QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of George FENECH**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	12 July 2019
FILE NO(s):	2017/5035
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	CORONERS: nursing home, falls, treatment and care.

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Background

George Fenech was 89 years old. He lived at the TriCare Nursing Home at 71 Brighton Street Biggera Waters. His past medical history included atrial fibrillation for which he took Warfarin, chronic kidney disease, congestive heart failure – ejection fraction 44% February 2014 and cardiomyopathy. Mr Fenech had an abnormal gait (including ataxia and spastic gait) and had difficulty walking. Additionally, he was unable to grip well with his hands.

At 2:10am on 9 November 2017, a carer working at the nursing home alerted the Registered Nurse (RN) that Mr Fenech was unwell and unable to mobilise. He was leaning to the left side, was pale and had slurred speech. On review by the RN, Mr Fenech was sitting in a commode chair slumping to the left side and was incontinent of urine.

At 2:45am the carer again alerted the RN that Mr Fenech was found on the floor wedged under the bed by the wardrobe and had a large head laceration, as well as several smaller ones. An ambulance was called and it was noted that Glasgow Coma Scale (GCS) was fluctuating around 10-12, head wound bleeding which was stabilised and he was subsequently transferred to hospital.

At 5:15am on 9 November 2017 Mr Fenech was taken to the Emergency Department of the Gold Coast University Hospital (GCUH) by the Queensland Ambulance Service (QAS) from the TriCare Nursing Home. Mr Fenech had an unwitnessed fall and sustained a head laceration with suspected arterial bleed. At the time Mr Fenech was not on anticoagulation therapy.

During handover, the nursing home reported declining GCS levels over the last days, unknown at what levels of GCS the patient was when he was found at approximately 3am on the floor with a bleeding head laceration and epistaxis. It was estimated that there was approximately 100ml of blood on the floor of the nursing home.

Dr Hyunjen Kim treated Mr Fenech for a fracture to the C1 and C2 vertebrae as well as a minor laceration to his head. Mr Fenech was found deceased at 9:00pm on 11 November 2017. At 3:30am on 12 November 2017, police were notified and subsequently commenced inquiries on behalf of the coroner.

Gold Coast University Hospital records

At 4:48pm Dr SB, Emergency Department Consultant noted that Mr Fenech had become less responsive in the last 1-2 hour window and reported - pearl, winces to eyes being opened or abdo palpation. At this time it was indicated from consulting with Ms Marea Fenech that her father had been 'ready to die' for months and had previously asked his daughter Marea for some pills so he could demise. It was noted that he had been declining steadily following a fall which decreased his mobility, appetite and strength.

At 7:02pm Dr SG, Neurosurgical PHO reviewed Mr Fenech and noted that Mr Fenech required an MRI, but that he was not suitable for general anesthetic. This was discussed with the family who were happy to trial a soft collar and optimise medical management but that Mr Fenech was not for resuscitation.

Following these reviews, Dr ND consulted with Dr SB and Dr G and reviewed the CT results. The results showed a partial subluxation of the lateral mass C1 on C2 which was more likely to represent an acute injury rather than chronic as no significant degenerative changes were present at the site.

Dr ND noted a Grade 1 anterolisthesis of C7/T1 with no thickening of the prevertebral tissues which he considered to be chronic. There was also soft tissue contusion haematoma noted overlying the right temporal region. Dr ND also confirms in his medical note that an Adult Resuscitation Plan (ARP) was completed. At 11:21am on 10 November 2017, Mr Fenech was referred to palliative care. While in the ward Mr Fenech's state of consciousness fluctuated and following discussion with the family, it was accepted that he was not for resuscitation. He continued to deteriorate and the care of dying pathway was instituted. On 11 November 2017 at around 9:00pm he was found unresponsive and pronounced deceased.

Autopsy Report

On 13 November 2017 an external post-mortem examination was conducted by Senior Forensic Pathologist, Dr Alex Olumbe. Dr Olumbe reviewed the medical records from the GCUH as part of his examination of the cause of death.

Mr Fenech showed signs of recent injuring including:

- a laceration on the right forehead measuring 30mm x 5mm with a purple bruise measuring 80mm x 35mm.
- a dark brown bruise on the medial aspect of the distal right leg measuring 120mm x 60mm.
- a pale red bruise on the medial aspect of the knee which measured 25mm and 35mm across respectively.
- a red and purple bruise on the front of the middle section of the left leg measuring 50mm x 40mm surrounded by an area of yellowish discolouration due to the application of antiseptic ointment.
- a red bruise on the lateral aspect of the entire left leg.
- a minor scattered bruising on the lower limbs on the right thigh of varying dimensions.
- a red bruise on the distal aspect of the back of the right forearm measuring 30mm x 25mm.
- a red bruise on the lateral aspect of the right shoulder measuring 60mm x 45mm.
    - there are diffuse areas of red bruises (so called senile purpurae) on the back of the hands and almost the entire back of the forearms.

