CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr W**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	20 November 2024
FILE NO(s):	2022/368
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Pressure risk assessment and management, Hospital acquired pressure injury, Pressure risk mitigation strategies, Wound care management

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Background

1. Mr W was born on 13 April 1939 and died on 20 January 2022 at The Prince Charles Hospital. He was 82 years old.

2. A doctor from The Prince Charles Hospital reported Mr W's death to the Coroner because his death was identified as a potential healthcare related death within the definition of a reportable death in the *Coroners Act 2003*. He had presented to the hospital with a sacral pressure injury with osteomyelitis and sepsis.

3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

4. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am guided by the principles outlined in *Briginshaw v Briginshaw* (1938) 60 CLR 336. That is, I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

5. Prior to a prolonged hospitalisation in November/December 2021, Mr W had been living with his very supportive wife, in a granny flat attached to their son's residence.

6. Review of Mr W medical records shows he had significant pre-existing health issues including chronic myelomonocytic leukaemia; progressive cognitive decline and poor mobility; atrial fibrillation; congestive heart failure; asbestosis; hypothyroidism; gastro-oesophageal reflux disease; and dyslipidaemia.

7. During November 2021, Mr W mobility decreased with a rapid decline over a two-week period. He presented to The Prince Charles Hospital (TPCH) emergency department (ED) on Monday 29 November 2021, accompanied by his wife. This was because they could not get an appointment with Mr W regular General Practitioner (GP).

8. They reported to the ED clinicians that Mr W had had progressive leg weakness over the past few months, with a noticeable deterioration following a cystoscopy on Friday, 26 November 2021. While he usually mobilised with a four-wheel walking frame (4WW), he felt like his legs were giving way, causing him to fall twice. He had lost about 10kg in weight over the past year but otherwise felt quite well. His wife described some cognitive slowing over the past few months.

9. The clinical impression was of likely deconditioning in the setting of resolved bilateral leg cellulitis and recent day surgery. Mr W chose to use his private health insurance for a medical admission to North West Private Hospital, under the care of a private physician.

Admission to the North West Private Hospital

10. Mr W was investigated with imaging and blood tests and received allied health input including dietician assessment and physiotherapy. He was assessed as needing dietary supplements (Ensure Plus, three times a day) and was commenced on a food chart with ongoing dietician review, and he had regular physiotherapy sessions.

11. No pressure injuries or wounds were noted on the admission risk screening undertaken on 29 November 2021. The medical pathway on admission indicated wound care was not required but that twice daily skin inspection was required. A Pressure Injury Risk Assessment was attended to on 29 November 2021, and on 2, 3, 6, 13 and 15 December 2021. Mr W's was assessed as being in the 'high risk' category.

12. Under the 'high risk' category he was for "*use air mattress or alternating pressure mattress*". There are crosses in this section from 29 November 2021 to 5 December 2021. On 6 December 2021 there were ticks but it then reverts to crosses through to 12 December 2021. This indicates to me that Mr W was not on a pressure relieving mattress during this time.

13. Mr W was also for second hourly changes in position. The nursing staff record 'S', which I assume stands for 'Self'. Later there are ticks or dashes. He was also to have his skin inspected at each change of position and while this seemed to occur on the first day, it did not then occur. I am unsure how the form is to work, as both Plans 1 (patients 'AT RISK') and 2 (patients 'HIGH RISK') were completed.

14. According to the Risk Assessment Passport, Mr W's underwent a 'Comprehensive Skin Inspection'. It was noted this was to be performed on admission and at minimum every 72 hours. After admission, on 2 December 2021, the box 'Patient self-reports NIL skin integrity issues'; and on 6 December 2021, the box 'No skin alterations identified'.

15. On 6 December 2021, Mr W's legs had become swollen, red, and very sore. He was commenced on oral antibiotics for cellulitis. An ultrasound scan of his right leg showed a thrombosed vein, so he was restarted on his regular anticoagulation medication. A CT head scan showed no acute intracranial pathology.

16. Plans were made for Mr W to receive inpatient rehabilitation at a public residential transitional care service.

17. On 9 December 2021, Mr W developed bilateral pitting oedema up to his knees. He was medically reviewed with no acute clinical issues identified. His fluid retention was being managed with diuresis and fluid restriction. He remained clinically stable and was able to transfer and mobilise with assistance. His appetite and oral intake improved.

18. On 10 December 2021, a Comprehensive Skin Inspection was undertaken and the box 'No skin alterations identified' was ticked.

19. Over the course of Mr W's admission his family observed a deterioration in his mobility to the point of him requiring two-staff to assist mobilising him with a Sara Steady (type of mobility frame). His family have advised he spent many hours sitting up in bed or in a chair. He complained of being uncomfortable in the chair, so he was left in bed but not repositioned regularly.

