QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Ms C**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2012/4591
DELIVERED ON:	11 June 2015
DELIVERED AT:	Brisbane
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: investigation, aged care facility, treatment of pressure sores, communication with Enduring Power of Attorney

Introduction

Ms C was aged 90.

She was a resident at an Aged Care Facility at Kippa Ring.

She was wheelchair-bound and suffered from dementia, variously described as mild to advanced. She also had a history of heart disease.

On 16 December 2012, she was transported from the nursing home to Redcliffe Hospital. Medical records at the nursing home indicated that in the last two weeks she had declined to take fluid and food and as a result intravenous drips were established by the visiting medical officer Dr H.

On 11 and 13 December 2012, he took specimens, which were analysed by Queensland Medical Laboratories. As a result a decision was made that she should be transferred to Redcliffe Hospital.

When she came to hospital the treating doctors were concerned that she was suffering from severe dehydration, malnutrition and had deep seated bedsores.

Given her condition, which continued to deteriorate, she was placed on palliative care on 18 December 2012. She died on 20 December 2012.

After her death her physical condition was raised with the Coroner. Medical staff and her daughter had concerns as to the lack of care given to her whilst at the nursing home and whether this had contributed to her condition.

Autopsy results

A full internal autopsy examination was ordered. The report was only completed in March 2014. This included a review of the medical charts from Redcliffe Hospital and nursing notes from the nursing home.

It is evident that Ms C had been admitted to the nursing home from her home on 20 September 2012. It was noted she had dementia and was disoriented to time and place. She was assessed with congestive cardiac failure, gastro-oesophageal reflux disease and osteoporosis. On 3 December 2012, she was noted to be unwell and was not eating. She had also been coughing. Subcutaneous injections of saline were ordered to maintain fluids and an antibiotic was prescribed. She was seen to improve.

On 13 December 2012, she was noted to have improved but a large area of necrosis over the sacrum was noted. She was prescribed a fentanyl patch for pain relief. On 14 December 2012, multiple bruises were noted to the face. She was transferred to Redcliffe Hospital on 16 December.

An external examination found multiple areas of skin bruising. The pathologist stated that these were areas of bruising occurring as a result of minimal trauma in elderly patients with thin, poorly supported skin. However, there was a more

significant blue bruise over the left side of her face, likely related to an episode of fall noted in the nursing notes which occurred on 8 December 2012.

There were a number of pressure areas noted. The most significant was an 80 x 75mm area of blackened ulceration over the lower back, at the base of the spine. The ulceration had eroded into underlying muscle and had exposed down to the bone. There were also areas of ulceration on the right and left heels and some discolouration on the right elbow, possibly representing an early pressure change.

There was significant coronary artery atherosclerosis. It was considered that such pathology could be associated with a risk for a sudden death and there was one focus of severe narrowing in the left main coronary artery.

The heart was heavy and showed an increase in the thickness of the muscular walls demonstrating the heart had been under some strain. The mitral valve had also hardened and narrowed (stenosis).

The pathologist opined that the combination of coronary atherosclerosis, mitral stenosis and changes in the heart muscle contributed to clinically significant heart failure.

The sacral ulcer was examined microscopically and there was evidence of deep seated infection of the soft tissues down to the bone, although no direct infectious involvement of the bone was established.

An examination of the lungs showed changes of pulmonary infarction secondary to pulmonary embolus. The post-mortem examination confirmed the presence of such thrombi in the deep veins of the left calf. Immobility is often a predisposing cause of deep-vein thrombosis and it was noted she had a history of significant limitation in her mobility following on from her dementia.

Two rib fractures were found, which appeared to have been somewhat historical in nature of from one to several weeks in age.

The brain also showed signs consistent with the history of dementia.

The pathologist noted that her admission to hospital was prompted by the results of blood tests following on from medical consultations in relation to her deteriorating condition, lack of appetite, and following a fall on 8 December 2012. At the time of her admission the blood tests showed that she was markedly dehydrated. As well, her blood pressure was very low and she had a deep necrotic ulcer over the sacrum.

The nursing and medical notes describe a major event occurred on 15 November 2012 when she collapsed to the floor. The pathologist considered that this episode would fit with pulmonary embolus. It was considered that the pulmonary embolus infarct found post-mortem was of some age by the time of death and did not constitute the proximate cause of death.

The post-mortem evidence pointed to evidence of sepsis. The sacral ulcer was large, deep, black and was associated with gaseous change and emitted a strong foul odour.