The examination found that Mr Fenech had a longstanding cardiomyopathy, atrial fibrillation with right ventricular regurgitation with a few rounds of ventricular tachycardia. On admission Mr Fenech had an episode of hypertension.

A CT scan (ante mortem and post-mortem) showed partial subluxation of the lateral mass of C1 and C2 (upper section of cervical spine), which possibly represented an acute injury although it could have been a pre-existing injury due to absence of associated haemorrhage.

An MRI was not conducted at the time of admission as Mr Fenech could not sustain a general anesthesia. There were other chronic degenerative changes in the spinal column and soft tissue haematoma overlying the right temporal region of the scalp.

A review of the post-mortem CT scans (by consultant specialist radiologist) showed a collection of fluid in the chest cavity (pleural effusion) and congested/oedematous lungs, otherwise known as congestive heart failure on the background of cardiomyopathy (enlarged and dilated heart) and calcification of the coronary arteries i.e. coronary atherosclerosis.

Therefore, he developed terminal congestive heart failure due to an ischaemic cardiomyopathy as a consequence of coronary artery atherosclerosis. He had previously been treated for congestive heart failure. The finding of the neck injury (subluxation of C1 and C2)

and atrial fibrillation (clinical) could have contributed to his death.

TriCare Nursing Home

Mr Fenech was a palliative care resident at the TriCare Nursing Home from 21 December 2016 until his death.

Medical records maintained by TriCare identified that Mr Fenech had fallen, namely:

At 2:20am on 19 August 2017, Mr Fenech was heard calling out from his room and was found sitting on the floor. Mr Fenech had five skin tears on his head measuring approximately 1.5 x 1.5 in length. He was unable to stand up from the floor and a sling machine was used to transfer him to his bed. Mr Fenech was transferred to the Pindara Private Hospital at 3:20am.

At 5:00pm on 23 August 2017 Mr Fenech returned to the nursing home from his hospital visit at Pindara. On 24 August 2017 he was attended by the doctor who noted in the medical records that there was a scalp laceration with no intracranial haemorrhage or fractures. It was also noted that Targin 15/7.5 was ceased in hospital and not to be recommenced and instead to be prescribed Endone PRN.

On 14 September 2017, the doctor again reviewed Mr Fenech and noted that the left forehead lesion had not improved and recommended continued monitoring for the next few weeks.

The outcome recorded that staff were to ensure that only the top two bed rails were up while Mr Fenech was in bed. Further, that staff were to answer the bell promptly and ensure the bed height was at George's knee height at all times.

At 4:00pm on 22 September 2017, it was reported that Mr Fenech had a fall on 19 September 2017 whilst at Pindara, resulting in a skin tear to the right lower arm. Wound chart was commenced and the incident register completed.

On 17 October 2017 Ms Fenech contacted the nursing home to advise her father sent her a text message and was upset. Staff followed up with Mr Fenech who said that he slid out of his chair onto the floor the night before and was picked up by two staff members and helped into bed. It was noted that no record had been made of the fall.

At 2:45am on 9 November 2017, Mr Fenech had fallen in his room. This incident resulted in his admission to the GCUH and subsequent death.

The medical records also indicate that Mr Fenech was suffering from shortness of breath on numerous occasions, often after physical exertion such as going to the toilet.

On 14 September 2017, Mr Fenech was sent to Pindara as a result of chest pain, radiating to the left shoulder and wheeziness. He returned to the nursing home on 19 September 2017 and was again seen by the doctor on 21 September 2017 who noted that Mr Fenech had been diagnosed at hospital with crush fractures.

The next of kin, Ms Marea Fenech raised a number of issues, in particular relating to the lack of communication by TriCare to advise her of her father's deterioration in the days prior to his death. Ms Fenech noted that staff told her, her father had been unwell for the past few days prior to his unwitnessed fall on 9 November 2017.

A review of the medical records maintained by TriCare show that the last communication between TriCare and Ms Fenech was on 5 November 2017 when Mr Fenech had accidently

called his daughter's phone at 3am.

