butler MP

Minister for Health and Ageing

Minister for Disability and the National Disability Insurance Scheme

s 22 (1)(a)(ii)

s 47E(d)

Suite MG.51 | PO Box 6022, Parliament House, Canberra ACT 2600

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OFFICIAL:Sensitive

From: Health:Minister for Health <ministerforhealth@sa.gov.au>
Sent: Thursday, 5 March 2026 3:34 PM
To: Minister Butler <Minister.Butler@Health.gov.au>
Subject: Letter to Hon Mark Butler MP

OFFICIAL:Sensitive

OFFICIAL: Sensitive

Our ref: MHW-H26-0932

Good afternoon,

Please find attached signed letter from Hon Chris Picton MP, Minister for Health and Wellbeing.

Kind regards

**Office of the Hon Chris Picton MP
Minister for Health and Wellbeing**

Level 9, Citi Centre Building, 11 Hindmarsh Square | GPO Box 2555 Adelaide SA 5001
T: (08) 7117 6500 E: ministerforhealth@sa.gov.au | W: www.sahealth.sa.gov.au



Government of
South Australia



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Office of the Commissioner
Your Ref: MHW-H26-0932
Our Ref: LHW2026-06-01

The Hon Blair Boyer MP
Minister for Health and Wellbeing
Member for Wright
GPO Box 2555
ADELAIDE SA 5001

By email: MinisterforHealth@sa.gov.au

Dear Minister

I refer to correspondence of 5 March 2026 from the then Minister for Health and Wellbeing, the Hon Chris Picton MP, regarding the South Australian Deputy State Coroner's Inquest Findings in relation to the death of Mrs s 22 (1)(a)(ii) Mr s 22 (1)(a)(ii) as Ag Commissioner, acknowledged the correspondence from Mr Picton at the time.

I acknowledge the recommendations directed to the Aged Care Quality and Safety Commission (Commission) and acknowledge the significance of the issues identified in the findings, including matters relating to hydration management for older people, particularly those living with dementia, and educational supports for registered providers.

I am writing to you now to advise the Commission's response to the recommendations, including work being progressed in collaboration with the Department of Health, Disability and Ageing (the Department).

Recommendation Four

Recommendation 4 relates to the strengthened Aged Care Quality Standards, including matters relating to hydration and older people living with dementia.

The Commission, with the Department, is progressing updates to the strengthened Quality Standards provider guidance, specifically Outcome 5.5, to enhance the sector's understanding of the importance of assessing and monitoring older people's hydration status in the delivery of Commonwealth funded aged care.

Recommendations Five and Six

These recommendations relate to new and existing educational resources about detecting and preventing dehydration in aged care settings.

The Commission has undertaken expert clinical review of several existing hydration guidance resources, including posters, articles and web content, that are available to providers on the Commission's website.

We will retire the resource "Preventing Urinary Tract Infections - Recognise Dehydration" and look to develop new guidance that highlights the recommendations made by the Deputy State Coroner.

The Commission is also developing several resources to educate the aged care sector on best practice hydration management and is incorporating the suggestions contained in recommendations 5 and 6 in our considerations. Key resources include a Quality Bulletin article for publication, informed by practical sector insights, and a new fact sheet on preventing and managing dehydration in older adults.

Additionally, the Commission will publish a Clinical Alert from the Commission's Chief Clinical Advisor s 22 (1)(a)(ii) raising awareness of dehydration risk in older people. This Clinical Alert will emphasise in simple language the importance of hydration for older people and processes to monitor and manage it. It will include the importance of holistic assessment, and the need to escalate any clinical deterioration or changes in an older person, and doing this in line with the older person's wishes.

The Commission will continue to consider and implement, where appropriate, the recommendations outlined in the Deputy State Coroner's findings, to support continuous improvement in the quality and safety of Commonwealth funded aged care.

Yours sincerely

s 22 (1)(a)(ii)

s 22 (1)(a)(ii)
Commissioner

5 June 2026



The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

Ref No: MC26-004925

The Hon Blair Boyer MP
Minister for Health and Wellbeing
Member for Wright
GPO Box 1563
ADELAIDE SA 5001
Minister.Boyer@sa.gov.au

Dear Minister

This letter is responding to correspondence received from the former Minister for Health and Wellbeing, the Hon. Chris Picton MP on 5 March 2026 regarding the Coroners Court of South Australia's recommendations relating to the death of Ms Adelina D'Angelo in 2020.

I was saddened to hear of the circumstances surrounding the death of Ms D'Angelo while receiving aged care services. The safety, dignity and wellbeing of older people living in aged care homes is a matter of the utmost importance, and I thank the Government for raising these concerns. Issues relating to the quality of care for older Australians deserve careful attention, and I appreciate you taking the time to bring this important matter to attention.

I appreciate relevant recommendations were highlighted in the inquest report, including suggested amendments to the strengthened Aged Care Quality Standards (strengthened Quality Standards) at Recommendation Four relating to hydration.

