QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of RO'H**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	20 September 2017
FILE NO(s):	2013/761
FINDINGS OF:	James McDougall ,Coroner
CATCHWORDS:	CORONERS: nursing home treatment and care, bed sores, assessments, wound management, dietary requirements, documentation
Counsel Assisting	Ms Rhiannon Helsen

Background

Mr RO'H was 69 years of age at the time of his death. He had a significant medical history, having suffered from prostate cancer, hypertension and Parkinson's disease for a number of years. He resided in a Nursing Home, a high care facility, where he required assistance with all daily living tasks, and was unable to mobilise independently.

On 23 February 2013, Mr RO'H was transferred to the Logan Hospital via ambulance with a history of suffering from bed sores for a month. It was reported that whilst the bed sores were initially improving after two courses of antibiotics and wound dressing treatments, they had then started to worsen over the previous two week period. The day prior to Mr RO'H being transported to Hospital, it was noticed by nursing staff that pus was present in his hip wound, and he had a fever. He was assessed by a General Practitioner, who recommended that he be taken to Hospital. As contact was unable to be made with Mr RO'H's next of kin, he was not transferred to hospital until the following day.

Upon admission to Hospital, it was noted that Mr RO'H was unresponsive, hypotensive and febrile. He also had numerous pressure sores, at various stages (four being the deepest), which included:

- Right buttock (stage 4);
- Right buttock (stage 2)
- Right calcaneum (stage 4)
- Left calcaneum (stage 2)
- Left shoulder (stage 1)

He was admitted with suspected septic shock. After consultation with Mr RO'H's next of kin, an acute resuscitation plan was initiated, which indicated that he was not for intubation, invasive ventilation, defibrillation or admission to intensive care.

Mr RO'H was commenced on intravenous antibiotics and admitted for further assessment of his wound care needs. His other medical issues identified at this time included, acute kidney injury, suspected urinary tract infection and hypernatremia.

Unfortunately, despite therapy, Mr RO'H's condition did not improve. He continued to have a low grade fever, low blood pressure, and an increased white blood cell count and respiratory rate, which were all symptoms thought to be consistent with sepsis. Whilst debridement of his wounds were thought to be necessary, this was not carried out prior to his death at 7:50 pm on 27 February 2013.

Autopsy findings

An internal and external post-mortem examination was conducted by Forensic Pathologist, on 4 March 2013.

At autopsy, multiple decubitus ulcers were found, with one on the right hip reaching the underlying bone, causing it to be infected. Pneumonia was also evident in the lungs, with the kidneys also showing changes of pyelonephritis. Significant occlusion of the coronary arteries due to atherosclerosis with the heart was also present, with changes apparent as a result of ischaemic heart disease. General atrophy of the limbs was also evident, which was consistent with immobility. Changes of the brain consistent with Parkinson's disease and dementia were also found.

The cause of death was found to be septic shock, due to or as a consequence of, infected decubitus ulcers complicated by osteomyelitis.

Overview of Nursing Home records

Mr RO'H commenced his permanent residency at the Nursing Home on 24 August 2012.

Relevantly, the records from the Nursing Home, included the following notations:

- The electronic records suggest that Mr RO'H had a number of falls during his stay (2012-2013) and on a number of occasions was only found lying on the floor some hours later.

- Pressure sores were first observed on Mr RO'H's heels in September 2012, which was 31 days after he had commenced residing at the Nursing Home.

- Entries in October 2012, suggest that Mr RO'H was losing weight at a rapid speed.

- Necrotic blood blisters were observed on Mr RO'H's heels in October 2012. These were said to have resolved by November 2012.

- Pressure sores were observed on Mr RO'H's hip region in November 2012. The records note that he was to be repositioned every 2 hrs. There are no notations on the electronic records to confirm this regularly occurred.

- In January 2013, further heel pressure sores were observed. The wound was noted to be necrotic on 6 February 2013.

- Mr RO'H's wounds on his hip and heel were observed by Dr T, a General Practitioner on 8 February 2013. He was placed onto Dicloxacillin and wound dressing was to be undertaken. The wounds were noted to be oozing from the 10 February onwards. As of 15 February, the notes indicate that there was no change to the wounds despite anti-biotics and dressings. The wounds were still oozing with no change as of 18 February 2013. The anti-biotics were ceased as of 20 February and Flagyl was to be applied to the wounds indefinitely.

- On 15 February 2013, it was noted that Mr RO'H had lost 5.7 kg in a week. On 16 February, his blood pressure was recorded as being 80/50. His oral intake was said to be very limited, as he only sipped fluid and would not open his mouth.

