QUEENSLAND COURTS

Coroners Court of Queensland

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Enid Patricia Hiddle**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
DATE:	9 April 2018
FILE NO(s):	2016/4050
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Nursing home care, 81 year old female, rapid decline in 3/12 month residence, multiple falls, weight loss, family concerns with nursing home and GP, undiagnosed acute kidney infection

BACKGROUND

1. Enid Patricia Hiddle lived at the Seventh Day Adventist Retirement Village on Cleveland Redland Bay Road at Victoria Point in Queensland. She died at her residence on 14 September 2016 at the age of 81.

2. Initially a cause of death certificate was issued by Dr Hands stating Enid Hiddle died on 14 September 2016 due to cardiac arrhythmia over the previous four weeks on a background of ischaemic heart disease over 20 years. Hypertension was listed as a significant condition contributing to her death.

3. Family members contacted the coroner's office on 21 September indicating concerns regarding nursing home care over the preceding 3½ months. The next day, which was the day scheduled for funeral arrangements to proceed, the family provided initial information detailing their concerns. They were informed that a coronial review would require the family's consent to an autopsy being undertaken to provide an opportunity to review the stated cause of death and investigate the family's general concerns.

MEDICAL SUMMARY

4. In addition to a documented history of hypertension, Enid had Alzheimer's, osteoporosis (with previous lumbar and thoracic crush) colon cancer, anxiety, hypothyroidism, syncopal episodes, dizziness. She required full assistance with a number of activities of daily living including toileting, showering, dressing and grooming, she used a wheelie walker for mobility and required supervision when mobilising. Enid was considered a high falls risk and a number of strategies were implemented by the nursing home to manage this.

5. Enid was known to wander and in the months prior to her death was transferred to hospital following a number of unwitnessed falls.

6. On 30 July 2016, Enid was admitted to the Redland Hospital following an unwitnessed fall. Nil acute pathology was found other than a Urinary Tract Infection which was treated with antibiotics. A CT Brain and CT Cervical Spine were also conducted. Overall, there was no acute intracranial injury demonstrated and no acute skull fracture or cervical spine fracture.

7. On 16 August 2016, Enid presented at the Redland Hospital due to an unwitnessed fall. A CT scan and blood tests detected no abnormalities.

8. On Wednesday 17 August 2016 Dr Hands was faxed a letter from the Redland Hospital Emergency Department, asking him to perform a urine dip as able.

9. On 4 September 2016 Enid had another fall and was taken to the Redland Hospital by ambulance. On arrival she was alert but confused. Observations were stable. Enid was discharged at 12:48 pm the same day in the care of her son and was then later taken back to the nursing home. The discharge summary prepared by the hospital stated that if possible, Enid may benefit from a urine screen if able, as none was able to be attended to in the emergency department.

10. On the evening of 14 September 2016, nursing staff were called to attend Enid who was found on the floor next to her bed. On examination, there was no shortening or rotation of the limbs which was evidenced by a good range of motion. She was assisted back to her wheelchair, toileted and later taken for her evening meal. No

obvious head or other injuries were noted and neurological observations were stable.

11. Later on 14 September 2016 at 19:20, Enid was in the dining room when she was found unresponsive in her wheel chair with no signs of life.

FAMILY CONCERNS

12. Enid's daughter Jan Sari was the nominated senior next of kin for the family and communicated the family's concerns to the coroner. A summary of these concerns follows. At the outset it is noted that many of these matters are beyond the scope of the coroner's jurisdiction.

13. Enid Hiddle moved into the Seventh Day Adventist nursing home approximately 3½ months prior to her death. She had mild to moderate Alzheimer's disease and could no longer be cared for by her husband who was receiving treatment for cancer.

14. Initially she was placed in a respite room but this was not secure and she was then moved into a secure unit.

15. Her daughter was concerned that her mother's condition was far less advanced than the other residents. This impacted on her mother's overall wellbeing and her mother's condition began to decline.

16. The family investigated alternative arrangements and had planned to move her on 22 October 2016 but she died before this could occur.

17. During the interim period the family recalled as many as 13 incidents of falls. Enid's capacities to stand alone or verbally communicate deteriorated rapidly. She sometimes appeared dehydrated and her weight decreased markedly.

18. There was concern and a request made to transfer her to the high care facility, which was not achieved.

19. The family considered her north-facing room was too hot because air conditioning was turned off and there was no opening window.

