CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 22nd, 23rd and 24th days of June 2015 and the 8th day of February 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Marie Janet Ford.

The said Court finds that Marie Janet Ford aged 84 years, late of Christies Beach Residential Care Services, 50 Gulfview Road, Christies Beach died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 2nd day of April 2011 as a result of acute left subdural haemorrhage. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Marie Janet Ford died at the Flinders Medical Centre on 2 April 2011. She was 84 years of age. A pathology review was conducted by Professor Byard, forensic pathologist. Professor Byard gave the cause of death as acute left subdural haematoma[1], and I so find.

2. Background

2.1. Mrs Ford had suffered an unwitnessed fall from her princess chair at the Christies Beach Residential Care Services nursing home. The princess chair was located in the atrium section of the Rose Wing of the facility, approximately five metres from the nurses' station. The atrium was an area where staff were frequently passing in and out and Mrs Ford was under general observation. Staff were quickly on the scene following her fall and she was assessed and observed. She was on warfarin

[1] Exhibit C2a

anticoagulant treatment following a deep vein thrombosis that had been treated at the Noarlunga Hospital. Associate Professor Whitehead, consultant in geriatric medicine, who provided an expert overview of this case for the Court said in his report[2], Mrs Ford's case raises a question faced by all nursing homes: what should be the appropriate response to a fall with a minor head injury in a frail nursing home resident? In particular, what is the role of CT scanning in patients with a minor head injury who do not appear to have any obvious deterioration in mental state? And thirdly, what difference in response should occur with patients who are being treated with anticoagulation therapy?

2.2. I have found in this case that the Christies Beach Residential Care Services nursing home acted appropriately and according to the normal standard of care applicable to nursing homes generally in South Australia at the time of her fall. However, her case offers an opportunity for the Court to make recommendations about the questions raised by Associate Professor Whitehead, and to note the changes in practice that have occurred at the Christies Beach Residential Care Services nursing home following Mrs Ford's death.

2.3. Mrs Ford was a frail aged lady with dementia. She was immobile in the sense that she could not walk without assistance, although she could get up out of a chair. She was legally blind and verbally disruptive. She required full care at the facility. It was necessary for her to be hydraulically lifted in and out of bed. Mrs Ford's medical history also included deep vein thrombosis, pulmonary embolism, atrial fibrillation, congestive cardiac failure, macular degeneration, hypoglycaemia, glaucoma, cataracts, vancomycin resistance and, as I have noted, she was on anticoagulation therapy with warfarin following the deep vein thrombosis episode.

2.4. Associate Professor Whitehead noted that the use of warfarin in Mrs Ford's case reflected not only the deep venous thrombosis episode, but also the fact that she was in atrial fibrillation and probably at significant risk of stroke. He noted that her anticoagulation was managed appropriately with the assistance of her general practitioner and the locum service.

2.5. Associate Professor Whitehead commented that Mrs Ford's medical management overall at the nursing home was appropriate. She was on antipsychotic mediation

[2] Exhibit C25

risperidone as a result of a number of disturbed behaviours. Associate Professor Whitehead commented that in view of the fact that risperidone is associated with increased risk of falling and poor balance, and that Mrs Ford's mobility was very limited in any event, that it might have been worthwhile trialling her without risperidone for a period. This was a comment not by way of criticism, but a suggestion of optimising her medication.

2.6. Associate Professor Whitehead expressed the opinion that Mrs Ford was likely at high risk of falling. She had a history of falls and she was able to stand, but unable to walk. He said that patients in nursing homes who are able to stand or push themselves up from a chair, but not able to take any steps, are at a very high risk of falling. He noted that there is a question whether physical restraint is an effective preventative strategy for these sorts of falls. He said that the general consensus in both the aged care setting and the geriatric medical literature is that physical restraint is not effective. There are a number of reasons for this, including that patients who are physically restrained are more likely to suffer an injurious fall, although their frequency of falling may be lower. There is also a reported mortality rate associated with the use of physical restraints. He said that where aged care facilities have gone through restraint reduction programs there might be a slight increase in fall rates, but there tends to be no deterioration in injury rates. He said that the general consensus is to adopt a minimal restraint approach. Associate Professor Whitehead was not critical of Mrs Ford's placement in the princess chair and the observations that were being carried out on her prior to her fall.