- On 17 February 2013, Mr RO'H's temperature was recorded as being 38.7 degrees.

- Dr T reviewed Mr RO'H's wounds on 22 February 2013, and suggested that he be sent to Hospital with next of kin approval. Contact was only able to made with his next of kin on 23 February.

- Handwritten notes in the records suggest that the wounds were only being dressed every 2 days from 28 January 2013 onwards.

- There is a notation on the electronic records as of 22 February which indicates that an infection of the hip pressure sore was first identified on this date. That's clearly inaccurate given the previous notations. A handwritten record suggests that the hip sore was first identified in January 2013, and dressed every two days. Despite no change being noted in the wound, the same process of dressing was continued.

It appears that, despite Mr RO'H's dramatic weight loss, his raised temperature and the wounds present, he was only being reviewed by Dr T on a weekly/fortnightly basis. There are no notations in the records to suggest that Dr T was notified of Mr RO'H's deterioration on 16 February 2013.

Clinical Forensic Medical Unit review

A Forensic Medical Officer was asked to conduct a review of the matter and provide advice as to the adequacy of the care and treatment provided to Mr RO'H by the Nursing Home.

At the time of preparing her report in October 2013, the FMO did not have access to the complete original nursing home records due to delays by the Nursing Home in providing these records. Based upon the notes available, the FMO observed that the records were clearly incomplete and appeared to be a combination of handwritten and electronic notes. She stated that *'there appears to be a general paucity of the nursing notes, particularly given the number and severity of the bedsores Mr RO'H had at the time of admission to hospital'.* The FMO also noted that some of the entries in what appear to be an electronic medical record indicate that it is possible, at a later date, to change the date on which the pressure sore was first noted.
Having considered the material available, the FMO expressed concern in relation to the following issues:

- The nursing care provided to Mr RO'H whilst he resided at the Nursing Home, in particular, the care of his pressure areas and bedsores.
- The assessment of Mr RO'H's dietary requirements whilst he resided at the Nursing Home.
- The meals provided to Mr RO'H at the Nursing Home.
- The assistance with eating and drinking provided to Mr RO'H at the Nursing Home.
- The delay in transferring Mr RO'H to the Hospital from the Nursing Home once he became septic.

Expert opinion, Nurse Kerrie Coleman

An expert report was subsequently provided by Nurse Practitioner for Complex Wound Management at the Royal Brisbane and Women's Hospital, Ms Kerrie Coleman. Ms Coleman was asked to consider the sufficiency of the care and treatment provided to Mr RO'H, particularly in relation to the care of pressure areas and sores at the Nursing Home.

Having reviewed all of the relevant records provided, Ms Coleman raised the following concerns:

(i) Risk assessments

Ms Coleman notes that according to the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury, Australian Wound Management Association (AWMA 2012) risk assessments should be conducted as soon as possible following a patient's admission to a nursing facility, and are to be repeated whenever there is a change in the patient's condition.

The initial document outlining Pressure Injury Prevention monitoring for Mr RO'H was completed by the Nursing Home on 14 December 2012, some 112 days after he had been admitted. The official 'Skin Assessment – Pressure Ulcer Risk Form' was not completed until 19 January 2013, some 148 days after his admission.

Ms Coleman notes that there was limited documentation available outlining the assessment of Mr RO'H's risk of developing a pressure ulcer and the development of any individualised care plan for pressure ulcer prevention and management. Whilst the records did demonstrate that staff had identified a skin breakdown and implemented a treatment plan for Mr RO'H, the document was not extensive or descriptive in nature. There were also significant discrepancies between the different documentation generated describing Mr RO'H's condition, for example the Skin Assessment Form (19/01/13) described Mr RO'H as ambulant with help for activity and slightly limited in his mobility, whereas the care summary (completed 3 days earlier) stated that he could not mobilise and needed two staff members to assist with transfers.

Ms Coleman notes that the records clearly indicate that Mr RO'H developed pressure injuries on his heels 31 days after his admission, and then 63 days later on his hips. Whilst earlier risk assessments may have occurred, there is no documentation in the records supplied, which would support such an assertion. As such, if an earlier assessment was not carried out, the Nursing Home has failed to assess and put in place a Pressure Injury Prevention Plan for Mr RO'H within an acceptable period, as is defined in the AWMA 2012 guidelines. Further, it does not appear that there was regular, ongoing evaluation undertaken by the Nursing Home of the interventions carried out.