20. Enid Hiddle was hospitalised on several occasions and treated at the Princess Alexandra Hospital.

21. The family were unhappy with her overall care with respect to nutrition, hydration and medical care.

22. Family members were unhappy with the lack of communication with them and lack of documentation of care for Enid. The family were concerned with the apparent level of sedation.

23. Her daughter Jan stated the family never met her doctor despite attempts to do so. Their father eventually met him a few days prior to Enid's death. Dr Hands did not physically examine Enid at the time but agreed to take her off all medications and start again.

24. On the day of Enid's death her husband had been with her until 4:00pm. Dinner was served at 5:00pm, and he received a call at 7:15pm that his wife had died. Family members attended by 8:15pm.

25. They were informed Enid had a fall at about 5:30 but appeared to be unharmed. They stated they wheeled her out and she ate half her meal. It was then noted that she was quiet, and her colour had changed and her hand was cold. She was unresponsive when checked. She had been then taken back to her bed and the doctor was called.

26. The family were informed that she would have died of cardiac arrest.

27. The family were concerned that the account of events leading to her death was inconsistent with her poor condition earlier that day when visited by her husband and another sister. At that stage she appeared to be suffering delirium and felt like she had a temperature. She could only manage a few sips of fluid.

28. The family was distressed and in all the circumstances not willing to accept the cause of death certificate as accurate.

FURTHER CONCERNS

29. Further concerns were communicated to the Coroners Court by another daughter, Leigh Gouldstone. These issues are summarised as follows, but do not repeat matters already referred to by Jan Sari.

30. Enid Hiddle entered care at the Seventh Day Adventist Retirement Village on 16 May 2016. She had a history of painful crush fractures in the thoracic area due to osteoporosis. She had experienced one fall in the preceding two years whilst living at home.

31. On 5 July 2016 she fell, hitting the back of her head and suffering a skin tear to her left shin.

32. On 25 July 2016 she complained to Leigh Gouldstone of being itchy. She had sores on the top of her legs and body, and a spotty rash on her upper torso. Some cream was provided and a swab taken but no result was ever communicated to the family. The rash continued and there was only intermittent application of the cream, which was not resupplied.

33. On 27 July 2016 Enid remained in bed. The room was hot due to its northerly aspect and lack of ventilation. The air conditioning was set to heating because it was July. The temperature could not be adjusted effectively in her room.

34. Enid appeared to be declining quickly, experiencing shakes, having no energy and struggling to stand or walk. She appeared to be dehydrated.

35. From August she appeared to have difficulty feeding herself. She was having difficulty swallowing. She was lethargic and appeared sedated. She clearly required assistance to eat, but this was not happening.

36. On 10 August Enid had another fall and hit above her left eye.

37. There was another fall the following week where she sustained a large bruise across the right-hand side of her face. By this time she had lost weight.

38. A request was made for bedrails, but this was refused.

39. The clinical nurse Karen Hennessey was spoken to, requesting restraint for the wheelchair to prevent further falls. This was declined as a potential choking hazard.

40. There was no padded mat beside the bed to reduce the risk of impact if a fall occurred. These mats were only available in the high care unit. Despite an enquiry about this, a mat was not supplied.

41. On 23 August Enid's bed was moved against the wall on one side with a pressure mat placed beside the bed to alert staff if she tried to get up. There was no padding, however, to prevent injury or cushion her fall.

42. A request was made for consideration of Enid being placed in the high care area due to her inability to feed herself and requirement for greater assistance. The request put to the clinical nurse Karen Hennessey was refused, stating 'she was still wandering and able to feed herself'. This was disputed by the family.

43. Family attempted to contact Dr Hands but there was no return of the call.

44. A meeting was arranged with Karen Hennessey and family members on 29 August 2016 regarding various concerns, including lack of communication with Dr Hands. It was suggested that their father, who had enduring power of attorney, drive to Logan to speak to him.

45. The family commenced making arrangements for another doctor to visit, but were then dissuaded by Karen Hennessey on or about 5 September. The explanation was that the first doctor was more easily contactable.

46. There was contact by the emergency team from the Princess Alexandra Hospital who had been alerted by the Redland Hospital due to the number of falls and hospital admissions. They were proposing a review of medications by their geriatrician Dr Gray. This prompted Dr Hands to contact Enid's husband the next day. It was the first contact between Dr Hands and the family. However, an arranged meeting was postponed.

47. On 7 September 2016 the emergency team from the Princess Alexandra Hospital attended and spoke with Enid and her husband and held a tele-link meeting with the geriatrician Dr Gray. They remarked upon the overheating in her room. The review was to be forwarded to Dr Hands.