20. On 12 December 2021, an agency nurse records, 'PAC attended'. This being the first reference to pressure area cares in the progress notes. It may though be that staff at North West report by exception and it seems they use the Pressure Injury Prevention Form for documenting pressure area care.

21. On 15 December 2021 and 16 December 2021, a 'Comprehensive Skin Inspection' was completed. The box 'no skin alterations identified' was ticked on 15 December 2021 and no tick in the required box was made on 16 December 2021. There was though shading on the picture referring to Mr W's having bilateral leg oedema.

22. On 17 December 2021, Mr W was noted to have a 'skin break' on his buttock. A preventative dressing was applied. The skin break was noted on the Comprehensive Skin Inspection but under the section 'Use the Key below to indicate the type of skin alteration by writing that number on the body diagram where the alteration(s) exist' was not completed. That is, 1 (Stage 1 pressure injury) through to 6 (Deep Tissue Injury) was left blank. The section for the description of the wound was also not completed.

23. Mr W was not assessed using the Risk Assessment Passport 'Pressure Injury Risk Assessment' at this time. Had this have occurred he would have been assessed at 21 (as he had a 'skin break' to his coccyx). This would have put him in the Very High-Risk Category. Staff continued to complete the 'Pressure Injury Prevention' form, filling out both Plans 1 and 2 but by this time he should have been on Plan 3 (Patients 'Very High Risk'). The additional intervention is 'use alternating pressure mattress'. It appears from the documentation a mattress may have been put in place on or around 17 December 2021, but the documentation is unclear. The change in position was again recorded as S, which I assume meant Mr W's was to change his own position.

24. On 18 December 2021, nursing staff documented a very red but not painful sacral pressure area. A new sacral dressing was applied, and Mr W was encouraged to lie on his side in bed. He was for regular pressure area cares.

25. On the morning of 20 December 2021, Mr W became febrile. He was very weak and stiff and was not able to mobilise with assistance to the shower. He was grimacing while mobilising but denied any pain. He was not charted for analgesia due to his risk of excessive drowsiness. His observations were otherwise stable. He required assistance with meals and later complained of severe pain when his pad was changed and during pressure area cares. He was charted for Endone 2.5mg, as needed, with good effect.

26. On 20 December 2021, a Pressure Risk Assessment was carried out, and Mr W's was assessed as being at Very High Risk. The nursing staff completed the Pressure Injury Prevention form from 20 December 2021 to 24 December 2021, completed Plans 1, 2 and 3. This giving me confidence from at least 20 December 2021, Mr W's had an alternating pressure mattress in place.

27. On 21 December 2021, a comprehensive skin inspection was carried out, a nurse records 'dressing intact'. The required tick boxes on the form were not completed. The pressure injury had not been inspected since 18 December 2021.

28. On 21 December 2021, when reviewed by his physician, Mr W was noted to be well with stable vital signs. A transitional aged care facility bed had become available, so arrangements were made for him to be transferred the following day. It does not appear from the clinical records Mr W's physician was made aware of Mr W's pressure injury.

29. Overnight Mr W complained of a sore ankle and developed a new oxygen requirement as his oxygen saturations dropped to 94%. He was placed on supplemental oxygen 2L via nasal prongs. He was noted to be well when reviewed by his physician in the morning and was cleared for discharge. When seen by the physiotherapist, Mr W reported feeling a little better. He was noted to have a strong dry non-productive cough. He fatigued quickly when participating in physiotherapy. He was assessed as needing two-staff assistance with the Sara Steady for transfers. The planned transfer to transitional care was postponed. His sacral wound dressing was changed that afternoon.

30. Overnight on 23-24 December 2021, Mr W was found in the bathroom on a Sara Steady out of reach of a call buzzer. His sacral wound was checked when he was put back to bed. The nurse documented, "*most redness is blanching but evidence of ?pre-existing*

stage I + II pressure injuries." He was to be nursed on his side and an Allevyn dressing was to be applied to the wound before he was discharged to transitional care the next day. Mr W complained of a sore right buttock cheek after having been on the Sara Steady overnight for an extended period. His sacrum was checked and noted to be unchanged.

31. On the morning of 24 December 2024, Mr W's treating physician noted Mr W was well that morning and ready for transfer to transitional care. Nursing staff applied an Allevyn dressing to Mr W's sacrum before he left. The comprehensive skin inspection section of the risk assessment identified the sacral wound, noting "*broken skin + Stage I PI [pressure injury] Non blanching erythema*." The section on the form grading the pressure injury and the description of the skin was again not completed.

32. There is no mention of the sacral wound in the medical discharge summary.

Transfer to the Residential Transitional Care Program (RTCP)

33. The nursing admission assessment documented a stage II pressure injury on Mr W's left buttock. Nursing staff completed a Community Initial Wound Assessment and Management Tool. The wound was documented as open, measuring 1cm x 1cm with minimal depth. It was dressed. A Riskman report was completed for the stage 2 pressure injury and a wound care pathway was commenced.

