IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4948

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Jacqui Hawkins
Deceased:	Adele Di Quinzio
Date of birth:	26 October 1929
Date of death:	17 October 2016
Cause of death:	I(a) Sepsis complicating sacral decubitis ulceration in the setting of recent surgical correction of fractured neck of femur (secondary to fall)
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152
Key Words:	IMMOBILITY, PRESSURE WOUNDS, PRESSURE INJURIES, DECUBITUS ULCERS, AGED CARE, PREVENTION STRATEGIES, SUPPORTED RESIDENTIAL SERVICES

BACKGROUND

1. Adele Di Quinzio was 86 years old at the time of her death. She lived at Adare Supported Residential Service (**Adare SRS**) in Wantirna South.

2. Mrs Di Quinzio was born in Italy. She was the loving mother of two daughters and a son.

3. According to Knox Gardens Medical Centre General Practitioner Dr Bashir Ahmed (**Ahmed**), Mrs Di Quinzio's medical history included Type 2 diabetes mellitus, osteoporosis, osteoarthritis, hypertension, tricuspid valve regurgitation, a past fractured pubic ramus and dementia. She was described as frail, weak and generally not in good health.

4. Mrs Di Quinzio commenced living at Adare SRS in August 2015 following an unwitnessed fall and an admission to the Angliss Hospital where she was treated for a community acquired pneumonia.

5. By July 2016, approximately three months prior to her death, Mrs Di Quinzio's health had deteriorated, and she required staff assistance with personal activities of daily living, including showering. Prior to the fall that she sustained in September 2016, Mrs Di Quinzio mobilised with a four-wheeled walking frame with supervision.

6. Mrs Di Quinzio's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic).

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death and with some exceptions, the circumstances surrounding the death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

8. As part of the coronial investigation, several statements were obtained from Adare SRS, treating clinicians, Eastern Health and the Department of Health and Human Services (**DHHS**). Additionally, an expert opinion was obtained. The investigation also included reviewing the medical records of the Eastern Health, Knox Gardens Medical Centre, Adare SRS, the Royal District Nursing Service (**RDNS**) and the National Home Doctor Service (**NHDS**).

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

9. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

10. On 17 October 2016, Adele Di Quinzio was visually identified by her daughter, Rosaria Caruso. Identity was not in issue and required no further investigation.

Medical cause of death

11. On 18 October 2016, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Mrs Di Quinzio and reviewed the Form 83 Victoria Police Report of Death, a medical deposition, the medical records from Wantirna Health and the post mortem computed tomography (**CT**) scan.

12. Dr Lynch reported that the external examination of the body and the findings were consistent with the medical history. He noted a decubitus ulceration measured up to 10cm in maximum dimension with significant undermining of the adjacent skin over the presacral region, as well as decubitus ulceration of both heels.

13. Toxicological analysis of post mortem blood detected the presence of medication consistent with therapeutic use.

14. Dr Lynch provided an opinion that the medical cause of death was 1(a) sepsis complicating sacral decubitis ulceration in the setting of recent surgical correction of fractured neck of femur (secondary to fall).

Circumstances in which the death occurred

15. On 7 September 2016, Mrs Di Quinzio had an unwitnessed fall in her bedroom at Adare SRS. She was transported to Maroondah Hospital, where it was determined that she had sustained a fractured left forearm and left neck of femur (hip).

16. On 9 September 2016, Mrs Di Quinzio underwent corrective surgery to stabilise her hip fracture with the insertion of a short gamma nail. Postoperatively, Mrs Di Quinzio was able to weight bear as tolerated through her left hip, however she was not permitted to weight bear through her left forearm, which posed difficulties in her ability to mobilise and partake in rehabilitation. The post-operative course appeared uncomplicated, aside from a low haemoglobin count (Hb 78g/dL) detected which was possibly related to bleeding and managed

with a transfusion of one unit of packed red blood cells. A CT scan of the brain was done and was reported as being unremarkable. Mrs Di Quinzio's left wrist fracture was immobilised in a below elbow plaster cast. No diagnosis was made in respect to the cause of the fall. Mrs Di Quinzio was otherwise conservatively managed.

17. On 12 September 2016, in consultation with Mrs Di Quinzio's family, the hospital discussed her increased care requirements with Adare SRS, who confirmed that they were in a position to care for her. She was consequently discharged to Adare SRS on that day.

18. On 14 September 2016, Adare SRS staff observed a pressure wound at Mrs Di Quinzio's sacral area which was recorded in her progress notes. Adare SRS (then) Facility Manager Ms Kris Chau (**Ms Chau**) stated that Adare SRS contacted a locum General Practitioner and requested that they attend and review Mrs Di Quinzio.

19. On 15 September 2016, Dr Aria Adeli (**Dr Adeli**) from the NHDS attended to review Mrs Di Quinzio. Dr Adeli's notes indicate that the purpose of the visit was to attend to Mrs Di Quinzio's pain management in relation to her hip and rehabilitation program. There is no mention of the presence of a pressure injury. While it is possible that the pressure injury was present and not considered by Dr Adeli on 15 September 2016, it appears unusual that Adare SRS staff would not have drawn Dr Adeli's attention to it. Dr Adeli assessed Mrs Di Quinzio's general appearance, hydration and cognition status, her vital signs and focused on an examination of her left lower limb. It is unclear from the records whether Dr Adeli attended because of being notified about the pressure injury. Dr Adeli states that he did not observe a pressure sore and that the presence of one was not drawn to his attention.