Medical records show that from 7 November 2017, Mr Fenech had a significant decline in health as he was short of breath, unable to get comfort using an inhaler, was unsettled and was constantly needing to go to the toilet. This increased on 8 November when he required toileting every hour and was incontinent and further on 9 November when he was unable to mobilise and had slurred speech.

Aged Care Complaints Commission

On 11 December 2017 the Aged Care Complaints Commission (ACCC) received a complaint from Ms Marea Fenech about the care provided by TriCare to her father. The ACCC identified that there had been 6 contacts to the Complaints Commissioner in relation to TriCare since January 2016, with four complaints, including that of Ms Fenech. The complaints revealed similar themes in relation to falls resulting in severe injuries, consultation and communication, clinical assessment and health and personal care.

Ms Fenech raised five issues, namely:

1. TriCare did not take sufficient preventative measures or utilise agreed strategies in Mr Fenech's care plan to prevent him from falling on 9 November 2017 around 3:30am. In particular, the service failed to consistently ensure that his bedrails were in place.

2. TriCare did not inform Ms Fenech (who was the enduring power of attorney) when his health deteriorated prior to his fall on 9 November 2017.

3. Consistently when Mr Fenech called for help to go to the bathroom using his bell, staff would answer it but then walk away without providing immediate assistance. Instead they would return to assist him between 10-30 minutes later.

4. TriCare staff did not investigate, escalate, or respond to Mr Fenech's health, in particular:
    a. Prior to his fall on 9 November 2017 when he became agitated, disorientated and his need to urinate frequently increased.
    b. On 25 November 2016 his legs were swollen from his feet to his knee, they were red and hot to touch. Staff delayed and only called a doctor following the family's persistent requests.

5. On at least two occasions Mr Fenech's prescribed medications were not able to be commenced in a timely manner. Ms Fenech had to intervene and fill the prescriptions for them to be available.

In relation to issue 1, the Complaints Commission found that TriCare did not adequately ensure Mr Fenech had adequate falls risk strategies in place, considering his propensity to self-mobilise. There were gaps in relation to call bell use and sensor alarm such as:

- Mr Fenech was known by the service to self-mobilise, despite his physical limitations and due to his heightened anxiety which was related to his fear of being incontinent.
- Despite being considered able to ask for help. Mr Fenech would often not use his call bell to seek assistance. His need to use the toilet urgently often resulted in his impulsive behaviour to get out of bed by himself, and thus increased his risk of falling.
- The call bell and sensor alarms were not activated when Mr Fenech got out of bed by himself. The service cannot explain why the sensor beam was not activated by Mr

Fenech's physical movements in his room in the early hours of 9 November 2017.

The Complaints Commission reviewed the information provided by TriCare which showed that Mr Fenech's care plan identified him as being a high falls risk resident. Whilst the family had requested the top two rails of the bed to be left up, there was no restraint authority given by the family to allow for all four bed rails up thereby restraining Mr Fenech, neither was he assessed for restraint. TriCare was also unable to determine whether Mr Fenech had utilised his call bell at the time of his fall on 9 November 2017 due to renovations at the facility, which disabled the ability to audit the call bell records during the same period.

To improve this aspect of the complaint, TriCare has:

- Provided training to staff;
- Systems enhancements;
- Creating a falls risk committee consisting of clinical care staff, physiotherapists, occupational therapists and personal care attendant staff who meet monthly to review the policy and injury prevention strategies;
- Sensor alarms have been replaced with bed and chair assist alarms which monitor those residents at high risk of falling;
- The new bed and chair assist alarms are plugged into the nurse call system and cannot be turned off and will alert on every occasion it is activated;
- The alarm system can be audited at any point for the number of times alerts occur and the time taken to respond. A recent audit indicated a response time of 2 minutes; and
- RN's and EN's progressively auditing and updating resident care plans to reflect falls risk strategies.

In relation to issue 2, the Complaints Commission found that TriCare did not contact Ms Fenech about her father's change in health status during the time period 5-9 November 2017. To improve this aspect of the complaint, TriCare has provided education and training to clinical staff in relation to the importance of follow up with family members as incidents occur and when the health status of a resident changes.

In relation to issue 3, the Complaints Commission found it was likely that Mr Fenech experienced multiple occasions where he was made to wait for assistance, specifically in relation to his toileting care needs which resulted in his subsequent self-mobilising behaviours. TriCare records indicate that whilst Mr Fenech did use his call bell for assistance he would often resort to self-mobilising to a commode chair. The records are also deficient in documenting active monitoring of Mr Fenech's toileting needs during the period he was unwell. It was found that a greater level of assistance and supervision should have been provided during the period of rapid decline in the period 5-9 November 2017.