34. Mr W was assessed as being at high risk for pressure injury (Waterlow score 18). Dietician and speech pathology referrals were completed.

35. Mr W was assessed by a dietician who recommended a high energy, high protein diet with Resource supplement, three times a day.

36. Mr W was mobilising using the Sara Steady with two-staff assistance. He was reviewed by an occupational therapist who gave him a Jay 2 cushion to use when sitting to relieve the pressure area on his left buttock. The occupational therapist asked staff to monitor the pressure injury. An air mattress was in use. He was on two-hourly pressure area cares.

37. Mr W remained clinically stable. He was managed with regular multidisciplinary allied health input. He was medically reviewed by a general practitioner, on 31 December 2021, who noted he '*gets some nerve pain down legs only occasionally, gets better with pressure area care*'.

38. By early January 2022, Mr W was spending more time resting on his bed. His sacral wound was being managed with regular dressings on the wound care pathway and two-hourly repositioning. There is no clinical documentation of the sacral wound over 3-4 January 2022.

39. On 5 January 2022, the sacral wound was noted to have become sloughy with exudate ++ on the dressing. The wound dressing regime was changed on 5 January 2022 to Protosan soak and Cavilon with Aquacel as the primary dressing and repilex every second day. Mr W told nursing staff he was getting back pain when sitting up and was reluctant to sit out of bed.

40. On 6 January 2022, there was 75% strikethrough on the wound dressing. The Clinical Nurse Consultant reviewed the wound and changed the wound dressing regime to

Prontosan soak + solisite gel with Cavilon wipes every day. A case conference that day noted Mr W was very below baseline, with concern that he may need intensive rehabilitation to return to his previous baseline. Mr W told his case manager his progress towards weight bearing was being hampered by discomfort and pain.

41. On 8 January 2022, Mr W complained of pain during his sacral wound dressing change. He was given Endone 2.5mg with good effect.

42. On 9 January 2022, Mr W declined to shower, preferring to be sponge bathed in bed. He had a lot of difficulty transferring to the shower with two-staff assistance the following day. The sacral wound was noted to have deteriorated, "*looking like stage 3*". The nursing team leader was informed and advised to continue with daily solosite dressing. The wound care pathway was updated, and a referral was made for wound care review. Mr W continued to require pain relief with Endone 2.5mg, with good effect.

43. On 11 January 2022, a physiotherapist reviewed Mr W and noted significant functional decline with global weakness and alerted the occupational therapist to the now stage 3 pressure injury. The Jay 2 cushion was changed to a ROHO (different type of pressure relieving cushion) with education given to Mr W to relieve pressure by shifting side to side and leaning forward. He was advised not to sit for longer than two hours.

44. The sacral wound was reviewed by the wound management nurse that afternoon who documented:

    - *evidence of decline from PI* [pressure injury] *since 5/1/22 after chart r/v leading to further deterioration and escalation for r/v 10/1/22*
    - *r/v PI with pt in L) lateral position in bed – sage 4 PI to top of the natal cleft overlying the sacral bone*
    - *bone paloated 6-% unhealthy granular tissue 20% slough 20% bone pain scale 4-5*
    - *wound 2.5 x 2 x 3m deep with undermining of 2.5 towards L) buttock and 1cm towards R) buttock*
    - *tissue was not robust/boggy – surrounding non blanchable erythema – wound plan updated – protosoan soak 10mins – 2cm sorbact ribbon mepilex border 15 x 15 – strict repositioning regime max 2hrs side to side with greater trochanter (hips) protected with mepilex*
    - *Max stitting time 30 mins*
    - *noted r/v by dietician, OT, physio – had been on a gel cushion and roho arrived this morning - ?OT to adjust accordingly – once this has been modified (taking into account sacral PI) then sitting for* [up to] *1hr*
    - *already on Taley Quatro mattress* "

45. Mr W was commenced on a repositioning chart.

46. A nursing entry made that afternoon flagged that the mattress may not be functioning properly as it was beeping occasionally. This was to be monitored and replaced as a priority if it malfunctioned.

47. Sometime after the wound care nurse assessment, the facility was placed in lockdown after a patient tested positive to COVID-19. Mr W's family struggled to make phone contact with the treating team as the phone would ring out.

48. On 12 January 2022, Mr W declined to sit up for assessment by the speech pathologist due to pain associated with his sacral wound. He wanted the speech pathologist to give him tea lying flat. He requested Endone 2.5mg for backpain that night and again the following night, with good effect.