48. Enid's husband wrote to Dr Hands as enduring power of attorney, giving permission for Dr Hands to cease her medications so that staff could monitor reactions. However, Dr Hands was on leave and a further meeting was arranged for 14 September. That was the date on which Enid died.

49. Leigh Gouldstone visited her mother on 10 September. Her mother was very low, but she was able to take her out for a home visit. She was able to have a small amount of food, but there was a short period of 'blacking out' during the visit.

50. On 13 September she was declining as she remained in bed and had not eaten. She was less capable of mobility to access the bathroom, even with assistance. Whilst moving her back into the wheelchair she blacked out.

51. She was briefly reviewed by two nurses, by which time she had revived.

52. On 14 September Leigh Gouldstone met with her father in Enid's room to discuss arrangements directly with Dr Hands. Enid was unable to eat anything and appeared delirious.

53. Dr Hands reviewed the medications individually.

54. The family raised nutrition and the possibility of a drip. Sustagen was discussed as a supplement.

55. Dr Hands did not review Enid Hiddle physically or examine her or take any observations, even though he had been away for two weeks. On suggestion by Leigh Gouldstone, he shone a torch into her mouth and agreed she might have an infection and that antibiotics would be commenced. The discussion with the doctor was disappointing to the family.

56. Three hours later the family were notified that Enid had died.

57. Leigh Gouldstone considered her mother's care by Dr Hands was unsatisfactory.

58. She also felt the nursing staff did not successfully manage her mother's increasing rate of falls, nor care for her sufficiently regarding nutrition and dehydration.

CAUSE OF DEATH

59. Autopsy examination was conducted on 30 September 2016 by the forensic pathologist Dr Samarasinghe. Enid was described as elderly, frail and cachectic, consistent with her low body weight of 32.8kg. Minor bruises were noted on the back of the head, front lower right knee and shin, left knee, calf and shin. There was no underlying injury associated with minor bruise to back of head. CT imaging confirmed no fractures or head injuries. There was severe triple vessel coronary artery calcification.

60. The pathologist noted severe coronary artery disease blocking 80% - 90% of coronary artery. This could have caused sudden death at any time.

61. Tests revealed bacterial infection in the left kidney and possible septic changes within the spleen.

62. There was also pulmonary emphysema, but no pneumonia or aspiration.

63. The pathologist found definite evidence of bacterial infection in the left kidney. The underlying cause could not be identified.

64. Dr Samarasinghe expressed the opinion the deceased would have suffered a degree of renal failure at the time of her death.

65. Pyelonephritis is a urinary tract infection. Bacteria usually reach the kidney by ascending from the lower urinary tract or bloodstream. Timely diagnosis has a significant impact on outcome for the patient. Impaired kidneys cause hormone system to stimulate blood flow to increase supply to the kidneys. This causes greater workload for the heart. In Mrs Hiddle's case the combination of coronary heart disease and acute kidney infection caused her death. Underlying systemic hypertension and Alzheimer's disease contributed to her death.

RESPONSE FROM DR HANDS

66. During the course of the coronial investigation input was sought from Dr Hands. Dr Hands was asked to comment on whether the urine dip requested in August and

September 2016 were carried out and if not why. Dr Hands was provided with a copy of the concerns expressed by the family as well as the autopsy report.

67. Dr Hands advised that he only works at his practice on Tuesdays. He acknowledged that a fax was received by his practice on 17 August 2017 requesting that he "please perform a urine dip as able".

68. He advised that it is his practice when providing the nurse present with a copy of the correspondence he receives at his workplace, to discuss the correspondence and any subsequent treatment plan. He acknowledges that his progress note relates only to the recommendation of the discharge summary to review analgesia, however, he expects that as part of his normal practice, he would have also discussed the request to perform a urine dip

69. Dr Hands noted that the urine dips were performed by the staff at the retirement village. He is therefore unable to comment on whether it was performed. He also notes that that only recently, the retirement village has implemented a requirement that, where a test is performed and the result is negative, the result is required to be recorded. Prior to this, had the results not revealed anything significant then nursing staff did not record the result.

70. Dr Hands advised that taking urine samples from dementia patients can be very difficult due to patient's lack of capacity, compliance and behavioural issues. This is also reflected in the Redland Hospital records which state "awaiting urine dip, patient not complying with in/out catheter or passing urine".

71. He advises that this means staff at the retirement village rely more on clinical signs to identify the presence of a urinary tract infection and that in his experience, they were very good at identifying the clinical signs of urinary tract infection.