20. On 18 September 2016, locum General Practitioner Dr Saman Kazemi-Manshady (**Dr Kazemi-Manshady**) attended Adare SRS and consulted with Mrs Di Quinzio. He observed a sacral pressure injury of approximately 1cm diameter and the presence of mild discharge from the wound. No fever was noted. He reported that Mrs Di Quinzio had not suffered from any fever or rigors and had no systemic symptoms. She was alert and well perfused. There was no erythema around the ulcer and no tenderness over the bones. Dr Kazemi-Manshady reported that staff advised that the pressure injury had been present for approximately two days. Dr Kazemi-Manshady recommended a management plan which included a 10-day course of Keflex (antibiotic), ensuring that the sacral area remained clean, changing the Mepilex border sacral dressing every three days, ensuring that no pressure was placed on the sacrum and that a GP review the wound in one week. Dr Kazemi-Manshady advised Adare SRS to seek urgent medical attention if Mrs Di Quinzio were to deteriorate.

21. Mrs Di Quinzio was assessed by a physiotherapist on 19 and 20 September 2016. A Wantirna Health physiotherapy Aasessment dated 19 September 2016 notes that Mrs Di Quinzio was sitting in a recliner chair, indicating that the General Practitioner's instruction to "ensure no sacral pressure", as documented in Dr Kazemi-Manshady's 18 September 2016 progress notes entry, was not being followed. The physiotherapist attempted a sit to stand movement with Mrs Di Quinzio with two people maximally assisting her, however Mrs Di Quinzio was unable to perform this movement. The physiotherapist suggested that Adare SRS staff use a sitting hoist for transfers.

22. On 20 September 2016, the physiotherapy entry in the progress notes indicates that Mrs Di Quinzio was able to participate in sit to stand movements from a reclining chair with the assistance of two staff and a two-wheeled walking frame. The physiotherapist suggested that Adare SRS staff continue to transfer Mrs Di Quinzio with two staff assisting, using a standing machine.

23. On 23 September 2016, Mrs Di Quinzio attended a hospital orthopaedic follow up outpatient appointment. It was noted that her surgical wound was healing well.

24. On 24 September 2016, NHDS locum Dr Asanga Bandara (**Dr Bandara**) conducted a physical examination of Mrs Di Quinzio. He observed a rash on the perineal skin, near her buttocks, but did not observe a pressure injury. He states that Adare SRS staff did not bring a pressure sore to his attention. Based on his clinical diagnosis, he advised standard treatment for Mrs Di Quinzio which included the application of two creams to the affected area and keeping the area dry and clean. According to him, there were no signs of serious systemic illness apparent at the time of his examination.

25. Dr Ahmad said that he saw Mrs Di Quinzio on 26 September 2016 and did not consider that her sacral wound was infected. Dr Ahmad advised Adare SRS to continue with the appropriate wound care and to ensure that she was regularly mobilised. He stated that at that stage, there was no reason to initiate a transfer to hospital.

26. On 26 and 27 September 2016, Mrs Di Quinzio was reviewed by a physiotherapist. On 26 September 2016, the progress notes physiotherapy entry state that Mrs Di Quinzio participated in several repetitions of sit to stand movements with two staff assisting. She was unable to take any steps secondary to pain (having been provided with analgesia approximately half an hour prior to physiotherapy) and a reported fear of falling. On 27 September 2016, Mrs Di Quinzio was unable to participate in assisted sit to stand movements secondary to increased pain, despite being provided with significant analgesia prior to the session.

27. On 1 October 2019, the pressure ulcer was reviewed by Dr Nasier Ammad (**Dr Ammad**) who noted that the pressure sore had been present for two weeks and that the plan included continuing with the wound care nurse, daily dressings, cleaning the affected area with saline and frequent position changes.

28. According to the progress notes, on 3 October 2019, Adare SRS contacted Dr Ahmed and requested that he attend to review Mrs Di Quinzio, however, he was unavailable to attend that day. They advised Dr Ahmed that they took photographs of the pressure wound and would email them to him. Dr Ahmed states that he never received the photographs and suggested that they contact RDNS for attendance of a wound specialist. Adare SRS staff contacted the RDNS and requested an attendance. Mrs Di Quinzio was booked to be seen by the RDNS on 6 October 2016. Notes taken from the RDNS referral made on 4 October 2016 state that Mrs Di Quinzio was completely bed bound and that a hoist was being used to assist with transfer.

29. On 5 October 2016, Dr Ahmed said that he consulted with Mrs Di Quinzio and observed that the sacral wound was infected. Dr Ahmed commenced her on antibiotics, encouraged physiotherapy involvement, advised to regularly change her position and to contact him with any concerns. Dr Ahmed said that there was no clinical reason or indication for Mrs Di Quinzio to be transferred to hospital at that time. He considered that she was managed quite efficiently, having been regularly attended to by a physiotherapist, locum doctor, the RDNS and himself. He said that he did not know what else could have been done differently throughout her clinical course. Dr Ahmed was aware that Mrs Di Quinzio was scheduled to be reviewed by a RDNS wound specialist the following day.

30. On 6 October 2016, RDNS attended and assessed Mrs Di Quinzio and considered that the sacral wound was 'unstageable with copious purulent exudate'. They also reported that she had bilateral heel pressure injuries, oedematous hands and feet, and that she appeared dehydrated. They recommended that she be transported to Maroondah Hospital for management of the pressure ulcer and malnourishment. The following day, Mrs Di Quinzio was re-admitted to Maroondah Hospital.

31. The history obtained from the Maroondah Hospital Emergency Department notes that Mrs Di Quinzio was unable to provide any history, that there had been a gradual deterioration in her cognition following her recent discharge from hospital, that she required hoist transfers following physiotherapy advice and that she had developed a sacral pressure sore which had gradually worsened.

32. On examination, Mrs Di Quinzio was noted to have, aside from the 7-10cm full thickness sacral pressure area, bilateral necrotic areas over the heels without skin breaks, multiple variable stage ulcers on left and right lateral thighs and on her ears.

33. Between 7 and 11 October 2016, Mrs Di Quinzio was under the care of the Acute Medical Unit. She did not respond to antibiotic treatment and the pressure injury was considered untreatable. In consultation with her family, Mrs Di Quinzio was discharged to the Wantirna palliative care team, under whose care she died on 17 October 2016.