(ii) *Wound management*

Ms Coleman notes that the wound management forms for Mr RO'H were consistently not completed, including a lack of a full description of the wound. This was particularly evident given the findings by the Hospital upon admission, and the Forensic Pathologist following the post-mortem examination.

Ms Coleman expresses the view that this discrepancy in the descriptive nature of the Nursing Home documentation indicates that education is required for all nursing staff on the basics of wound healing, pressure injuries, and the importance of accurate documentation.

Ms Coleman notes that there is a wide variation in choices of treatments for pressure injuries amongst clinicians. However, the choice should be based on a comprehensive assessment of the patient, their wound and their healing environment, in accordance with the AWMA guidelines.

In Mr RO'H's case, the dressing initially used for the wound was reasonable, in Ms Coleman's view, with the infection having been diagnosed appropriately. However, a swab of the wound may have been useful to confirm that the bacteria involved were susceptible to antibiotics, in addition to the use of anti-microbial dressings.

(iii) *Documentation*

The documentation maintained by the Nursing Home did not meet the minimum standards as required by the Aged Care Standards and Accreditation Agency. Ms Coleman identified significant gaps in Mr RO'H's documentation spanning from his admission until after identification of the first pressure injury.

(iv) *Assessment of dietary requirements*

Ms Coleman notes that whilst there was documentation as to Mr RO'H's ongoing nutritional intake and lack of appetite, there was no identification of the possible correlation between his malnutrition and pressure ulcer formation. It is noted that there is a positive correlation between malnutrition and pressure ulcer incidence and severity.

Furthermore, there was no documentation in the records, which suggested that the Nursing Home had made any referrals to outside agencies or internal allied health, such as a dietician to handle his identified weight loss. Ms Coleman is of the view that given Mr RO'H's ongoing difficulties with eating and weight loss, he required an in-depth nutritional assessment, using a recognised tool, as well as a review by a dietician.

(v) *Transfer to Hospital*

Having considered the available Nursing Records, Ms Coleman notes that there was documentation outlining Mr RO'H's deteriorating condition, however, no specific escalation of his decline. Prior to his admission to Hospital, a General Practitioner was reviewing him weekly, however, there was no recognition by staff as to the significance of his deteriorating condition.

On 16 February, Mr RO'H's observations indicated symptoms suggestive of severe sepsis and dehydration, including a high temperature, a high respiratory rate and that he was hypotensive. It does not appear from the records that the General Practitioner was notified of these changes to Mr RO'H's condition.

It was not until the scheduled General Practitioner visit some six days later that a decision was made to transfer Mr RO'H to Hospital for definitive treatment. A further delay of 24 hours was then experienced, as the Nursing Home could not contact his partner. Ms Coleman notes that there was no documentation on file suggesting that an Advanced Care Plan was in place, which required the Nursing Home to contact Mr RO'H's next of kin before he was transferred to Hospital.

In Ms Coleman's opinion, nursing staff should have contacted the General Practitioner and Mr RO'H's next of kin on 16 February to arrange for his immediate transfer to Hospital for review of his condition. Whilst a delay of six days is significant, Ms Coleman notes that there is no evidence to suggest that had Mr RO'H been transported to Hospital earlier that he would have survived.

(vi) *Sufficiency of policies and procedures*

Ms Coleman notes that the current policies of the Nursing Home, as provided with the records supplied, appear to be of a generic nature and do not adequately guide staff as to what action to take when a wound or pressure ulcer occurs or deteriorates. Critically, the following areas are not canvased in the policies:

- Incident management;
- When to undertake risk assessment and skin assessment;
- The type of documentation required by their facility; and
- The reporting process when pressure injuries occur or deteriorate.

Ms Coleman suggests that the update of these policies need to include a stipulated course of action for staff, as well as an organisational incident reporting process, which will assist to ensure appropriate steps are taken in similar circumstances in the future.

Conclusions

In summary, Ms Coleman made the following findings:

- Mr RO'H developed pressure injuries within 31 days of being admitted to the Nursing Home.
- Within another 63 days, two more pressure injuries were identified.
- No record of initial risk assessment and appropriate risk management plan being put in place to prevent these pressure ulcers.
- The risk assessment document supplied was 148 days after admission. This is not to standard.
- No indication that Mr RO'H's co-morbidities (i.e. lower leg vascular status, malnutrition, inability to be repositioned) lent him to more prone to developing pressure injuries, or be in a state of 'skin failure' and have this recognised and notified to all parties involved.