To improve this aspect of the complaint, TriCare replaced all older call bell systems and provided education to increase staff awareness and responsiveness to call bell activity, now averaging response times of 2 minutes. Further, that staff would prioritise the most urgent needs of residents.

In relation to issue 4(a), the Complaints Commission found that TriCare failed to investigate, escalate or respond to Mr Fenech's altered health status in a reasonable manner in accordance with the standard expected. TriCare was unable to provide the Complaints Commission with documentation demonstrating regular observations were undertaken until the night preceding Mr Fenech's fall there is also no record that he was referred for clinical assessment or that medical intervention was sought prior to his fall on 9 November 2017.

In relation to issue 4(b), the Complaints Commission could not determine that TriCare had delayed medical treatment for Mr Fenech's celluitis legs in November 2016, but they did find

that there was a failure to properly document this event and how it was addressed, monitored and evaluated. TriCare were aware that Mr Fenech had skin tears and cellulitis legs and was reviewed by a doctor in relation to his oedema and also had his fluids monitored by a doctor and the service. Despite this care, this was not communicated to the family.

In response, TriCare has:

- Provided further education to clinical staff to improve clinical assessment skills and capabilities, including appropriate escalation when a change in health status occurs.
- Implemented fortnightly clinical education sessions for registered staff to reinforce clinical knowledge.
- Provided further education on improving assessment and care planning documentation.
- Recruited a new Clinical Manager who will receive additional support from the Clinical Governance Support Officers.
- Implemented clinical handovers twice daily.

In relation to issue 5 the Complaints Commission found that the family had made prior arrangements that they would supply their father's medication. The Complaints Commission found that it was reasonable that this would continue until such time as other arrangements. Once Mr Fenech became a permanent resident of the facility arrangements were made for medication to be provided via the pharmacy. When new medications were required, this was communicated to the family.

In response to this issue TriCare has implemented an electronic messaging system called 'Message Board', used to remind all clinical staff to check stock levels and order medications every shift. Further, a whiteboard communication tool is used for temporary agency staff so that regular staff can order in a timely manner.

The Complaints Commission found that after discussions with all parties, that TriCare had address each issue to the satisfaction of the Commissioner.

Next of Kin Concerns - Marea Fenech (Daughter)

Ms Fenech's father had been residing at the Tricare Nursing Home since 15 November 2016. Initially he was in respite care until 21 December 2016 when he became a palliative care resident.

At approximately 3:30am on 9 November 2017, she received a phone call from the on-duty nurse at Tricare, named Kim. She advised Ms Fenech that her father had a bad fall. Ms Fenech enquired whether there was a lot of blood and if her father was conscious which she responded yes to both questions.

Ms Fenech was advised that staff had checked on her father and when staff returned 10 minutes later her father was found on the floor. Staff told her that he had been unwell for a couple of days, that he had been agitated and disorientated. The duty nurse also told Ms Fenech that her father had been going to the toilet a lot in the last couple of nights and that they had done a dip stick to test for infection. However, she had not been made aware that he was unwell despite making daily contact with TriCare. Ms Fenech asked for her father to be taken to Pindara as he had previously been taken there.

At 5:30am Ms Fenech received a further call from the nurse to advise her father had been taken to the GCUH where he had sutures in his head and was conscious.

Ms Fenech was concerned that her father may have attempted to go to the toilet by himself that night. She indicated that her father had told her in person and via text message that the night staff were reluctant, too busy, not caring, not interested in taking him to the bathroom or dismissive if they had already taken him to the toilet that night. He told her that he had waited between 10, 15 and 30 minutes for staff to assist.

Ms Fenech went to TriCare Nursing Home to collect her father's belongings for hospital. She went into his room and saw the blood on the floor from where he had fallen.

Ms Fenech asked the duty nurse whether her father's bed was up, but the duty nurse did not know. Ms Fenech was concerned as in August 2017 her father had either rolled out of bed or tried to get out of bed and fallen at approximately the same time at night. This was on the occasion that he was taken to Pindara by ambulance. On that occasion Mr Fenech sustained lacerations to his head and shoulder. It was then that Ms Fenech discussed with staff that the side of Mr Fenech's bed must be up at night to prevent future falls.

When Ms Fenech arrived at the GCUH to see her father, he was complaining that his tummy was sore and calling out 'up, up, help' and pressing his finger down on her hand as if he was trying to ring the buzzer at the nursing home.