49. On the morning of 14 January 2022, Mr W continued to complain of pain from the sacral wound and was given more Endone 2.5mg. The wound was reviewed by the wound care nurse who noted the dressing had already been attended that morning, so she only rolled back the mepilex noting *"surrounding discoloured periwound thin partially blanching in some areas – r/v of PIP staging and as bone only palpated and not on view this should be classified as a stage 3 not a stage 4 as classified on my last r/v 11/1/2022…Noted talley quatro mattress alert/alarm again this has been commented on previously therefore please swap out mattress as a matter of urgency."*

50. On 14 January 2022, a Riskman report was completed regarding the pressure injury wound deterioration first reviewed by the wound care nurse on 11 January 2022 whose review of the wound care documentation identified that the injury showed signs of significant deterioration since around 5 January 2022. The report documents the wound as "*Wound cavity L 2.5 cm x W2cm x D 3cm with undermining / tracking of 2.5cm towards L) buttock and 1cm towards R) buttock. Approx 20% bone palpated with a thin layer of connective tissue. There is surrounding non blanchable erythema extending approx 3cm circumferentially around PI".* The report also noted the mattress pump stated 'failure' which was corrected by a nurse turning the pump on and off and adjusting the power cable. The report documents this was noted again, leading the wound care nurse to question whether this had been an ongoing issue.

51. When reviewed by the medical team that day, Mr W had just seen the wound care nurse who he said, "*just stirred me up*". He voiced concern that his wound was giving him more problems than what he came in with. The wound was now "*very very painful*" with "*pain++ with a change in dressing and movement*". He was noted to be taking regular paracetamol and PRN Endone (about one dose a day) and mostly getting a good night's sleep. They discussed the option of adding in a slow release Targin in the short term while the wound pain was a major issue. Mr W was hesitant to take stronger pain killers. The plan was for him to trial Targin 5mg/2.5/mg, twice daily with ongoing wound cares and physiotherapy.

52. On 15 January 2022, Mr W required Endone 2.5mg prior to his dressing change. There was a change in his blood pressure and oxygenation over the course of the day and evening.

53. On 16 January 2022, when the sacral dressing was changed there was "*exudate ++ minimal pus*". Mr W received Endone 2.5mg in preparation for the dressing change. He refused to sit out of bed. His vital signs were stable.

54. On 17 January 2022, Mr W did not manage any breakfast as he was very sleepy. He managed half of his lunch and all the dessert. The sacral wound was reviewed by the Clinical Educator who attended the dressing change and updated the wound care pathway. The wound now measured 4cm x 3cm x 3.5cm deep. It was being dressed daily with Aquacel + Leluvit + Tegaderm. There was some blanchable redness noted on his left heel, so mepilex was applied. The change in Mr W's condition with increasing sleepiness

was discussed with the nursing team leader who recommended a wound swab be collected at the next dressing change.

55. Mr W required a second dose of Endone 2.5mg that evening due to strong pain when he was repositioned. He slept well overnight.

56. On 18 January 2022, a wound swab was collected during the dressing change. Mr W had limited participation in the physiotherapy exercises that day, with difficulty moving his legs.

57. Mrs W spoke with her husband by phone at some stage that day. He told her he was in a lot of pain then the phone went silent. Mrs W had her daughter phone the facility to have someone check on him. It took over half an hour for them to find someone to check on Mr W. Staff phoned Mrs W telling her he was fine.

58. At around 7:15pm, Mr W reported feeling cold and shivering. He asked for two blankets and for the air conditioning to be turned off. His condition deteriorated over the next 90 minutes with hypotension, reduced oxygen saturations (85%) and fever (39.1C). He was awake but not orientated. Following discussion with a medical officer, Mr W was transferred by ambulance to TPCH ED.

59. A retrospective entry made by an occupational therapist the next day noted that the allied health assistant had told the occupational therapist that the ROHO in Mr W's room had deflated and did not have a cover. It was to be replaced with a new ROHO sufficiently inflated with a cover.

Admission to The Prince Charles Hospital

60. On arrival in the ED, Mr W was very unwell with signs of sepsis, severe hypokalaemia and metabolic acidosis. He had acute kidney injury, acute urinary retention and was faecally loaded. He was commenced on intravenous fluids, potassium supplementation and antibiotics (gentamicin and flucloxacillin).

61. On examination there was a large malodourous sacral ulcer weeping dark brown fluid. A wound swab was taken. CT imaging of the pelvis revealed a deep sacral ulcer with air pockets suggesting the possibility of underlying osteomyelitis with the wound communicating with the spinal canal.

62. The surgical team reviewed the wound, identifying it as being consistent with necrotising fasciitis. They spoke with the family about management options namely wide open excision and extensive surgical debridement versus palliation. The family elected for palliation.

63. On 20 January 2022, Mr W was admitted under the medical team for end-of-life cares. He was commenced on a syringe driver and died peacefully that day.