Family concerns

34. On 18 October 2016, Ms Di Quinzio's family wrote a letter of concern to the Coroners Court in relation to the quality of care she received whilst a resident at Adare SRS.

35. Mrs Di Quinzio's daughter, Ms Lucy Fuimara, was concerned that Adare SRS was not able to meet the high level of care required by Mrs Di Quinzio. The family were apparently assured by the (then) Adare SRS Facility Manager, Ms Chau, that Adare SRS was suitably qualified and equipped to deal with Mrs Di Quinzio's higher level of care.

36. The family were consequently devastated when they learned of Mrs Di Quinzio's re-admission to Maroondah Hospital on 7 October 2016, that the sacral pressure injury was no longer able to be actively treated and of her terminal prognosis.

37. The family also expressed concerns about the high staff turnover at Adare SRS and questioned the qualifications of new staff. The family held concerns for other elderly residents in their care.

Adare SRS Response

38. In April 2017, in response to a request for a statement, Ms Chau, (then) Facility Manager of Adare SRS, advised that she updated Mrs Di Quinzio's care plan and increased the level of her care once Mrs Di Quinzio was discharged from hospital.

39. Ms Chau reported that the pressure wound was observed on 14 September 2016 and that they implemented an air mattress and ROHO cushion. I note that I have not been informed of precisely when these pressure area care measures were implemented.

40. Ms Chau stated that Mrs Di Quinzio was regularly seen by her GP, locum doctors and was prescribed antibiotics. She stated that Mrs Di Quinzio was regularly assessed and reviewed by physiotherapists, attended the hospital outpatient clinic for follow up and she received assistance from the RDNS.

41. Ms Chau stated that Adare SRS used a reference, 'Falls Prevention, Risk Assessment and Management – Residential Care' for falls management.

42. In June 2017, the Court wrote to Ms Chau requesting further information in light of the family's letter of concern, a copy of which was provided to Ms Chau at that stage.

43. Ms Chau was asked to provide her response by July 2017. Ms Chau applied for and was granted an extension until early August 2017. The Court did not receive the response by the appointed date and a Court representative contacted Ms Chau *via* telephone on 15 August 2017. Ms Chau apparently explained that she was waiting to receive statements from General Practitioners involved in Mrs Di Quinzio's care. A further extension was granted until late August 2017.

44. Ms Chau provided a second statement dated 28 August 2017. Ms Chau stated that Mrs Di Quinzio was seen by an 'United Physiotherapist' as well as a physiotherapist arranged by Wantirna Health. Ms Chau stated that the suitability of Mrs Di Quinzio's equipment was reviewed by more than one physiotherapist, and that Adare SRS did not receive any report of inadequate equipment from either physiotherapist during her residency at Adare SRS.

45. Ms Chau referred to and provided a page of a guideline in relation to 'management of residents' health condition'. This guideline speaks generally to contacting residents' nominated General Practitioner in the event that they are unwell and states that mobility assessments are performed by physiotherapists. This guideline does not speak to pressure area care management, nor did Ms Chau's statement, despite having been asked to specifically address this issue.

46. A formal request for Mrs Di Quinzio's records held by Adare SRS pursuant to section 42 of the *Coroners Act 2008* was made on 27 September 2017. Adare SRS provided the records in October 2017. Further records were requested pursuant to section 42 of the *Coroners Act 2008* in December 2017.

47. On 28 May 2019, a formal request for statement made pursuant to section 42 of the *Coroners Act 2008* addressed to Ms Chau was served on Adare SRS. This request was returned to the Court on 5 June 2019.

48. A Court representative contacted Adare SRS on 6 June 2019 to determine why the request had been returned. The Court representative was informed that Ms Chau was no longer employed at Adare SRS and that the current Facility Manager was Mr Jerry Zhang (**Mr Zhang**).

49. A formal request for statement made pursuant to section 42 of the *Coroners Act 2008* dated 21 June 2019 was issued to and served on Mr Zhang. This too was returned to the Court and on 27 June 2019, Mr Zhang contacted the Court, explaining that he had assumed his position at Adare SRS in mid-2017. Mr Zhang stated that Ms Chau was the proprietor of Adare SRS at the time of Mrs Di Quinzio's residency and therefore suggested that we issue the formal request to her. Further clarification was sought, and it was determined that the current proprietor of Adare SRS is Mr Jinson Thomas (**Mr Thomas**).

50. A Court representative contacted Mr Thomas who stated that Adare SRS did not currently hold any records in relation to Mrs Di Quinzio. He stated that they had encountered a similar situation recently in relation to another respite care resident who had previous admissions for which no records existed. Mr Thomas explained that contact was made with Ms Chau, who reportedly said that she had taken a number of resident records with her upon her departure from Adare SRS and was storing them securely.

51. I directed that the Coroner's Investigator, Senior Constable Rohan Bull, obtain a formal statement from Mr Thomas in light of the above.

52. Mr Thomas' statement dated 24 June 2019 confirms that on 22 December 2017, he became part-owner of Adare SRS. He confirmed that Adare SRS does not have any records in relation to Mrs Di Quinzio and that it is his belief that Ms Chau would have her records, as "[o]ther staff members have previously contacted Ms Chau in relation to other patient records which we couldn't find and she stated that she had taken them with her". Mr Thomas noted that he had not personally had such conversations with Ms Chau, rather had been informed of them by other Adare SRS staff.

DHHS Investigation of Adare SRS

53. The DHHS is responsible for the registration and regulation of SRS's to ensure that services are provided for the care and wellbeing of residents. The DHHS monitors compliance with and ensures that proprietors are meeting their obligations as set out in the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) (**SRS Act**). The DHHS meets its responsibilities through the provision of guidance and advice to SRS proprietors and the application of appropriate sanctions when the proprietor's behaviour places residents' interests at risk.