The medical notes indicated that a lesion at this site had been intermittently noted in the nursing home.

Ms C was already markedly dehydrated when she was admitted to the nursing home, demonstrated by the elevated level of sodium in the blood. It was noted she had only been intermittently eating and drinking and attempts to correct the water deficit were made by giving subcutaneous fluids. Her poor nutritional intake further depleted her proteins and as well, her severe congestive cardiac failure contributed. The pathologist noted the cardiac disease was very significant with the potential to result in death at any time.

The pathologist considered that the rib fractures played little role in her death and were likely related to the falls noted in the chart. Given her bones were brittle from osteoporosis, reduced forces would have been required for these fractures to have occurred.

The cause of death was considered to be due to the infected sacral ulcer and fluid imbalances as a result of the poor hydration and nutritional status prior to death. The sacral ulcer and fluid nutritional status were both related to her dementia. The seriously comprised cardiac function, compromised lung function by recent pulmonary embolus and her advanced age were also contributing factors.

The investigation

Aged Care Nursing Home notes

A review of the nursing home notes indicates Ms C was first admitted on 11 September 2012, having recently arrived from New Zealand with her daughter. It was noted she had lost 13kg over the last 12 months. On 19 September a request was made for a medical review which occurred on 20 September.

The medical review noted the history of advanced dementia, osteoporosis, gastro-oesophageal reflux disease and other conditions.

Further medical reviews took place on 31 October 2012, and 3, 5, 11, 13 and 14 of December 2012.

The nursing home notes first record small sores on her bottom for which cream was applied and changes were made as to how she lay on her bed.

The notes record her refusal from time to time to take medication, food or fluids. Similar experiences were expressed with respect to her refusing all care including washing and dressing her.

The nursing notes indicate that she had lost more than 5kg and she continued to refuse food and fluids from time to time. Concerns were expressed by her

family about her deterioration and staff are recorded as saying that she had been refusing to eat or drink and staff could not force her to do so.

On 2 December 2012, the notes record that she had developed a pressure area on the sacrum, which was attended to with small multiple dressings. The visiting medical officer, Dr H was contacted and informed about the deteriorating condition.

The GP visited on 3 December 2012 and Ms C was commenced on antibiotics as well as subcutaneous fluids.

The nursing notes on 6 December confirm efforts were made to reposition her and provide her with heel protection, and dressings to the coccyx were attended to.

On 8 December she was found on the floor on her left side in the very early morning. There was no witness to the fall. It was apparent she had hit her head and sustained a skin tear. A dressing was applied. Subcutaneous fluids continued.

On 8 December 2012, it was noted that she was moaning when her bottom was being cleaned around the wounds and a new dressing was applied. She was continually repositioned and turned during this period. On 9 December 2012, the sacrum area was noted to be red and necrotic tissue was observed. She was still at this stage refusing meals and fluids.

Medical reviews took place on 10 and 11 December.

At the review on 13 December 2012, the large area of necrosis on the sacrum was noted and the notes show an intention was made for that to be debrided the following day or the next. A medical review on 14 December noted the lack of progress and multiple bruising probably from the fall.

On 16 December 2012, the medical practitioner received the results of blood tests that had been run by the pathology laboratory, which noted elevated sodium levels (hypernatraemia) resulting from likely dehydration. The doctor felt that as Ms C had been reluctant to eat or drink, he felt it best she be transferred to hospital for IV fluids.

Pressure Sores

Pressure sores occur by constant pressure or friction, particularly in those with reduced mobility. Risk factors for pressure sores include a poor physical condition, immobility, malnutrition and advanced age.

They are well known to be difficult to treat and can lead to serious complications.

Prevention includes regular positional changes, skincare, good hygiene and a healthy diet. The skin of older people tends to be more delicate, which means

they have an increased risk of developing pressure sores during a prolonged stay in bed.

Review by Clinical Forensic Medicine Unit

The Clinical Forensic Medicine Unit (CFMU) was requested to review the nursing and medical response in relation to Ms C's nutritional status and pressure area care.

Dr Griffin considered there was an overall apparent lack of communication between the family and the doctor caring for her in the nursing home. It was clear on his initial consultation that he recognised she had dementia and that her verbal recollection of her medical history was insufficient for him. He then appears to make decisions for her in relation to medication and treatment, but without consultation with the appointed Enduring Power of Attorney (EPOA) for her health. This rested with her daughter.