64. The treating team at TPCH attributed Mr W's death to necrotising fasciitis.

Response from Metro North Hospital & Health Service

65. MNHHS undertook a clinical incident analysis of the care Mr W received during his admission to the Zillmere Residential Transitional Care Program (RTCP). The review identified the following issues:

    a. ***Clinician handover from North West Private Hospital was incomplete*** – to address this, the RTCP reviewed its intake process to ensure documentation by the referrer on the patient's clinical status is current, comprehensive and complete. It was also implementing processes to ensure all necessary information is gathered to inform the patient's baseline and develop their management care plan;

    b. ***Wound assessment and management*** – the review recognised the importance of comprehensive wound assessment on admission to determine the patient's baseline, and regularly throughout the admission to monitor wound progress and inform a wound management plan. Following Mr W's death, registered nursing staff completed refresher training on wound assessment, wound photography, and wound management to ensure assessments are accurately documented in the patient record to inform further management.

    c. ***Comprehensive medical review*** – the medical model of care at RTCP was provided by a General Practitioner service. The review observed there were difficulties with this model due to increased numbers of patients presenting with complex health conditions and acuity. RTCP were reviewing the medical governance arrangements and the escalation process for Recognising and Responding to Acute Deterioration (RRAD) to identify opportunities for enhanced and timely medical reviews to support staff and patient's concerns.

    d. ***Pressure relieving support surface/equipment (air mattress and Roho cushion)*** – following Mr W's death, RTCP conducted an audit of all pressure relieving support surfaces to identify overlays/mattresses that are no longer functional and require replacement; revised the process for reporting malfunctioning equipment, follow up actions and documentation and required registered nurses to complete in-service education on pressure relieving support surfaces and documentation on the Adult Pressure Injury Risk Assessment (APIRA) to ensure the appropriate pressure relieving equipment is provided to the patient.

    e. ***Recognising and responding to acute clinical deterioration*** – the GP-led model of care meant that access to medical support can be challenging. RTCP subsequently developed an escalation process for recognising and responding to clinical deterioration and health care workers undertook graded assertiveness training in conjunction with RRAD training.

    f. ***Pathology process –*** RTCP subsequently implemented a documented process for review/follow up/escalation of pathology results to ensure results are reviewed and actioned in a timely manner.

66. On 20 August 2022, MNHHS conducted an open disclosure meeting with Mr W's son following completion of the Clinical Incident Analysis. A follow up phone call was made on 7 September 2022 to provide some further information.

67. I have been advised the recommendations from the clinical review have been implemented. The initiatives are referred to below in response to the expert opinion of Professor Strivens.

Expert Opinion

68. Professor Strivens, specialist physician in geriatric medicine from FNQ Geriatrics reviewed the patient records with a view to identifying whether there may have been an opportunity to have changed the outcome for Mr W.

69. Professor Strivens identified that Mr W had significant risk throughout his admission to North West Private Hospital for the development and progression of pressure wounds including but not limited to urinary and faecal incontinence, fluctuating cognition, reduced mobility and weight loss. While some mitigation occurred, including regular skin inspections, his family report concerns regarding both the regularity of continence pad changes and long periods of immobility in both his chair and bed, both of which would be a significant risk factor for the development of pressure injuries.

70. Professor Strivens identified the clinical documentation was inconsistent and incomplete. It also appears disconnected from the medical care, recorded in the notes, of Mr W, with further functional and cognitive decline noted throughout his stay, increasing his risk still further.

71. Professor Strivens noted the pressure injury appears to have developed around 17 December 2021, although even after this had been recognised and recorded, there are limited records of the need for specific wound care until 20 December 2021. This despite dressings being applied on 18 December 2021 and nursing notes on that day describing severe pain on changing his continence pads and attending to his personal care. Mr W was found in the bathroom in the early hours of 24 December 2021 after stating he had been there for 'hours', with his pressure injury that morning recorded as being 'unchanged' from last night.

72. Professor Strivens noted the transfer letter from North West Private Hospital to the RTCP did not include the Falls and Pressure Area Risk Assessments, though a timely wound assessment and management tool was completed on transfer to the RTCP. The reference to the skin integrity being intact in the transfer letter was inconsistent, with both yes and no circled. The handwritten medical discharge summary was incomplete, making no mention of the pressure injury, follow up plans or medications on transfer.

73. The stage 2 pressure injury was identified promptly in the RTCP admission notes and was appropriately reported on 'Riskman'. Professor Strivens identified some inconsistency of assessment/risk tools used at the RTCP, with both community and inpatient tools used, and inconsistently recorded in the notes around whether Mr W was repositioned regularly as ordered.