54. The DHHS conducted regular monitoring and planned inspections of Adare SRS. Once the DHHS became aware of Mrs Di Quinzio's death, DHHS authorised officers, Vicki Mutiba

and Houa Tia conducted an unscheduled inspection of Adare SRS in April 2017 and reviewed Mrs Di Quinzio's support plans, which were found:

(a) to lack adequate information about wound care; and

(b) to not have been updated upon her return from hospital. The support plan did not reflect that Mrs Di Quinzio required two staff members assisting her for all aspects of mobility. This aspect of her care requirements was also not identified within the progress notes.

55. During the April 2017 visit, the DHHS authorised officers reviewed the support plans of six residents who were immobile and found that four of these residents had sacral pressure sores. It was also determined that staffing levels were insufficient to adequately support the needs of residents in relation to the care of pressure sores. This included noting that a single staff member was rostered for the overnight shift when support plans for two residents specified the need for two hourly position changes requiring the assistance of two staff.

56. On 4 May 2017, during an unscheduled visit to Adare SRS, Ms Vicki Mutiba noted that Mrs Di Quinzio's file contained an on-going support plan, dated 14 September 2016 and it was Ms Mutiba's position that this document had *not* been present on the file during the previous inspection conducted by the DHHS on 28 April 2017. Ms Mutiba also considered that the computer records in relation to Mrs Di Quinzio had apparently been altered on 28 April 2018, following the previous visit. Inconsistency between the notes of the proprietor, Ms Chau, the support plans and notes of the GP were also identified. After being cautioned, Ms Chau reportedly advised that the 'modifications' were done to correct poor language.

57. On 13 May 2017, Ms Austin advised that the DHHS attended Adare SRS and identified certain sections of the SRS Act had been contravened, including inadequate monitoring of residents that require more personal support and inadequate number of appropriately trained staff. Ms Chau was requested to cease all new admissions for seven days and to ensure that staffing levels were increased so that two qualified nurses were always on shift, thereby enabling resident's needs to be adequately met. Ms Chau agreed to these recommendations and entered into three Voluntary Undertakings pursuant to the SRS Act which were deemed to have been complied with on 8 August 2017.

Coroners Prevention Unit

58. To assist me with understanding the complexities of Mrs Di Quinzio's case and my investigation in general, I referred this case to the Coroners Prevention Unit (**CPU**). The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a

healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the autopsy report and any particular concerns which have been raised.

Engagement of Expert Opinion - Professor Joseph Ibrahim

59. As part of my investigation, I obtained an expert opinion from Professor Joseph Ibrahim, Consultant Specialist in Geriatric Medicine. Professor Ibrahim reviewed the statements,[2] the Adare SRS records and Mrs Di Quinzio's medical records.

60. Professor Ibrahim noted that Mrs Di Quinzio's post discharge immediate care requirements following the surgical management of her hip fracture included:

    (a) substantial assistance with mobility, as Mrs Di Quinzio was at that stage described as being 'bed bound'; and

    (b) specific strategies to prevent complication of immobility, including pressure injury.

61. Professor Ibrahim commented that in general terms, the level of care required by Mrs Di Quinzio at this time would exceed the capacity of most SRS's. He further commented that the requirement for 'two persons assist' for bed mobility (i.e. rolling from side to side, moving up and down the bed) is concerning and often a challenge to provide in aged care accommodation, particularly overnight.

62. Issues identified by Professor Ibrahim included:

    (a) the level of surveillance of Mrs Di Quinzio's skin integrity conducted by Adare SRS Staff on the days prior to the sacral pressure area being noticed – in particular, whether staff inspect her sacral area during bathing and general hygiene care;

    (b) once noticed, how the sacral pressure wound was monitored to ensure that it was healing, and failing that, the process for escalation of care; and

    (c) Adare SRS staff adherence to the instructions provided by relevant practitioners for pressure relief.

[2] Aside from Ms Chau's statement dated 20 December 2019, Mr Thomas' statement dated 24 June 2019 and various statements provided by Eastern Health staff which were not in existence at the time of Professor Ibrahim's engagement.

Adare SRS records

63. Professor Ibrahim noted that information about the care provided to Mrs Di Quinzio between 13 and 17 September 2016 lacked sufficient detail and that he was consequently unable to determine when the pressure injury was detected. Further, he was unable to ascertain from the records whether strategies for the prevention of pressure injuries were implemented at Adare SRS, including whether additional staff were required.

64. Professor Ibrahim stated that between 19 September and 5 October 2016, the pressure injury continued to deteriorate, despite the initiation of wound dressings, the administration of antibiotics and repeated instructions for pressure relief to the sacral area. Multiple health professionals attended Mrs Di Quinzio, including locum GPs and her regular GP, Dr Ahmed. Adare SRS staff also recognised the pressure injury was deteriorating and made a referral to the RDNS.

Diagnosis of pressure injury

65. Professor Ibrahim reported that a pressure injury is the formal term to describe a bed sore, pressure sore, pressure ulcer or a decubitus ulcer. A pressure injury occurs if there is unrelieved pressure, shear forces or friction which separately and in combination damage the skin and underlying tissues. This mechanism interrupts the tissue's blood supply which causes the tissue to die.

66. According to Professor Ibrahim, Mrs Di Quinzio was at risk of developing a pressure injury due to her age, dementia, comorbidities, incontinence and long periods of immobility which occurred secondary to her fall and fractured femur. Professor Ibrahim explained that pressure injuries are well within the scope of knowledge and practice of hospitals and SRS facilities. He noted that the best way to substantially reduce the likelihood of pressure injury is to employ devices such as an air mattress for periods of bedrest and a ROHO cushion for periods of sitting, as well as regularly monitoring skin integrity.

67. According to Professor Ibrahim, due to a lack of robust empirical evidence, it is difficult to determine the time it takes for a pressure injury to develop; however evidence reveals that a pressure injury can develop within hours to days, highlighting the need for continued vigilance as for each day that a person is immobile, the risk for pressure injury is present.