2.7. For the purposes of his report Associate Professor Whitehead conducted a literature review of rates of injury in patients with minor head injury over the age of 65, both on and off anticoagulation. He noted that published articles refer to rules for when a CT head scan should be done and that some institutions adopt the use of the Glasgow Coma Scale (GCS) and no history of loss of consciousness or normal neurological examination. However, he pointed out that most older patients with dementia would not score a GCS of 15. That is because of disorientation and the fact that patients with cognitive impairment are frequently disoriented. Associate Professor Whitehead noted that he did not believe that it is routine practice in nursing homes in Adelaide at the moment for patients such as Mrs Ford to have had a CT scan. However, it was Associate Professor Whitehead's opinion that all patients who have a minor head

injury should have a CT head scan. He noted that there is some degree of controversy in the literature as to whether this should apply to all patients, or only those on warfarin or other forms of anticoagulation. He noted that the rates of intracerebral bleeding are much higher for those who are on anticoagulants than those who are not. Certainly it was Associate Professor Whitehead's view that the aged care sector should be considering CT head scanning in all patients who are on anticoagulants who suffer a minor head injury. He was less firm in his opinion about patients not on anticoagulation therapy.

2.8. Associate Professor Whitehead made the point that patients with pre-existing cognitive impairment have a lot of cerebral shrinkage and this means that it is often difficult to detect intracranial bleeding until it becomes too late. Thus with a smaller brain, as is typically the case in people with dementia, there will be a greater asymptomatic period as the blood accumulates because there is more space inside the skull. Hence the haemorrhage will only be found when it is quite large. In younger patients there is generally more warning earlier on with a headache and other symptoms that allow for earlier investigation. He also pointed out that in patients on anticoagulation there is some potential for reversibility of the anticoagulant. He said that if a small bleed is identified in a patient who is on warfarin, that drug can be reversed and the size of the clot can be limited. He summarised his view by saying that patients with a minor head injury who are on an anticoagulant should have a CT head scan to rule out intracranial bleeding, excluding those where there is a clear advanced care directive or palliative care plan such that they did not wish intervention or hospitalisation.

3. The events following Mrs Ford's fall

3.1. Nurses attended very quickly after Mrs Ford's fall and registered nurse Ms Vincent immediately implemented neurological observations. She also advised Mrs Ford's family of what had occurred and provided a fax report form to the general practitioner. She handed over the need for continued neurological observations to the next staff member on duty, Ms Razborsek. Ms Razborsek attempted to conduct neurological observations at 3:15pm and 3:30pm but Mrs Ford was very resistant and refused to permit Ms Razborsek to carry out the necessary observations. During this time Mrs Ford was placed by the nurses' station at the initiation of Ms Vincent and remained there until 7:30pm when it was assessed that she was able to be returned to

her room. Ms Razborsek dealt with the refusal of neurological observations by awaiting the arrival of another carer whom she knew Mrs Ford related to very well. She was aware that Mrs Ford had favourite carers. The arrival of enrolled nurse Ms Brandenburg solved the difficulty and she was able to take the neurological observations without Mrs Ford resisting. Mrs Ford denied having a headache and was able to ask for a drink of water at that time.

3.2. Unfortunately, overnight, an agency nurse had responsibility for Mrs Ford's care and conceded that she had not adequately recorded her observations. In fact, her record keeping was certainly not up to an acceptable standard. Furthermore, she accepted that she did not wake Mrs Ford in order to carry out neurological observations. This was because, on her account, a confused patient such as one with dementia would find it difficult to go back to sleep. The agency nurse was forced to accept that by not waking Mrs Ford she was unable to carry out proper neurological observations and assess levels of consciousness. It is beside the point that a demented patient might be confused and find it difficult to go back to sleep. This smacks of staff convenience more than concern for the patient and reflected a compromised standard of care at the hands of this agency nurse. I note that Christies Beach Residential Care Services made a complaint to the agency responsible for that nurse and it is noted that, to the extent that there was a lack of care, it was not at the hands of a permanent staff member of Christies Beach Residential Care Services.

3.3. Finally, I note that the Director of Nursing at Christies Beach Residential Care Services acted very promptly following Mrs Ford's death to amend the facility's protocols with respect to dealing with a patient who has a fall. It is now a requirement at the facility that any patient subject to anticoagulation therapy must be sent to hospital for assessment following a fall resulting in a minor head injury.

4. Conclusion and recommendation

4.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

4.2. I respectfully agree with Associate Professor Whitehead's opinion in relation to the need to consider the implementation of a policy in which nursing home patients who

suffer a fall resulting in a minor head injury should be referred to hospital for assessment. If the patient is on anticoagulation therapy, consideration should be given at the hospital for the need to conduct a CT scan.

4.3. I recommend that the South Australian Minister for Health, the South Australian Minister for Ageing and the Commonwealth Minister for Health and Aged Care consider this finding and work together to consider the possible adoption of a protocol under which nursing facilities would refer patients following falls resulting in minor head injuries to hospital for assessment, and that hospitals receiving such patients should give consideration to the carrying out of a CT scan for at least those patients who are on anticoagulation therapy.

Key Words: Anticoagulation Therapy; Nursing Care

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 8th day of February, 2016.

State Coroner