74. Professor Strivens noted comprehensive occupational therapist review of Mr W for pressure area management on day three of his admission including prescription of a pressure relieving cushion for his chair. He observed that while initially there is clear documentation of actions associated with the pressure area care, including two hourly repositioning, this documentation drops off after 3 January 2022 for the next two to three days, with only dressing changes recorded before the wound is noted to have significantly deteriorated on 5 and 6 January 2022.

75. Professor Strivens noted that Mr W appeared to have been reviewed by the Wound Care Clinical Nurse Consultant in conjunction with the ward nursing staff on 6 January 2022, with a further review and specific comprehensive notes and a wound care plan on 11 January 2022 (Day 18), by which time the pressure injury had progressed to a stage 4. The Riskman report dated 14 January 2022 noted potential issues with the active powered alternative pressure relieving mattress with pump failure noted by the Wound Care nurse on both 11 and 14 January 2022. Dr Strivens advised this would also likely contribute to the worsening of any existing wound and increased vulnerability to further pressure areas.

76. The key themes identified by Professor Strivens arising from his review of Mr W's care at both North West Private Hospital and the RTCP as contributing to the development and progression of Mr W's pressure injury are:

    a. ***Adequacy of clinical documentation*** – he considered the North West Private Hospital clinical documentation to be inconsistent and incomplete, with little evidence provided of clinical handover of issues between the nursing, medical and allied health teams, and lacking documentation of completion of actions on the results of risk assessments, including pressure reliving strategies, repositioning and continence pad changes. The documentation by nursing and allied health staff was better during the Zillmere RTCP admission with clear documentation of actions associated with care of the Stage 2 Pressure Injury during the initial segment of his stay from admission to 2 January 2022.

       There was also an inconsistency across forms and pathways that conflict and are not reflected in the body of the written notes, for example with community based wound forms being used in a residential/inpatient setting.

    b. ***Issues with inter-professional communication***, especially the nursing/allied health team and the medical team, with little evidence of medical escalation of care with Mr W's deteriorating wound or indeed earlier specialist nursing wound care involvement.

    c. ***Little evidence of a medical handover of any wound care concerns*** from the supervising medical team at North West Private Hospital although the pressure area was present on admission to Zillmere RTCP. Professor Strivens considered this may have significantly impacted on any escalation of care and interventions, with opportunities potentially missed to mitigate and definitively treat, for example via combined wound care nursing, pressure area support, mobilisation, and specialist/surgical review.

77. Professor Strivens also identified a missed opportunity for Mr W's declining cognition to have been reviewed by a geriatrician/old age psychiatrist given his declining cognition was reportedly due to a 'rapidly progressing dementia'. He considered that while it is likely there was a degree of underlying cognitive impairment, there were likely several other potential contributors to his presentation at the time that diagnosis was made, including a hypoactive/mixed delirium, of which there were several possible precipitants.

Forensic Pathologist Examination

78. An external autopsy and an internal autopsy to the extent necessary to identify the cause of Mr W's death was ordered.

79. The postmortem CT scan showed a sacral ulcer extending to the S5 sacral segment and adjacent coccyx with bony changes consistent with osteomyelitis. There was abnormal

soft tissue thickening extending to the posterior aspect of the lower sacral spinal canal, but no discrete epidural collections identified. Gas locules extended laterally from the sacral ulcer over the gluteal regions and in the sacral dorsal epidural space. Partial internal examination revealed a large and deep sacral ulcer reaching deep into the sacrum.

80. The forensic pathologist concluded the cause of Mr W's death was sepsis due to, or as a consequence of an infected sacral ulcer.

Response from North West Private Hospital

81. North West Private Hospital acknowledges there were opportunities during Mr W's admission to improve on the consistency of written documentation. I have been advised,

    a. To ensure documentation meets the minimum required standards, the hospital has provided targeted training for all clinical staff. This has occurred annually since Mr W's death.

    b. Earlier this year the hospital introduced an audit to monitor clinical documentation to ensure it was meeting minimum standards.

    c. It has been identified a formal referral process to senior nurse clinicians with wound care qualifications would be beneficial for all staff. While a referral may not have been warranted in Mr W's case, using the skills and knowledge of these nurses to develop education and training resources will be paramount.

    d. If Mr W had been found in the bathroom for hours that was not in line with the expected level of care. This because there have been clear expectations set regarding patient rounding and bedside clinical handover.

    e. The error on the transfer documentation will attempt to be avoided in the future through the audit process and a review of the transfer form.

    f. The consultant caring for Mr W was an independent Accredited Practitioner who was not employed by the hospital.