68. Professor Ibrahim noted that the evidence gathered in the coronial investigation about when Mrs Di Quinzio's pressure injury developed presented apparently contradictory information. Professor Ibrahim stated that the documentation does not support that Mrs Di Quinzio had a

pressure injury before 12 September 2016. The hospital discharge summary, physiotherapy and nursing notes made no mention of a pressure injury. The first reference to a pressure injury was documented in the progress notes of Adare SRS on 14 September 2016. However, he noted that due to the evidence of Ms Mutiba, the veracity of the progress notes is questionable, due to them possibly having been altered after Ms Di Quinzio's death.

69. Professor Ibrahim noted the feasibility that Mrs Di Quinzio had sustained damage to underlying tissue that occurred during the last one to two days of her hospitalisation that became apparent when she returned to Adare SRS.

70. However, since Dr Kazemi-Manshady was the first clinician to document the pressure injury on 18 September 2016, Professor Ibrahim concluded that the pressure injury was likely to have been evident around 16 September 2016, although he could not rule out that the pressure injury may have occurred earlier than this.

Severity of pressure injury

71. Professor Ibrahim reported the severity of the pressure injury may be indicative of a substantial initial trauma, significant clinical impairment, gaps in health care or neglect. He said that a pressure injury is classified according to the damage to the body and is divided into four categories (Stage I being the least severe and Stave IV being the most severe).

72. On 18 September 2016, the pressure was reported to be a Stage II injury, which then rapidly progressed over two weeks to a Stage IV – unstageable injury, which was noted by the RDNS on 6 October 2016.

73. Professor Ibrahim did not consider that there was evidence of malicious or deliberate neglect or abuse, primarily based on the number of times clinicians and specialist services were called to review Mrs Di Quinzio. However, he noted that there was evidence of gaps in care which meant that under different circumstances, Mrs Di Quinzio's premature death, may have been avoided.

Risk factors associated with pressure injuries

74. Professor Ibrahim advised there are intrinsic and extrinsic factors that can determine whether or not someone may develop a pressure injury. He stated "[d]etermining whether there were deficits in the quality of care requires consideration of the foreseeability and initiatives available to reduce the risk of a pressure injury occurring". According to Professor Ibrahim, Mrs Di Quinzio had a number of individual risk factors, including her age, immobility,

dementia, presence of other chronic diseases and incontinence. Extrinsic factors relevant to Mrs Di Quinzio included the provision and quality of care and equipment.

75. Upon her 12 September 2016 discharge from Maroondah Hospital, Mrs Di Quinzio was completely bed bound, requiring two people assisting her for bed mobility. The discharge summary stated that a hoist was to be used to assist her with bed to chair (and chair to bed) transfers. Ms Chau's evidence was that an air mattress and ROHO cushion were put into place by Adare SRS. The timing of the implementation of these strategies is unclear from the material before me. Further, there is evidence that Adare SRS did not have access to a hoist suitable for Mrs Di Quinzio's size, so how often and how safely she came to be transferred to the recliner chair is also unclear.

76. Professor Ibrahim was unable to comment on the level and skill set of the staff at Adare SRS from the information provided. However, in general terms, it was his opinion that the level of care required by Mrs Di Quinzio would have exceeded the capacity of most supported residential services.

Was Mrs Di Quinzio in the appropriate place to receive the care she required?

77. Accommodation in residential settings are classified into residential aged care and supported residential services. The funding models, governance and service delivery vary in each setting and are not interchangeable. Professor Ibrahim said that the differences in accommodation are profound and that most health professionals do not appreciate the distinctions.

78. Professor Ibrahim commented that failure to recognise that a patient's needs exceed the service's scope of practice or recognition and failure to escalate care are important considerations when a premature death occurs.

79. Professor Ibrahim noted that it was important to understand the standards pertaining to residents returning to a facility following a hospital admission and, the assessment, prevention and management of residents with pressure injuries.

80. Professor Ibrahim provided the following opinions in relation to Mrs Di Quinzio's care:

    (a) Adare SRS appeared to be an appropriate facility for accommodating Mrs Di Quinzio's care needs based on the available documentation prior to the September 2016 fall leading to the fracture;

    (b) transfer to Maroondah Hospital was appropriate to manage a person who had fallen and sustained a hip fracture;

(c) the discharge planning by Maroondah Hospital was consistent with usual practice. This does not mean that a patient does not have ongoing complex care needs. Professor Ibrahim noted that the hospital records note "Plan D/C to NH today"- however, this does not indicate that hospital staff were aware of the difference between Adare SRS and a NH (nursing home) which provides a significantly higher level of residential aged care. The family raised an issue about whether the facility could meet the high care needs of Mrs Di Quinzio following the September 2016 fall, an issue which arguably would have been the responsibility of the hospital staff. However, Professor Ibrahim stated that there was insufficient documentation to draw a conclusion about the appropriateness of the discharge to Adare SRS. Professor Ibrahim said that there were several other options available to the hospital such as continued inpatient stay, transfer to a subacute service which would have provided ongoing geriatric medicine care and/or slow stream rehabilitation or transfer to a bed-based Transition Care Program; and

(d) that the needs of Mrs Di Quinzio upon discharge from Maroondah Hospital were at a high level. Mrs Di Quinzio's family states that Ms Chau reassured them that the facility could manage her post-operative care. However, despite this, Professor Ibrahim considers that high level care is not usually delivered by a SRS. He noted that that it is possible, as a short-term measure, to meet the needs of a resident with additional support resources and that this need appears to have been considered. He further notes that there is insufficient documentation to draw a conclusion if the relevant plans were implemented.

81. When looking at the ability of Adare SRS to meet Mrs Di Quinzio's needs once the pressure injury was established and not healing, Professor Ibrahim commented on the medical, nursing, allied health and executive and management care provided to Mrs Di Quinzio.

