QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Florence Lillian THOMAS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
DATE:	3 May 2016
FILE NO(s):	2012/2723
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Fall in nursing home, failure to follow residents care plan, unattended/unsupervised on toilet.

Florence Lillian Thomas lived at the Bundaleer Lodge Nursing Home at 100 Holdsworth Road, Ipswich in Queensland. She died in the Princess Alexandra Hospital on 2 August 2012. She was aged 85 at the time of her death. She died due to a neck injury as a consequence of a fall in the nursing home and therefore her death was reported to the coroner.

Mrs Thomas' background medical condition

Mrs Thomas' medical history included amnesia, severe dementia, falls, scoliosis, rheumatoid arthritis, incontinence, cataracts and depression. She had been non-communicative for approximately two years prior to her death. Mrs Thomas took a range of medications.

The incident

On 31 July 2012, Mrs Thomas had an unwitnessed fall from a shower chair positioned over the toilet in the en-suite bathroom. She was unattended at the time. The incident occurred in the following circumstances.

Assistant in nursing (AIN) Rouse arrived at Mrs Thomas' room at about 0600 to help her with her morning requirements. Usually AIN's worked in teams of two but her partner was helping another resident at the time. AIN Rouse helped to position Mrs Thomas on the shower chair which was placed over the toilet in her en-suite. AIN Rouse then left Mrs Thomas in that position while she went to strip and remake her bed. This was a distance of some 2-3 metres from the toilet in the adjacent room.

AIN Rouse heard another resident calling out. She thought that resident may have fallen. She said she thought that Mrs Thomas seemed to be fine and she wanted to give her the opportunity to open her bowels so she decided to leave her on the toilet. She went to investigate why the other resident called out.

AIN Rouse did not think to use the nurse's call button which was located in the bathroom to seek assistance from or communicate with other nursing staff. She did not carry a phone or any other device to enable her to communicate with other staff.

AIN Rouse identified the other resident who called out as Joyce. She needed assistance in showering and AIN Rouse did so and then took her to the lounge room before returning to Mrs Thomas. It was then she found Mrs Thomas lying on the floor of the en- suite in the shower section. It was estimated she had fallen at about 0615.

AIN Rouse thought that Mrs Thomas was probably on the floor for 5 minutes, and no more than 10 minutes. It is noted that whatever the interval of time, it was sufficient for AIN Rouse to shower Joyce who was then dressed and assisted to the lounge room before AIN Rouse returned to Mrs Thomas. It is also noted that the interval was sufficient for Mrs Thomas to have lost body heat by the time she was found.

AIN Rouse immediately went to the nursing station and informed the registered night nurse RN Dixon who was about to finish her shift. Registered Nurse Johnson was also present receiving a handover from RN Dixon.

RN Dixon went with AIN Rouse back to Mrs Thomas's room to help. AIN Rouse then returned to the nurses' station and informed RN Johnson that RN Dixon had requested she also attend.

Mrs Thomas had a jagged laceration on her forehead and this was bleeding. There was a moderate to large amount of blood on her clothes. She was assessed and it was considered she had a normal range of movement. She was mumbling and there was no sign of any other injury. They therefore all lifted her back into bed and settled her. Her vital signs were reviewed and it was noted she was hypothermic. She was warmed up and a dressing and pressure bandage was applied to her forehead.

Following these measures RN Dixon stayed with Mrs Thomas while RN Johnson called the ambulance and Mrs Thomas' family. It is noted that RN Dixon and RN Johnson were both very experienced nurses having worked for more than 30 years each and both had worked at Bundaleer for 17 years.

Medical treatment

Ambulance services were called at approximately 0630. On arrival those offices assessed Mrs Thomas to have a Glasgow Coma Scale score of 11 out of 15 which was apparently her normal level of functioning. It was noted the abrasions had been attended to by nursing staff and she was transported to the Ipswich Hospital where she arrived at 0715.

She was assessed and no bony deformity or apparent fracture was evident visually. Imaging of her head and neck was performed to exclude spinal or intracranial injuries. A CT scan of her head and neck revealed a C1 Jefferson fracture and type 2 odontoid peg fracture in the neck. A Philadelphia neck collar was applied and her lacerations were reviewed and treated. The Ipswich Hospital contacted the orthopaedic registrar at Princess Alexandra Hospital and arranged for transfer to that hospital where she arrived at approximately 1830 that evening on 31 July 2012.