Response from MNHHS

82. MHNHS was provided with a copy of Professor Strivens' report and was requested to provide a response to the concerns raised by Professor Striven regarding the care provided to Mr W at the RTCP. I have been advised,

    a. *The RTCP implemented the following improvement strategies to address gaps in wound assessment and management:*

        i. *Establishment of multidisciplinary champions within RTCP to assist in developing staff and key stakeholders. This group comprised of Podiatrists, Wound Specialists, Nurse Educators and Clinical Nurses (CNs).*

        ii. *Development of wound box in each wing of RTCP with a camera, instructions for image download, dressing information and education.*

        iii. *A baseline audit was undertaken to evaluate completion of wound assessment, photography, and educational requirements.*

iv. *A survey was undertaken by the Wound Clinical Nurse Consultant (CNC) to understand and evaluate RTCP nursing staff knowledge regarding wound care and education requirements. Following the survey staff education sessions were conducted on wound dressings used by the Wound CNC.*

v. *The CN Champions x three (3) attended 'Wound Worksop Evaluation'.*

vi. *A Wound Assessment and Documentation Work Instruction was developed, presented, endorsed, and published by Community and Oral Health Skin Safety Committee (Attachment 5). The Work Instruction is aimed at providing specific guidance to RTCP staff on wound assessment, clinical photograph/s and documentation requirements.*

vii. *An audit of all pressure relieving support surfaces including overlays/mattresses was conducted and mattresses were replaced as a result.*

viii. *A malfunctioning equipment flow chart was developed to clarify the process for reporting malfunctioning equipment and the follow-up actions required including documentation ensuring all staff are familiar with the process.*

ix. *Inservice education on pressure relieving support surfaces and documentation on Adult Pressure Injury Risk Assessment (APIRA) was conducted.*

x. *A clinical audit in February 2023 was conducted which demonstrated staff could articulate the process for malfunctioning equipment.*

b. The RTCP reviewed the existing intake process to ensure the documentation provided by the referrer on the patient's clinical status is current, comprehensive, and complete by:

i. *Developing and Implementing a 'Referring Ward Clinical Information Transfer Checklist' that incorporates specific information required prior to admission to RTCP.*

ii. *Developing and implementing a 'Clinical Handover – Residential Transition Care Plan' tool including comprehensive information for referring facilities to complete about the patient to be admitted.*

83. In addition to the Transfer Checklist and Clinical Handover tool, a RTCP Referral Process and Requirements Fact sheet was developed to advise all referral partners of the expectation regarding the provision of relevant clinical information. Work was also undertaken to ensure appropriate documentation was received from the referring party and a daily meeting established to assess the suitability of transfer of a patient to the RTCP. Staff have been encouraged to complete an incident report (Riskman) if inadequate information has been provided by a referrer.

84. I have been advised,

A Short Notice Assessment audit was conducted in January 2023 to review compliance with all National Safety and Quality Health Service Standards

including clinical communication. There were no findings of non-compliance for referral information.

85. Regarding escalation and communication between medical and nursing staff, the RTCP has implemented an Acute Deterioration: Escalation of Care Work Instruction from October 2022. With this rollout, graded assertiveness training was provided to ensure patients' conditions are communicated effectively to ensure timely identification and intervention. In addition, an Afterhours Nurse Practitioner model of care has been implemented and the team leader role extended across the weekends and afternoon shifts. Workload allocation was also re-designed.

86. Another initiative was to trial a change in the medical governance at RTCP from a GP to a Geriatrician and Senior Medical Officer model. Following the trial, in June 2023, the GP model was replaced with a Geriatrician being appointed with Senior Medical Officer support from Monday to Friday.

Further Response from North West Private Hospital

87. I sought further clarification from North West Private Hospital concerning a number of issues.

88. The hospital had confirmed Mr W'Fs pressure injury should have been reported as an incident on Riskman, it was not. Staff have been reminded this is to occur and auditing will be undertaken to ensure compliance.

89. The hospital has no explanation as to why when Mr W was scored as 'high risk' for the duration of his admission that he was not placed on an air mattress on admission. Education has commenced to ensure all staff are aware of the requirements for the implementation of pressure injury prevention strategies.

90. The hospital had acknowledged the inconsistencies in the Pressure Injury Prevention form. There is a current project in place to review all risk stratification tools in use. Ramsay Health Care Australia (RHCA) have also begun releasing organisation wide standardised tools to ensure that there is no conflicting advise in these tools.

91. The hospital has confirmed the reference to 'S' in Pressure Injury Prevention form denotes Mr W was managing his pressure injury relief independently. The Chief Executive Officer states,

> *I would agree that given this clinical condition, this was not an appropriate assumption nor intervention and that all pressure relieving interventions are to be acknowledged and actioned by the nurse caring for the patient. This has been raised with* (sic) *directly with the staff members who cared for Mr W throughout his admission as well as with all staff.*

92. The hospital has no explanation to explain the omission of escalation to the admitting doctor regarding the development of the pressure injury and it has been acknowledged this was not documented within the medical record, nor the details contained in the medical discharge. This has been raised with staff and they have been reminded of the need to escalate the development or worsening of a pressure injury to the admitting doctor.