Medical care

82. Several medical practitioners were involved in the assessment and management of Mrs Di Quinzio following her discharge from Maroondah Hospital. According to Professor Ibrahim, this appears to have created discontinuity in her care and perhaps a lack of appreciation of the deterioration in her condition. Professor Ibrahim said that the subsequent deterioration of Mrs Di Quinzio should have prompted consideration of transfer back to a hospital for assessment. However, Professor Ibrahim acknowledged that "this is more difficult than it sounds as the resource constraints under which most acute care hospitals operate would have probably led to an argument that [Mrs Di Quinzio] should continue to remain at Adare SRS as

the clinical care required is pressure relief and wound care." Such situations also need to be balanced with the concept that an older person should stay in their own environment, as transfer to acute care brings additional risks of harm.

Nursing

83. Escalation of care from nurses to the GPs occurred on several occasions and the care provided appeared to be in line with the medical practitioner's advice. There was a two-day gap between referral and the RDNS attending which Professor Ibrahim commented was a little slower than desirable. Professor Ibrahim acknowledged that the provision of care may have been affected by a Victorian public holiday which fell on Friday, 30 September 2016, during Mrs Di Quinzio's deterioration.

84. Professor Ibrahim said it is not possible to determine whether the pressure injury deteriorated because of failure to implement strategies or because of other factors.

Allied health

85. Professor Ibrahim acknowledged that Mrs Di Quinzio had access to a physiotherapist, however considered that an occupational therapist may have been best equipped to provide advice on pressure relief. He also suggested that a dietitian may have been helpful to improve Mrs Di Quinzio's nutritional status, which he noted is crucial to wound healing.

Executive and management

86. Professor Ibrahim commented that the risks of pressure injuries are well established in the aged and health care setting, and that they can be mitigated with proper governance. Professor Ibrahim noted that Adare SRS's operations are under the guidance of the DHHS and as such, he would expect that they be aware of the available education, training and standards of care required based on existing resources. As such, I consider that the responsibility of instituting relevant policies, procedures and resources to manage residents (and corresponding staff training) lies with management and executive.

87. Professor Ibrahim stated that he would expect Adare SRS to be well prepared for screening, preventing and managing pressure injuries. It is of note in this respect that when Ms Chau was specifically asked to identify any policies, procedures or guidelines relevant to pressure area management, she provided in response only a general guideline regarding escalation of care which did not address pressure area identification, care or management.

Other issues

88. There is evidence that the records of Adare SRS may have contained falsified documents, which creates uncertainty surrounding certain parts of the information contained as part of the coronial investigation and whether (or to what extent) it can be relied upon.

89. In respect to pressure injuries, Professor Ibrahim noted that:

> *[p]ressure injury is a common problem in aged and health care system and causes death and disability. Mechanisms exist for the prevention of this injury and requires comprehensive approaches to screening and management. It continues to occur because of broad system issues around coordination of care, lack of awareness of best practice, poor education and training and lack of prompt access to resources. The causes of pressure injury are well described as are the prevention strategies. The gap is implementation.*

90. He further noted that "[Mrs Di Quinzio's] pressure injury was a preventable complication and caused her premature death." He further commented that "[t]here is not a single causative factor, rather multiple contributing factors and questions remain about the quality of care provided at Adare SRS".

Further Statements Obtained Following Professor Ibrahim's Expert Opinion

Acute medical and allied health care

91. Statements were obtained from relevant Maroondah Hospital medical and allied health departments following the receipt of Professor Ibrahim's report.

Orthopaedics

92. Maroondah Hospital Orthopaedic Registrar, Dr Pamela Boekel, provided a statement dated 30 May 2019. Dr Boekel had not provided care to Mrs Di Quinzio and provided her statement based on having reviewed Mrs Di Quinzio's medical records.

93. Dr Boekel stated that it appears that the Orthopaedic team were under the impression that Mrs Di Quinzio normally resided in a high-care facility (**HLRC**), which was recorded on her 8 September 2016 initial nursing assessment upon admission.

94. Dr Boekel stated that nursing staff checked with Adare SRS on the third postoperative day to arrange for Mrs Di Quinzio to be transferred back to Adare SRS and to determine if an appropriate level of care would be provided. The nurse in charge documented that she informed Mrs Di Quinzio's family of the transfer.

95. Dr Boekel stated that Mrs Di Quinzio was reviewed by a Post-Acute Care physiotherapist at Adare SRS on 19 September 2016 and that there were no documented apparent concerns regarding the level of care that she was receiving.

96. When Mrs Di Quinzio was reviewed in Orthopaedics outpatients on 23 September 2016, it was documented that she was from a '*NHome*' (nursing home), again indicative of the Orthopaedic team's impression that Mrs Di Quinzio was residing in a high-level care facility.

97. Dr Boekel noted that Mrs Di Quinzio was not initially offered inpatient rehabilitation as she was not permitted to weight bear through her left wrist, which often limits rehabilitation goals.

98. Dr Boekel stated that based on Mrs Di Quinzio's medical records, it does not appear that her family were concerned about her discharge back to Adare SRS, or that Adare would not be able to properly care for her.

99. Dr Boekel stated that Adare SRS informed the Orthopaedic clinicians that they were able to provide high-level care to Mrs Di Quinzio, and the Orthopaedic team were consequently under the impression that this is what she was receiving.

100. Dr Boekel stated that there were no concerns documented by the Orthopaedic team, nursing or allied health teams during Mrs Di Quinzio's admission regarding Mrs Di Quinzio's safe discharge from the Orthopaedics team that would have warranted a social work referral.