Accordingly, Ms Coleman is of the view that the pressure injuries may have been prevented if the Nursing Home had followed evidenced based guidelines and instituted initial risk assessment and regular re-assessment of risk and prevention plans.

Ms Coleman also noted that as of October 2013, the Nursing Home had employed a Clinical Team leader to provide clinical oversight and leadership to the home, which will hopefully improve the risk management processes in place.

Referral to the Office of Aged Care Quality and Compliance

Given the seriousness of Mr RO'H's condition upon admission to Hospital, and the concerns raised by the FMO, a referral was made to the Office of Aged Care Quality and Compliance (OACQC) for consideration as to the adequacy of the care provided to Mr RO'H.

Following this referral, OACQC commenced working with the Nursing Home to address the shortcomings identified. A number of significant changes have been made since Mr RO'H's death, including:

- Transition to a fully electronic records system, which includes the uploading of all wound treatment charts.
- A Clinical Team Leader (RN) has been appointed, who has responsibility for, not only, the management of clinical issues in the facility, but also for the management and assessment of wound care, staff education and assessment.
- A Wounds Management Team has been established, which meets every two weeks to discuss wounds, wound management strategies and staff education on wound care.
- A new pressure area audit tool, which audits the complete care being provided to residents has also been introduced. The tool reviews an individual patient's risk of pressure ulcers, what wounds are present, what pressure relieving equipment and aids are used, what the repositioning, moving and handling requirements are, whether an occupational therapist or physiotherapy assessment has been conducted and what resources, training and education are available in the management of pressure ulcers.

This tool is completed upon a patient's admission to the Nursing Home, and then every three months in line with a review of residents care plans or sooner if required.

- Additional education is also being provided internally to staff with regards to wound care/management, nutrition and the importance of maintaining proper and detailed records.

- External training opportunities have also been sourced in wound care and management.

- Fortnightly nutrition meetings are held to discuss resident's weight and dietary requirements.

- The transfer policy for residents to Hospital has also been updated by the Nursing Home to stipulate that *'a resident must be transferred to hospital for assessment/review under the following conditions…Sudden or unexplained deterioration of condition…The residents GP and next of kin should be notified immediately. In the event that the Registered Nurse is unable to contact the residents' next of kin, they should still send the resident to hospital unless written instructions are on file stating that the resident does not want to be sent to hospital for medical intervention'.*

Given the measures implemented by the Nursing Home, OACQC have indicated that they are satisfied that the concerns raised have been sufficiently addressed.

It should be noted that records cited by the OACQC provided by the Nursing Home seem to be more extensive, and include assessments not detailed in the records provided for the purpose of the coronial investigation.

Conclusion

Mr RO'H was 69 years of age when he died on 27 February 2013, as a result of septic shock caused by decubitus ulcers. I accept that Mr RO'H suffered from a number of co-morbidities, for which he required assistance with daily living tasks as a high care needs resident of the Nursing Home.

The condition Mr RO'H was in when he was admitted to the Hospital was clearly quite dire, suffering from numerous pressure sores and ulcers, two of which were of a significant depth. Records indicate that his condition had clearly begun to deteriorate on 16 February, however, he was not admitted to Hospital for a further six days. Unfortunately, despite significant efforts by the Logan Hospital, Mr RO'H condition did not improve.

I share the concerns raised by the FMO and Ms Coleman in relation to the evident shortcomings in the care provided by the Nursing Home to Mr RO'H. A lack of adherence to evidenced based guidelines and regular risk assessment and prevention plans, clearly led to poor treatment and management of Mr RO'H's bedsores. The paucity of the patient records held by the Nursing Home in relation to Mr RO'H were also of significant concern, and would have undoubtedly made effective management of his condition very difficult.

Since Mr RO'H's death, the Nursing Home have worked with OACQC to rectify the inadequacies identified in relation to the care provided. I accept that a number of significant changes have since been made to address the these shortcomings, most notably the appointment of a Clinical Team Leader, who has responsibility for managing clinical issues within the facility, including an assessment of wound care, and the introduction of further risk

assessment tools to effectively recognise and manage a patient's risk of developing pressure sores. I am satisfied that, if followed and enforced, the implemented measures by the Nursing Home will sufficiently address the concerns arising in relation to Mr RO'H's death.

Given the circumstances of this matter, I am of the view that an inquest into Mr RO'H's death would not be in the public interest, and the matter can be closed by way of findings.

James McDougall
Coroner
CORONERS COURT OF QUEENSLAND
SOUTHERN REGION
20 September 2017