93. The RHCA Clinical Governance Unit provides both Police and Guidelines for 'Pressure Injuries – Preventing and Managing'. I have been advised within these documents is the requirement that in the management of pressure injuries:

    a. *Wound reassessment should occur at least weekly and as directed by the medical practitioner.*

    b. *On internal/external transfer, critical information relating to the patient's episode of care is to be handed over including, skin/pressure injury status.*

    c. *A photograph may be considered as additional information and kept in the patient's medical record.*

    d. *The patient's consent must be obtained and documented in the medical record.*

    e. *A metric scale measure is to be placed next to the pressure injury when taking the photograph.*

    f. *Screening, assessment and prevention strategies are to be documented in the patients' medical record including where preventative strategies are not implemented.*

94. The hospital had advised the wound care referral pathway project has been commenced with key stakeholders including their Wound Care Nurses and Comprehensive Care Working Group with the aim to provide clear guidelines for referral. Targeted education on wound care has commenced.

95. In conclusion the Chief Executive Officer states,

> *NWPH acknowledges that there are various deviations from policies and guidelines that occurred in respect of Mr W. We hope that this response communicates the seriousness with which this matter has been taken and the various steps taken to prevent recurrence in the future.*

Conclusion

96. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings in relation to Mr W's death.

97. The underlying premise is that most pressure injuries are preventable. In a frail and elderly person, once a pressure injury develops it can rapidly deteriorate leading to a catastrophic outcome. This is because of the difficulty in healing a pressure injury in a compromised patient once a pressure injury has developed.

98. When Mr W was admitted to the North West Private Hospital on 29 November 2021, he was elderly, had multiple medical co-morbidities, poor nutrition, poor mobility, declining cognition, incontinence and had a developing bilateral leg oedema. I accept he was at high risk of developing a pressure injury on his admission to the hospital.

99. The evidence supports Mr W's mobility continued to deteriorate during his hospitalisation at the North West Private Hospital. His family have advised he was left to sit in his bed or in his chair for long periods. I have found no evidence to dispute this. I note however, he was receiving daily physiotherapy sessions. There is evidence despite the physiotherapy,

Mr W had to progress from a 4WW to a Sara Steady mobility frame due to his deteriorating condition.

100. Mr W was at high risk of developing a pressure injury and the hospital had tools in place to assess and monitor such a risk. Despite this, it appears on the documentation Mr W was left to essentially manage his own change of position every two hours up until it was identified he had developed a pressure injury. Given Mr W's poor mobility and deteriorating cognition, he would not have been able to do this, and I consider this was inappropriate in the circumstances.

101. Even though a pressure injury had been identified on 17 December 2022, on the material, a pressure relieving mattress was not implemented until 20 December 2022. Mr W should have been placed on one on his admission to the hospital. I consider this was a missed opportunity in the appropriate management of Mr W's risk of developing a pressure injury.

102. Further, there was no wound care chart, accurate description of the skin, or photographs of the pressure injury after it had developed to allow staff to appropriately monitor the pressure injury.

103. I find these failures in care by the hospital in the management of Mr W's pressure care, in the context his poor clinical condition, led to Mr W developing a stage 2 pressure injury, which ultimately became a significant pressure injury.

104. The stage 2 pressure injury was identified promptly by the RTCP on Mr W's admission to that facility. While interventions to manage his pressure injury were put in place, as identified by Professor Strivens, there were some missed opportunities with documentation and the pressure relieving equipment. I am also of the view there was a missed opportunity for earlier referral to a higher level of medical care for the assessment and potential treatment of Mr W's pressure injury.

105. Within the two weeks of Mr W's discharge from North West Private Hospital, his pressure injury had progressed from a Stage 2 to a Stage 4. I find the deterioration in his pressure injury was multifactorial, including the deficits identified at the RTCP, and Mr W's poor clinical condition which impeded his healing ability.

106. I have been impressed by the self-initiated response by the RTCP to this incident and the interventions it has put in place to improve the care of patients it receives at the RTCP.

107. North West Private Hospital have responded to the identified failures in care and I am satisfied they have adopted interventions to try and avoid similar issues from occurring again in the future.

108. I am hopeful the processes adopted by North West Private Hospital and the RTCP will assist in mitigating the risk to future high risk patients.

109. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing). I have though sought approval from Mr W's family to publish these findings so other clinicians are able to consider and reflect on the events which occurred in this case. Further, that this case may result in the implementation of practices to improve and/or reinforce the importance of effective pressure area management in a vulnerable high risk patient in the acute care, and transitional care, settings.

110. I accept the forensic pathologist's opinion as to the cause of Mr W's death.

111. I extend my condolences to Mr W's family and friends for their loss.

I close the investigations.

Melinda Zerner
Coroner

20 November 2024