Dr Griffin stated it is not clear at any point as to whether the nursing home or the doctor was aware that an EPOA existed. Certainly care plans and treatment were instituted and changed with some communication recorded to the daughter, but Dr Griffin considered there was no evidence of decision-making or similar discussion occurring.

He considered the level of communication fell below the standard that would be expected of a GP and this may have been improved if there was clear communication as to who was the decision-maker.

Dr Griffin considered the care of the pressure area on the sacrum appears reasonable up until 13 December. The doctor indicated that he intended to debride this area, which would have been appropriate. Alternatively it would have been appropriate to refer her to hospital for such a procedure to be undertaken. The doctor indicated his intention to debride this lesion on 14 December. It is not clear why he did not debride it, or did not refer her for this procedure to hospital.

Dr Griffin opines this management also falls below the standard of what would be expected from a general practitioner on the basis of the information provided.

It is possible that despite debriding of the wound and additional care she may have suffered the same outcome due to her debilitated state and significant cardiac disease.

Ms C was in a poor nutritional state at the time of her blood tests as evidenced by her low protein state. This would not assist with wound healing or her ability to respond to infection.

The nursing home was disappointing in its acknowledgement of her poor oral intake. A speech pathology review and input from a dietician would have been expected as normal standard of care. The doctor could also have made a referral to a speech pathologist or dietician.

Dr Griffin stated the decision as regards whether nutrition and hydration could occur through invasive means or not, needs to be made by the EPOA. The decision appears to have instead been inappropriately made by the doctor or nursing staff at the nursing home.

Response by Dr H

Dr H was provided an opportunity to respond. It was noted that Dr H had been a medical practitioner since 1965. He has stated he retired from active practice as a medical practitioner in July 2013.

Dr H stated that it was standard practice for the nursing home to document all information in relation to EPOA and family contact details.

He states he was not aware of an EPOA. In circumstances where an EPOA was in place, he would have taken steps to contact them directly to participate in decision-making on patient care.

He stated he relied heavily on nursing staff to update him or pass on information in relation to family questions and the patient's condition. He states he was not advised of the fall on 6 December 2012.

Dr H states he was not asked to review the patient's sacral pressure ulcer until about 13 December 2012. At that time he was advised that nursing measures had been in place to treat the pressure ulcers on her heels and sacrum.

He noted she had a large area of necrotic tissue. There were limited treatment room facilities at the nursing home and there were no surgical instruments. There was also limited availability of support from nursing staff to assist. He did tentatively organise debridement for the next day if staff and equipment could be arranged.

However, on review the next day, he noted the patient lacked progress and noted multiple bruising through a possible fall. He decided to further assess the patient with blood tests. When the results of blood tests came to hand on 16 December 2012 he realised there was severe fluid derangement and decided that treatment was urgently needed at Redcliffe Hospital. He also believed the hospital was more clinically appropriate for debridement of the ulcer to be undertaken.

He does not believe a short delay in having the area debrided would have made a difference to her outcome and his focus had shifted to trying to identify any metabolic reason for the ongoing deterioration.

Review of Nursing Home by Aged Care Quality and Compliance

The Aged Care Quality and Compliance section of the Commonwealth Department of Social Services reviewed the care of Ms C at the Aged Care Service (the Service) in response to a complaint by her daughter.

The scheme imposed sanctions on the service on 14 September 2013 in relation to the identification, assessment and management of care recipients' skin care needs, including wound management.

A number of issues were identified for resolution.

Issue 1

Concern that the Service failed to communicate changes in medication management, clinical conditions including pressure area sores and changes in health status to care recipient, Ms C's next of kin.

It was found that her daughter was not consulted when Ms C's care plan reviews were conducted, except on admission and subsequent discussions with staff were infrequent and informal. Given that Ms C had a diagnosis of dementia and that her daughter was her next of kin with an EPOA, it is reasonable to expect that her daughter should have been consulted in regard to her mother's care on an ongoing basis.

Whilst the progress notes indicated that staff advised her daughter on 16 December 2013 of the changes to her mother's medications, it appears that this only occurred when her daughter contacted the Service to take her mother out for the day, and was not a planned information session on the part of the Service.

The Department found that as a result of the concerns raised in relation to the need for closer consultation and communication, it was satisfied the Service has implemented a range of strategies to ensure that initial and ongoing assessments of the care recipient's clinical care needs are conducted and documented, and include consultation with care recipients, their representatives and health professionals.