The PAH emergency department assessed Mrs Thomas as stable with respect to cardiovascular and neurological examinations which were found to be normal. Her Glasgow Coma Scale was measured and recorded to be 10. She was moved to the orthopaedic ward.

At about 2230 that evening her orthopaedic condition was assessed and recorded as being stable.

However, by the next morning at 0915 on 1 August 2012, a medical emergency was called because Mrs Thomas' level of consciousness had declined to 9 on the Glasgow Coma Scale. She was unresponsive to verbal stimuli. Pain relief (fentanyl) had been provided at 0845.

The orthopaedic treating team consulted with Mrs Thomas' family members having regard to the existence of an advanced healthcare directive. (This had been discussed by Florence's husband, Stanley with a nurse consultant Laidlaw on 30 May 2012. Mr Thomas spoke of his love for Florence and his daily visit- just hoping one day she will recognise him again.)

The treating team did not recommend invasive intervention and an agreement to refer her for palliative care was proceeded with. Mrs Thomas was cared for by the palliative care team until the time of her death on 2 August 2012.

Autopsy

Autopsy examination was conducted on 6 August 2012 by the forensic pathologist, Dr Samarasinghe. In the circumstances, it was appropriate to make an order for external examination only together with CT imaging, toxicology testing and review of medical information in the records.

CT imaging confirmed an upper cervical spinal injury. There was no obvious internal head injury. External examination showed a number of abrasions, bruises and small lacerations on the front of the head, arms and legs which were consistent with a fall.

The forensic pathologist concluded on the basis of all of the information that Florence Thomas had died due to neck injury as a consequence of a fall. It was noted she was an elderly woman with multiple age-related medical problems. The neck injury was considered severe enough to cause her death particularly in the context of her age and other co-morbidities.

Family concerns

Mrs Thomas' family expressed concern that Florence had been left unattended while on the toilet and fell, causing her injury and death. They raised in particular the issue that Florence had fallen on a number of occasions, including in similar circumstances when she was alone on the toilet. They had been assured that she would not be left unattended in situations where she was at risk of falling. Family requested a full investigation and consideration of an inquest to understand how this situation had occurred. They wanted the process to improve safety for others and help to prevent similar incidents with tragic outcomes.

Investigation/Review

Mrs Thomas' death was reported to the coroner as it was caused by a fall which resulted in injuries that caused her death. Her death was also investigated by the Office of Fair and Safe Work Queensland (OFSWQ).

Records and documents were obtained, including from –

Bundaleer Lodge,

Ipswich Hospital,

Correspondence from family,

Investigation material from the Office of Fair and Safe Work Queensland,

Correspondence from Aged Care Complaints Scheme.

Falls history as recorded in incident reports

Mrs Thomas had a long history of falls. Details of falls that occurred since 2010 are as follows;

On 16 February 2010 at 2030, Florence was in bed and was frightened by the storm and rolled out of bed. No injuries were noted.

On 15 April 2010 at 1545, Florence had been placed on the toilet with the buzzer in her hand. The Assistant in Nursing staff member exited and subsequently Florence fell and sustained a haematoma on posterior side of her head with a small burst laceration of skin. Dr Bodetti examined her and recorded 'I do not believe it requires sutures. No focal neuro signs. Suggest bandage scalp overnight to prevent further swelling. Need supervision at toilet, etc. as she is a high falls risk. '

As a result of this fall it was documented **"'Flo should not be left alone on the toilet as she is a high falls risk.'**

On 16 August 2010 at 1115, Mrs Thomas was in the lounge room. She was found on the floor by another resident. She was alert and trying to sit up. She sustained a haematoma to the central back area of her head requiring first aid. A cold compress was applied and neurological observations were performed for four hours. The doctor was contacted to review Mrs Thomas that afternoon and her family were informed and her husband visited.

On 23 April 2011 at 12 00, Mrs Thomas was in the lounge room. A fellow resident called out for help and when staff attended they found Mrs Thomas sitting on the lounge room floor. She had two open cuts above her right eye and on top of her head which required first aid. Neurological observations were performed. Her family were informed and her husband visited. As a result of this fall it was documented 'informed staff to monitor Flo regularly.'