72. In relation to the facsimile of 4 September 2016, he is unsure if the midstream specimen of urine was performed as he was away during this time and a consultant physician took over the care of the village

73. When he returned, he met with the family and was advised by her husband (who held enduring power of attorney that he wanted to be conservative with the use of medication however he said other family members expressed different desires particularly re pain medication. During this meeting he says that there were no concerns expressed by the family that suggested the presence of a urinary tract infection or renal failure

74. He noted that on 1 August 2016 when Enid was discharged from the Redland Hospital, she was being prescribed with antibiotic for a urinary tract infection and that there was no recommendation in the discharge summary to continue this medication.

RESPONSE FROM THE NURSING HOME

75. The CEO of Adventist Retirement Plus provided a response to the coronial investigation.

76. At the time of Enid's death, there were no formal codified policies and procedures regarding the documenting of "no abnormality detected" urinalysis results. There was an expectation that staff would record all urinalysis results (positive or negative) on the computer system. However, during the time Enid resided at that the facility, there was no formal training around this. Staff would not always record negative results nor would

they always record urinalysis results in the computer system. Staff would often record results in the residents' progress notes. Adventist acknowledge there were gaps in their training.

77. Adventist advised that they have reviewed processes to improve urinalysis documentation and urinary tract infection treatment. The new policy has implemented a codified version of the processes (reflective of the existing processes that staff were already required to follow identifying, testing and recording urinary tract infections.) The policy is that staff should record all positive and negative urinalysis test results.

78. In addition to this, Adventist have implemented a urinalysis test sample competency for Registered nurses and Enrolled nurses to complete. This includes provision for the recording of negative and positive urinalysis test results. All Registered Nurses s and Enrolled Nurses have been informed of the "new package" (including the policy and procedure and competency components). As at 9 March 2018, it was expected that staff would complete the formal training in the coming weeks.

79. It is further noted that a day book entry regarding the implementation of the new policy and procedure document and competency learning objectives has been created, viewable by all staff.

80. In January 2018, all staff were provided with and are required to complete a training module which provides information regarding detection and management of urinary tract infections. As at 9 March 2018, 108 of 157 staff had completed the training. The nursing home provided evidence of a number of communications with staff since October 2017 where they have been reminded of the documentation requirements in relation to urinary tract infections as well as the need to ensure they are aware of the symptoms, causes, risks, treatment and prevention of these infections in the elderly.

81. The importance of documenting all urinalysis results has been reinforced with staff (as part of their process of continual improvement).

82. The nursing home advised that as a general rule there is no difference in policy or procedure for residents that have dementia and those who do not. The Adventist policy is that urine tests are always preferred. It is common practice that if a resident demonstrates behaviour that is different from their usual behaviour, staff will perform a dip stick urine test and the general practitioner will be notified if the test is positive. Where the resident is able to use the toilet, a slipper pan is often used to capture a sample.

83. Registered Nurses do not diagnose residents, but will perform dip stick urine tests if they are able, and if it will be beneficial to the particular treating doctor.

84. The nursing home advised that it is not common or usual practice for staff to rely on clinical signs of a urinary tract infection. However there are instances where Registered Nurses s and Enrolled Nurses may identify urinary tract infections by relying on clinical signs, E.g. where staff cannot get a sample from a resident. In such instances (when a resident is exhibiting difficult behaviour), it is usual practice for the doctor to be contacted and for staff to await advice as to whether the resident may require a catheter. As this can be unsettling to the resident, some doctors choose to prescribe antibiotics based on a clinical assessment. The process of contacting a doctor in instances where a sample cannot be obtained is included in the new policy and procedure.

CONCLUSION

85. It is acknowledged that there are some inconsistencies between the responses from the nursing home and Dr Hands in relation to the management and documentation of urinary tract infections at the time of Enid's death. The nursing home is now working to improve their processes and training staff in relation to this.

86. The focus of the coronial jurisdiction is to make the findings required by s 45 (2) of the *Coroners Act 2003* and there is sufficient information available to do so.

87. Enid was suffering a functional decline and was at risk of sudden death due to her severe triple vessel heart disease. She then developed a kidney infection (most likely from a urinary tract infection) which was not diagnosed or treated at time of her death. The combination of these conditions caused her death. Unfortunately the treating general practitioner was on leave until 14 September. The review on that day did not diagnose the infection which, together with heart disease caused her death later that day. Antibiotics were prescribed on the day she died.

Chris Clements

Coroner