I recognise the serious and important concerns raised by the Coroners Court of South Australia regarding dehydration of residents in aged care, particularly those living with Dementia. The strengthened Quality Standards seek to address risks associated with hydration and dehydration. These issues are specifically and comprehensively addressed through strengthened Quality Standard 6 on food and nutrition, and strengthened Quality Standard 5 on clinical care.

The strengthened Quality Standards commenced on 1 November 2025 as part of the Australian Government's landmark *Aged Care Act 2024* (Act). The strengthened Quality Standards enhance expectations on aged care providers to deliver safe, quality and person-centred care and services. Like the Act, the strengthened Quality Standards increase the focus on placing older people and their rights at the centre of the aged care system. They also enhance requirements for clinical care, food and nutrition and to support people living with dementia.

The strengthened Quality Standards were developed following significant stakeholder consultations with from 2022, with valuable input from older people based on their lived experience; subject matter experts on dementia; food and nutrition experts; health professionals; peak bodies and providers. The final version of the strengthened Quality Standards incorporate findings of a pilot by the Aged Care Quality and Safety Commission (Commission) in 2023, the Commission's consultation on the development of supporting guidance materials and public consultation on the Aged Care Rules in early 2025. The new dedicated Quality Standard 5 on clinical care was developed through the expertise of the Australian Commission on Safety and Quality in Health Care.

The legislated requirements in strengthened Quality Standard 6 significantly enhance the previous nutrition expectations that were in place during Ms D'Angelo's care under the previous Quality Standards. Some of the mandatory requirements for residential aged care providers under strengthened Quality Standard 6 relating to hydration include:

- demonstrating they understand the specific nutritional needs of older people under Outcome 6.2 (for example, through regular assessments of older people's nutrition, hydration and dining needs and preferences)
- providing food and drinks that meet older people's nutritional needs under Outcome 6.3 (for example, with menus designed in partnership with older people and with the input of chefs, cooks and an Accredited Practising Dietitian).

Hydration requirements are also highlighted in the new dedicated Quality Standard on clinical care (strengthened Quality Standard 5). Under this Quality Standard, providers must ensure older people receive person-centred, evidence based, safe and effective clinical care that meets changing clinical needs, is in line with older people's goals and preferences, and focusses on prevention as well as treatment of conditions. Specifically, under Outcome 5.5, it is a legislative requirement for providers to identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services, to ensure the delivery of safe, quality clinical care services and to reduce the risk of harm to older people. The supporting actions identify ways a provider can demonstrate meeting this outcome, and identifies nutrition and hydration as one of the high impact and high prevalence clinical care risks a provider must manage.

Recommendation Four also identifies dementia as a related risk factor for dehydration. Dementia was one of key focus areas highlighted by the Royal Commission into Aged Care Quality and Safety for inclusion in the review of the previous Quality Standards. As such, key concepts to support providers to deliver quality care to people living with dementia have also been embedded throughout the strengthened Quality Standards. For example, under:

- Outcome 5.6, providers must ensure that older people who experience cognitive impairment whether acute, chronic or transitory, need to receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences.
- Outcome 3.2 providers must deliver care and services in a way that meets the older person's needs, goals and preferences, including delivering care and services in a way that is appropriate for people with specific needs, including dementia.

Recommendation Four suggests amending 'action' 5.5.5 of the strengthened Quality Standards to include more specific hydration requirements. It is worth noting the supporting actions in the strengthened Quality Standards are not mandatory but serve to guide providers on how they can demonstrate they meet the legislated outcomes in the strengthened Quality Standards. The Department of Health, Disability and Ageing has added the suggestions in Recommendation Four to be considered in the next review of the Quality Standards, required every five years under the Act.

In the meantime, the department is working with the Commission to consider incorporating the suggestions in Recommendation Four into the Commission's guidance materials to further support the sector's understanding of the importance of hydration in the delivery of aged care services. This is also consistent with Recommendation Six of the inquest report relating to educational resources for aged care providers, directed to the Aged Care Quality and Safety Commissioner to consider.

I have also referred Recommendation Two relating to grant opportunities under the Medical Research Future Fund (MRFF) to the Health and Medical Research Office in the department. Priorities for MRFF grants are set out in the Australian Medical Research and Innovation Strategy 2021-2026 (Strategy) and related set of Australian Medical Research and Innovation Priorities 2024-2026 (Priorities).

The Australian Medical Research Advisory Board will be consulting with stakeholders on the updated Strategy for 2026-2031 and the associated Priorities. The consultations will be conducted in accordance with requirements under the *Medical Research Future Fund Act 2015*.

I encourage the Coroners Court of South Australia to contribute to these consultations when they commence. It can keep updated through the MRFF consultations website at www.health.gov.au/our-work/mrff/consultations.

Yours sincerely,

s 22 (1)(a)(ii)

Mark Butler

01 / 04 / 2026