On 31 July 2012 at 0615, it was recorded that Mrs Thomas had fallen off a shower chair which was over the toilet. She was found lying on her right side and right arm. She had a deep jagged laceration and bruising on her forehead. There was bleeding from the nose with moderate blood loss from the laceration on the forehead. There was no sign of rotation or shortening of limbs indicating no other injury had been sustained. Mrs Thomas was making garbled vocalisation. She was settled quickly once repositioned into bed. First aid was administered and the ambulance was called. She was transferred to the Ipswich General Hospital. Mrs Thomas's son Lee and her doctor, Dr Bodetti were informed. As a result of this fall it was documented *(again*) **'do not leave unattended on toilet.'**

It is noted that according to the entries made in the incident reports, none of these falls were tabled at occupational health and safety meetings. However on 2 June 2010 in the progress notes it was recorded that a workplace health & safety recommendation from the WH&S officer documented that Mrs Thomas was **'not to be left unattended on the toilet- staff is to remain with her.'**

Care Plans

Bundaleer Lodge had a significant level of structured and documented care plans[1] and mini care plans[2] covering a wide range of topics.

Significantly the summary care plans between 2010 and 2012 included the following relevant information;

- Flo requires full assistance of one staff member for all personal care and hygiene needs;
- Toilet Flo 3 hourly;
- high falls risk;
- Toilet Flo 3 Hourly. MUST NOT BE LEFT ALONE ON TOLIET, FLO WILL GET UP AND FALL;
- Flo requires assistance with positioning on toilet;
- Assist Flo with positioning on toilet. Do not leave alone on toilet, Flo will get up and fall.

Information in the mini care plans also recorded similar information including instructions to fully assist her for all toilet activities and repeating that she was a high falls risk.

In the bowel chart there were instructions to 'sit out over toilet and supervise'.

On an authority for continuation of protective assistance/restraint document, dated 25 January 2012 it was noted Mrs Thomas was an extreme falls risk.

How could this have happened?

Given this long history of falls, followed by evaluation and recognition of the risk of falls, and documented plans of how to avoid this harm, it is a matter of great consternation and concern that Mrs Thomas was left alone on the toilet, fell to the floor and sustained injuries that caused her death.

AIN Rouse explained her action of leaving Mrs Thomas unattended on the toilet as an instinctive response. She went to investigate and help another resident who had called out. She thought Mrs Thomas would be all right. She had not encountered a situation like this before where she had to manage two different residents' apparent needs at the same time.

When interviewed by workplace health and safety officers AIN Rouse acknowledged she had been working as an assistant in nursing for some 12½ years. She confirmed her work role included helping people out of bed, dressing, showering and feeding. She stated she was aware of Mrs Thomas' care plan and extended care plan which

[1] Summary care plan: medical history, mobility and transfers, communication, personal-care, nutrition and hydration, continence management, toileting, medication, skin integrity, sleep and resting, pain management, cognitive and mental health–behaviour, cognitive and mental health–cognition, cognitive and mental health–depression, social, cultural and spiritual care, wound management, physiotherapy, speech pathology, palliative care.
[2] Mini care plan: bed mobility/transfers, walking/AIDS, restraint, showering, mouth care/dentures, toileting, pressured area care, meals, fluids, fluid type, fluid restriction, solids, meals texture, special needs, communication/cognition, bed rails, smoking, bed pole, additional information.

goes into great detail. She was aware these documents were on the computer and it was her responsibility to keep up-to-date with this information.

She said that every day you work there would be information available on the system about where you were working.

However she acknowledged that she would look up the care plan when a new resident arrived but may not look up the plan again.

She acknowledged she was aware of the instructions regarding Mrs Thomas' toileting requirements. However, she could not be sure whether she knew this due to referring to the care plans on the computer or by verbal knowledge from other staff members.

She said she always had a person with her and she would work together but sometimes, she worked alone.

She confirmed she was aware that when Mrs Thomas was taken to the toilet she was not to be left by herself.

She confirmed there were call bells for nurses/patients to use in the rooms. She did not carry a phone.

On this particular day AIN Rouse had a partner to work with but she was not with her at the time because she was getting somebody else out of bed.

AIN Rouse confirmed she had helped Mrs Thomas out of bed and sat her on the toilet. She then went to make the bed when another resident called out and she went to see what was wrong. Her explanation of why she left Mrs Thomas unattended was that she simply reacted to the call for help by another resident.