General Medicine

101. General Medicine Consultant Physician, Dr Uma Parameswaran, provided a statement dated 21 June 2019. Dr Parameswaran noted a nursing entry dated 8 September 2016 documenting a small skin tear to the right shin and calf area, but otherwise observing good skin integrity when Mrs Di Quinzio was rolled to perform pressure area care. The nursing entry on the day of Mrs Di Quinzio's discharge from hospital documented that a dressing was in place over her left hip and that a plaster cast over her left forearm with no other skin issues noted. She notes that the Skin Inspection and Pressure Injury Risk Assessment Form did not indicate the presence of a pressure injury.

Physiotherapy

102. Eastern Health Director of Physiotherapy, Ms Kimberley Williams, provided a statement dated 17 June 2019.

103. Ms Williams stated that Mrs Di Quinzio was "identified incorrectly as from Residential Aged Care rather than SRS on EH Initial Patient Assessment Acute..., a nursing document at

Maroondah". She commented that the transfer document from Adare SRS contained in Mrs Di Quinzio's notes indicates that her home facility was an SRS providing a low level of care.

104. Ms Williams noted that Mrs Di Quinzio required the use of a hoist to transfer out of bed. On 12 September 2016, a physiotherapist completed her discharge summary. Ms Williams stated that the usual practice would be that this summary would be printed and provided to the discharge destination facility. Ms Williams noted a 12 September 2016 nursing note that indicated that Adare SRS was contacted and were happy to accept Mrs Di Quinzio back into their care. The treating physiotherapist subsequently completed a further discharge summary on 15 September 2016, with a recommendation:

> *Understanding patient was returning to HLRC (High Level Residential Care) however was in fact returning to SRS providing high care needs. No physiotherapy provided within facility.*
>
> *For PAC (Post Acute Care) PT (Physiotherapy) to Ax (assess) patient in SRS and Ax scope for progression of mobility as able. Possible progression to CRP (Community Rehabilitation Program) if scope for participation and progress.*
>
> *Goals: Step transfer SOOB (sit out of bed), ambulant ?when able to WB (weight bear) left Wrist.*

105. Ms Williams noted that the hospital physiotherapist referred Mrs Di Quinzio to Post-Acute Care (**PAC**) for PAC-funded physiotherapy to determine Mrs Di Quinzio's ongoing need for physiotherapy involvement and suitability for a Community Rehabilitation Program (**CRP**) once she was able to attempt mobilising. The PAC referral noted that Mrs Di Quinzio had a "moderate skin integrity risk". Mrs Di Quinzio required hoist transfers and two people assisting her with all aspects of mobility. PAC accepted the referral for four physiotherapy visits, one per week, to assist with slow stream progress and ensure access to CRP if clinically indicated.

106. Ms Williams referred to a documented telephone conversation that occurred on 15 September 2016 between a physiotherapist and an Adare SRS staff member during which the PAC and CRP process were explained. The staff member reportedly stated that Mrs Di Quinzio was experiencing increased pain and was currently remaining in bed for all personal care. It is documented that Adare SRS staff were *not* using a hoist for transfers. A GP was scheduled to review her in the coming days.

107. Ms Williams observed that the Maroondah PAC notes indicate that on 20 September 2016, an extensive telephone phone discussion between a senior physiotherapist and the visiting PAC

physiotherapist occurred regarding Mrs Di Quinzio's current care needs and options regarding in-patient rehabilitation and other like programs.

108. Ms Williams noted that on 29 September 2016, the PAC physiotherapist visited Mrs Di Quinzio for a second time. Adare SRS staff reportedly informed the physiotherapist that Mrs Di Quinzio was able to perform sit to stand transfers with maximal assistance from two people and a four-wheeled walking frame. The physiotherapy assessment notes that there was a standing hoist at Adare SRS however that the particular hoist for too big for Mrs Di Quinzio, as she tended to slip down in the hoist. Adare SRS staff reportedly explained that this was the smallest hoist available to them.

109. The PAC physiotherapist attempted to assist Mrs Di Quinzio from sit to stand with two people maximally assisting but was unable to perform this manoeuvre. The PAC physiotherapist reportedly liaised with the facility manager (Ms Chau) regarding whether Mrs Di Quinzio was a candidate for inpatient rehabilitation. Ms Chau reportedly informed the physiotherapist that Adare SRS could provide physiotherapy twice per week but also reportedly indicated other times that staff would not be able to assist Mrs Di Quinzio with her exercise program. The PAC physiotherapist records that she requested Ms Chau liaise with Mrs Di Quinzio's family to pass the physiotherapist's contact details to them for the purpose of a discussion. Mrs Di Quinzio had been transferred back to Maroondah Hospital by the time the PAC physiotherapist next visited.

Occupational Therapy

110. Eastern Health Clinical Lead Occupational Therapist, Ms Rebecca Nicks, provided a statement dated 18 June 2019. Ms Nicks noted an occupational therapy entry recorded in Mrs Di Quinzio's hospital progress notes on 10 September 2016 in response to the receipt of a blanket occupational therapy referral. The entry noted that Mrs Di Quinzio had been admitted from a high-level care facility and required full assistance with activities of daily living. An occupational therapist reviewed Mrs Di Quinzio's file and determined that occupational therapy intervention was not indicated.

Dietetics

111. Eastern Health Director of Dietetics, Ms Erin Brennan, provided a statement dated 17 June 2019. Ms Brennan noted that in accordance with Eastern Health clinical practice guidelines, Mrs Di Quinzio was subject to a Malnutrition Screening Tool (**MST**) upon her 8-12 September 2016 admission. Although Ms Brennan noted that Mrs Di Quinzio's MST score was sufficient to indicate that a dietetic referral was required, no such referral was

documented or received during this admission. A referral was received in relation to Mrs Di Quinzio upon her 6 October 2016 admission, when her MST score was 2 (which I note was the same score as upon her 8 September 2016 admission). A dietetic assessment documented on 7 October led to a diagnosis of severe malnutrition related to increased requirements, pressure ulcers, infection and fractures as evidenced by severe subcutaneous fat loss and muscle wasting.