Scans revealed that his bladder was full and a catheter was inserted.

Ms Fenech remains concerned that TriCare did not respond to her father's concerns and did not advise her that her father was unwell. She was also concerned that TriCare had not documented that her father was unwell.

Ms Fenech listed a number of issues that arose during her father's residency at TriCare Nursing Home including:

- On 25 November 2016, following admittance to the facility, Mr Fenech's feet and legs were swollen. After insisting for many days that a doctor should be called, an after-hour doctor attended and admitted Mr Fenech to Pindara.

- After Mr Fenech had a fall in the shower, none of the staff were aware or documented the incident.

- Again when Mr Fenech's legs were swollen, an after-hours doctor was called who prescribed medicine. Ms Fenech asked when her father would commence his medicine she was advised that it would take 3 to 4 days as it was a show day and the chemist had changed. Ms Fenech drove to the facility and spoke with the nurse manager who juggled medication to start Mr Fenech's script immediately.

- In August 2017 when Mr Fenech had fallen, he had been prescribed Targin twice daily at TriCare. When he was admitted to Pindara, doctors questioned the amount being prescribed to Mr Fenech and recommended that the medication be ceased.

- On the day of discharge from Pindara, Mr Fenech was in the bathroom by himself and had a fall which resulted in a long wound to his right forearm. The wound was still being treated up until Mr Fenech's death. Pindara staff only made a verbal notification to TriCare and no formal record was made.

- In early 2017 Mr Fenech was taken outside on the veranda on at least 3 occasions to look at the Broadwater. He was left out in the heat and on one occasion ants were biting his feet. He was not checked on by staff and had to send a text message to his daughter to contact staff at TriCare to bring him inside. The nursing staff said that they

would give Mr Fenech a bell to ring when he wanted to come inside. Ms Fenech was concerned that there should have been regular checks by staff.

- Incidents when nurses would dispense medication to Mr Fenech without providing water and leaving to get water while he had a mouth full of tablets.

- The air conditioner not on in the room in heat wave conditions.

- The bed wooden type rails hurt Mr Fenech when he would get in and out of bed, resulting in bruising from knee to ankle. Ms Fenech mentioned that this should have been present when he arrived at the GCUH.

- An incident where Mr Fenech had asked to go to the bathroom at night, but the staff had told him he had already been. The staff then locked the bathroom door which distressed Mr Fenech.

In assessing the material obtained, the following issues are relevant:

- There was a lack of adequate communication between TriCare staff and the family, in particular Ms Fenech as the enduring power of attorney (EPOA) to advise of the rapid decline in Mr Fenech's health status.
- It is likely that Mr Fenech was not attended to in a timely manner to allow for his toileting needs, resulting in himself self-mobilising. This being a particular risk issue considering he was a high risk of falls and a care plan was in place to manage the risk.
- Only two of the four bed rails on Mr Fenech's bed were raised which provided an opportunity for Mr Fenech to self-mobilise. However, the family had not authorised for restraint nor did staff assess Mr Fenech or raise concern with the family.
- Additionally in relation to the bed rails, Ms Fenech identified that Mr Fenech would suffer pain and bruising trying to get in and out of bed. The autopsy report reflects a large amount of bruising on his legs which could be as a result of the bed rails, although this was not articulated in the autopsy report.

All of these issues were adequately addressed by the Aged Care Complaints Commission. In particular, the information obtained from the Aged Care Complaints Commission demonstrates how each of the concerns have since been addressed by TriCare to the satisfaction of the Commission so similar deaths do not occur in the future.

Conclusion

The autopsy conducted on 13 November 2017 confirmed, and I find, that George Fenech died on 12 November 2017 at Gold Coast University Hospital. The cause of death was ischaemic cardiomyopathy, due to or as a consequence of coronary atherosclerosis. The other significant conditions noted at autopsy were neck injury – fall and atrial fibrillation. I find that it would not be in the public interest to proceed to inquest.

Findings required by Section 45

Identity of the deceased: George Fenech

Place of death: Gold Coast University Hospital, 1 Hospital Boulevard, SOUTHPORT, QLD, 4214

Date of death: 11 November 2017

Cause of death:

1(a) Congestive heart failure due to, or as a consequence of
1(b) Ischaemic cardiomyopathy
Other significant conditions
2. Neck injury - fall, atrial fibrillation

I close the investigation.

James McDougall
Southeastern Coroner
CORONERS COURT OF QUEENSLAND
SOUTHERN REGION

12 July 2019