As a result it was determined that no further action needs to be taken.

Issue 2

Concern that the Service did not provide appropriate interventions to address Ms C's hydration or nutrition needs.

The review noted that documentary and verbal evidence indicates that whilst care staff assisted Ms C to eat and drink, her ability to swallow normal liquids was not assessed by a registered nurse or other health professional, e.g. speech pathologist or dietician. Whilst there is information which indicated Ms C's food and fluid intake, there is no information which indicated how this information was used and whether or not the information was assessed and evaluated by a registered nurse, speech pathologist, dietician or other health professional. Additionally, there is no information available in the records which indicated whether or not clinical staff explored the reason why Ms C refused food and drink.

The Department was satisfied that the Service has implemented a range of strategies to ensure that care recipient's initial and ongoing assessments are conducted in consultation with the care recipient and/or their representative and

their doctor. The Service will also refer care recipients to Allied Health professionals when assessments indicate that a referral is required, and ensure that registered nurses initiate required reassessments when a change is identified in the care and well-being including on their return from hospital.

As a result it was determined that no further action needs to be taken.

Issue 3

Concern that the Service did not provide appropriate pressure area care to Ms C. When Ms C was admitted to Redcliffe Hospital, the hospital identified she had a significant pressure area wound on her coccyx.

The Department resolved that documentary and verbal evidence indicates that wound charts were not maintained consistently for all of Ms C's wounds. There was no information to support that care plans and care plan reviews were consistent with her wound care charts. It was noted that on admission Ms C had wounds; however there is no information to support that a wound care assessment and treatment plan was formulated for these wounds. There is no information available to indicate the wounds were recorded elsewhere.

In this respect the Department had issued a sanctions notice that there was a particular concern that the Service's systems to support wound management and pressure area care is ineffective.

Issue 4

Concern that the Service did not provide appropriate equipment pressure area care including pressure relieving cushions for a wheelchair and a pressure relieving mattress.

As a result of these concerns, the Service advised the Department that it has reviewed each care recipient's assessed needs to ascertain what equipment they require and that they have been allocated the equipment. In addition the Service has purchased additional stock so that it has stock available for emergencies and when new care recipients are admitted to the Service and to ensure that it maintains adequate supplies to meet care recipient's needs.

The Department was satisfied the Service has taken steps to ensure it provides appropriate equipment to care recipients.

Conclusions

An autopsy examination found that Ms C died as a result of a combination of factors, which primarily related to an underlying dementia. Her fluid and nutritional status had been a source of concern and the medical notes indicate a pattern of accepting food and fluids and then refusing. She was by this time somewhat immobile and in combination with her age, dementia and poor physical condition (exacerbated by increasing poor nutrition intake) these were risk factors for the development of pressure sores.

These were monitored when first noted by nursing staff and reported to the visiting medical officer. Various strategies were in place including the dressing of the wounds, positional changes, antibiotics and medical reviews. A decision

had been made by the visiting medical officer to debride the wound, however pathology results came back which resulted in a decision that she required assistance in hospital and appropriately she was transferred.

It is evident from the material that her daughter as EPOA was largely not consulted in relation to her mother's health and care to be provided. She was not told she was deteriorating. She should have been.

A review by the CFMU has expressed concerns as to the treatment provided. Given the medical officer has since retired from active practice, a referral to the Office of Health Ombudsman will not be made. The nursing home was the subject of an extensive investigation by The Department of Social Services and a number of matters of concern were identified. The nursing home has complied with sanctions and has addressed the concerns of the Department.

Ms C was of advanced age with a number of consequential co-morbidities, however she would not have died at the time she did if her necrotic sacral sores and nutritional status had been provided for in an appropriate manner.

Given those matters, it is determined that no further investigation is required and an inquest is unnecessary as any recommendations that would be made to prevent such instances occurring in the future have already been investigated and implemented.

Findings required by s. 45

Identity of the deceased – Ms C

How she died – Ms C died as a result of infected bed sores in the context of poor hydration and nutritional status.

Place of death – Redcliffe Hospital Redcliffe Qld

Date of death– 20 December 2012

Cause of death – 1(a) Infected sacral ulcer and fluid imbalances
1(b) Dementia

2 Coronary atherosclerosis; mitral valve stenosis; advanced age; recent pulmonary embolus

I close the investigation.

John Lock
Deputy State Coroner
Brisbane
11 June 2015