She could not explain the reason why she had initially left Mrs Thomas on the toilet alone to make the bed. This was about 2- 3 metres away (estimated.) She considered she was still 'with' Mrs Thomas although she recognised in retrospect that this was not the case.

She said the other resident was yelling out and she went to investigate. She thought she was away for about five minutes.

The more senior staff in attendance at the time, Registered Nurse Johnson stated afterwards that in all the time she had been caring for Mrs Thomas, she had never had an occasion requiring her to speak with assistant in nursing staff about leaving Mrs Thomas unattended on the toilet.

It was noted that AIN Rouse was said to have very good rapport with residents. The registered nurse she worked with considered AIN Rouse provided exceptional quality of care and engendered a feeling of confidence that she was performing her job to a high level. There were no negative events or incidents recorded in her personnel file. All of her appraisals suggested she was performing as expected, above expectations or exceptionally.

Previous training

AIN Rouse commenced employment as a kitchen hand with Bundaleer in 2000. She was therefore inducted regarding topics of health and safety training, accident/incident reporting, safety policy and roles and responsibilities, resident safety, and requirements of the OHSW Act and Regulations.

She was subsequently employed as an AIN after completion of certificates III and IV in Aged Care in 2003 and 2008. The training for these certificates included 'implement and monitor OHS policies and procedures for a workplace'.

Bundaleer also had self-paced learning packages including 'Falls Prevention for Employees'.

There were also training workbooks with accompanying DVD's for;

- Falls prevention; the principles
- Falls prevention; implementing a falls prevention program and
- Duty of Care and negligence.

AIN Rouse had completed manual handling training annually as required and in 2010 completed the safe work procedures. Falls prevention training was carried out in October 2009, June 2010 and November 2012.

At various times during her employment AIN Rouse completed evaluation questionnaires applicable to her position. The process asks questions about confidentiality, resident's safety and well-being, dealing with residents, family and others. A review of this material noted that AIN Rouse answered these questions on a number of occasions with references to having input into the nursing care plan. She had answered the question that a nursing care plan should record information about a resident, e.g. regarding mobility, past/present information about the resident, how to care effectively and consistently for needs of a person receiving care, including;

- what assistance is required, any physical disabilities, any social or emotional issues and diet needs.

She identified the computer system, iCare as the source for information about a resident's care.

The assessor indicated she had a good understanding of all policies and procedures.

Generally, it was noted that upon orientation of new staff, the safe work procedures manual was provided as part of the training and the staff member reads it and signs it upon completion.

All new staff are provided with access to the online record keeping system which includes residents' care plans and mini care plan documentation.

The staff are also given a copy of memory jogger documents with extracts from the relevant Workplace Health and Safety Act. They are reminded they must be aware of a resident's care plan and mini care plan which is updated every two months.

Responses by Bundaleer Lodge Nursing Home

Subsequent to Mrs Thomas' death, AIN Rouse completed additional training for Duty of Care and Negligence on 8 September 2012 and Falls Prevention on 2 October 2012. In completing the Falls Prevention training she included reference to the mini care plan and the necessity to read these regularly.

Standard fall prevention strategies had previously been completed on the 22 October 2009. As well, annual manual handling training had been completed and the safe work procedures manual had been completed in 2010.

The next Continuous Improvement Meeting which occurred after Mrs Thomas' death was convened on 8 August 2012. The following actions were documented to occur:

- Memory joggers / reminders for all nursing staff
- Counselling for staff traumatised by the death of Mrs Thomas
- Direct education to staff involved
- Staff to view DVD on duty of care and complete worksheet

Restraint and bed rail list reviewed and two extra columns added regarding risk level, and not to be left unattended.

A number of messages were placed on the computer program by way of information/instruction to all staff following Mrs Thomas' death.

On 1 August 2012 the following message was placed –

'please ensure your residents are safe to leave, if you leave them unattended on the toilet. If very drowsy at the time, highly likely a fall will occur. Past history of falls also indicates a high risk. Accidents will happen BUT prevention and careful assessment of risks will reduce injuries to our frail residents. If you are not sure who can be left, read care plan OR ask RN or EEN in charge of shift.'

On 6 August 2012, a message was recorded on iCare for all staff, part of which read-

'It should now be a learning event whereby ALL nursing staff re-read the care plans and not be complacent. Read the sections relevant to the work you do. Read 2-3 each day instead of wasting time when tasks are complete….Keep up-to-date with resident information, read back progress notes since your last shift. No one can possibly tell you everything at handover.'

On 13 August 2012 staff were informed to –

'read restraint information in front of bowel book. It now indicates who is high risk of falls and who is not to be left unattended……. Read care plans a minimum of second monthly after they are updated and read changes on progress notes. They are written to guide best care practice.'

On 10 September 2012 staff were informed that-

'all staff, especially if new to an area, check which residents cannot be left alone on the toilet. If in doubt REMAIN WITH the resident. Use the list in front of each bowel book. This is your duty of care.'

On 26 September 2012, staff were informed to-'read care plans and follow directions, e.g., do not leave alone, two assist needed, hoist needed, type of meal/fluids.' This message was repeated on 2 October 2012.

A notice to all staff dated 9 August 2012 was provided which clearly stated that staff should be aware of a resident's care plan and mini care plan which are updated every two months. Staff must attend to the resident as per the care plan in particular relating to staying with the resident.

Office of Fair and Safe Work Queensland investigation.

Their report identified the hazards to be managed in this situation as;

- Leaving a person who has a history of falls and
- Not complying with direction provided in the care plan.

Staff members involved on the day were interviewed and their responses considered in the context of the identified hazards and Bundaleer Lodges' instructions and policies regarding residents' safety.

The report concluded there was a failure by the staff member to follow Bundaleer Lodge instructions regarding Mrs Thomas' care. This failure placed Mrs Thomas in a position where she was alone and unassisted on the toilet where she fell and sustained injury.

Office of Fair and Safe Work Queensland concluded they would not prosecute Bundaleer Lodge following Mrs Thomas' death. No reasons were provided.

On 24 July 2015, OFSWQ responded to the Office of the State Coroner and advised-

'It was however considered that there was not a broad workplace health and safety issue. While Mrs Florence Thomas was left on the toilet unattended in breach of the extended care plan for her, the nursing home operator had adequate staffing and safety procedures in place. The evidence could not establish the reason for the staff member leaving the resident unattended beyond going to the aid of another resident who had called out.'

Conclusion

When interviewed by OFSWQ Assistant in Nursing Rouse could not really explain how/why she made the decision she did, to respond to another resident calling out while she had sole responsibility for an elderly, frail, high falls risk resident who suffered from dementia sitting on a toilet chair alone in her en-suite.

Perhaps it is because there was really no satisfactory reason that could have been given for such a decision. It was an instinctive response where the assistant in nursing, who was working alone rather than with a partner, was suddenly and unexpectedly faced with a second resident calling out for attention when she was already caring for Mrs Thomas.

The decision to leave Mrs Thomas unattended on the toilet was wrong, against the specific instructions of Bundaleer Lodge recorded on multiple occasions not to do so, and disastrous for Mrs Thomas.

The interview clearly indicates the assistant in nursing was extremely sorry for her actions and the impacts her action caused to Mrs Thomas and her family in their loss.

Bundaleer Lodge had a comprehensive regime of training, risk assessment, instructions and communication with staff in place. Since Mrs Thomas' death they have reviewed their procedures and re-educated and re-emphasized the imperative responsibility of all staff to keep themselves informed about residents' care plans and act strictly in accordance with these plans.

Vigilance, leading by example by senior staff and back up spot checks and audits of staff compliance with care plans could be considered by Bundaleer Lodge Nursing Home as additional reinforcement of the training and improvements they have already initiated.

An inquest is unlikely to add anything to the information about what occurred on 31 July 2012.

However, these findings are published in the public interest. Many of us will be reliant in our old age upon the skill and care of those who work in aged care facilities. The safety of residents depends on many factors including a safe physical environment and ongoing risk assessment of individual's needs. Appropriate measures to ensure safety depend upon vigilant adherence to individual care plans, particularly regarding reducing falls risk which so often precipitates death in the elderly.

Findings

The findings in accordance with section 45 of the *Coroners Act 2003* are;

Florence Lillian Thomas, who was born on 3 August 1926, died as a result of injuries to her neck which were sustained in a fall from a toilet seat at Bundaleer Lodge Nursing Home at Ipswich. She required assistance to be placed on the toilet and had been left unattended by staff when she fell on 31 July 2012.

She died in the Princess Alexandra Hospital at Woolloongabba in Queensland on 2 August 2012.

She died due to a neck injury as a consequence of the fall.

Chris Clements
Coroner
3 May 2016