Ms Chau's further response

112. On 29 October 2019, a formal request for statement made pursuant to section 42 of the *Coroners Act 2008* was issued to and served on Ms Chau, requesting that she provide a statement within 21 days of receipt of the request.

113. In early November 2019, Ms Chau requested and was granted an extension until 22 December 2019 to comply with the Form 4 request for statement.

114. Ms Chau provided a statement dated 20 December 2019 which addressed the following matters:

    (a) On 25 May 2015, Adare SRS was purchased by a Supreme Care Company Pty Ltd for which she acted as sole director;

    (b) Adare SRS was sold by Supreme Care Company Pty Ltd on 21 December 2017;

    (c) Ms Chau acted as Facility Manager from 25 May 2015 until 21 December 2017. As such, she was responsible for the daily operation of Adare SRS (aside from nursing and clinical decisions), marketing and client relationships;

    (d) Ms Chau's qualifications are a Bachelor of Commerce and a master's degree in health information management. She does not hold nursing qualifications;

    (e) Ms Chau was required to complete a written test and oral interview prior to the DHHS granting her approval to purchase Adare SRS;

    (f) the names and qualifications were provided for Adare SRS staff who worked with Mrs Di Quinzio between 12 September to 3 October 2016 (although the list did not indicate who worked on which days/shifts). I note that qualifications of the Adare SRS staff listed were:

        i. three Registered Nurses (Div 1);

        ii. one Registered Nurse;

        iii. two Enrolled Nurses (Div 2);

iv. one Enrolled Nurse;

v. one staff member with a Bachelor of Science in International Nursing;

vi. three nursing students;

vii. two staff holding a Certificate IV in Aged Care;

viii. six staff holding a Certificate III in Aged Care;

ix. one staff holding a Certificate II in Aged Care; and

x. two staff holding a Certificate III in Disability Work;

(g) on 13 September 2016, the night shift staff level was increased from one 'upstanding' staff and one 'sleepover' to one 'upstanding' staff (either enrolled nurse or patient care assistant (**PCA**)) and one sleepover staff (PCA) and Ms Chau as a backup sleepover staff for any emergency. I note that there remained a possibility of two PCAs being rostered overnight;

(h) during the day, a nursing staff member or PCA '*checked on [Mrs Di Quinzio] every 2 hours and assisted her for meal intake and drinking*'. I note that the expression 'checked on her' does not clarify what such checks entailed and whether this included pressure area care/monitoring (for example, 2 hourly repositioning);

(i) during Ms Di Quinzio's residency at Adare SRS, there were approximately 28 residents, with the majority of residents requiring low-level residential care.

(j) Ms Chau therefore identified the staffing ratio:

i. **7.00am-2.00pm:** nine staff (including one manager, one nurse/coordinator, three PCAs, one cleaner, one cook, one general duty/laundry worker and one handy man);

ii. **2.00pm-5.00pm:** six staff (including one manager, one nurse/coordinator, two PCAs, one cook and one handy man);

iii. **5.00pm-10.00pm:** four staff (including one manager, one nurse/coordinator and two PCAs); and

iv. **10.00pm-7.00am:** three staff (including one upstanding nurse/PCA, one sleepover PCA and one staff sleepover for emergencies).

(k) Ms Chau stated that during this time and according to the occupancy rate, the staff to resident ratio complied with section 64 of the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) and relevant Regulations.

(l) Mrs Di Quinzio was discharged from Maroondah Hospital on 12 September 2016 without medication and/or a discharge summary, which Adare SRS staff had to chase;

(m) the sacral wound was identified on 14 September 2016. Mrs Di Quinzio's GP was informed, and a locum GP was called to see her. Mrs Di Quinzio was reviewed by a locum GP on 18 September 2016. I note that Ms Chau's statement is silent on what pressure area management measures were put in place from 14 to 18 September 2016;

(n) Mrs Di Quinzio's ongoing support plan was updated on 14 September 2016 once the paperwork was received from Maroondah Hospital. It stated 'regular repositioning every two hours'. Ms Chau states that '*[r]epositioning was conducted by staff in her room on her 'high low bed' and transfer from bed to recliner chair. She was seen by a doctor on 14 and 18 September'*. I note that the progress notes indicate that Mrs Di Quinzio was reviewed by Dr Adeli on 15 September 2016 and that Dr Adeli states that Adare SRS staff did not draw his attention to a sacral pressure injury. I also note that Ms Chau does not point to documentation that demonstrates that such repositioning occurred, nor does she describe how Mrs Di Quinzio was transferred (in light of the physiotherapist noting that the hoist sling was not appropriate to be used for her transfers);

(o) Mrs Di Quinzio was seen by RDNS on 6 October 2016, who advised that she should be transferred to hospital to treat her sacral wound and bilateral heel pressure areas. Ms Chau states that Adare SRS staff called '000' straight away and that Mrs Di Quinzio was sent to hospital;

(p) both physiotherapists who reviewed Mrs Di Quinzio on 19, 20, 26 and 27 September 2016 recommended regular position changes and the use of equipment such as an air mattress and ROHO cushion. Ms Chau states that '*they were implemented accordingly*'. Ms Chau, although specifically asked, does not identify when these measures were implemented or any associated documentation in support. I note that Ms Chau later states that the air mattress and ROHO cushion '*were arranged immediately*' however I cannot identify what 'arranged' means in this context. I am unable to identify when an air mattress or ROHO cushion were placed and used in Mrs Di Quinzio's room and care;

(q) Ms Chau stated that two staff were allocated to assist Mrs Di Quinzio with her transfers, general hygiene and toileting every two hours;

(r) Adare SRS staff inspected Mrs Di Quinzio's wound during bathing and general hygiene care for continence management. Ms Chau refers to the 'Bowel Chart' form 1 to 31 September 2016 and the 'Toileting chart + Pressure area care' chart (**Toileting chart**)

from 19 September to 6 October 2016. I note that the Bowel chart has nothing documented on 14 September, 21 September and 23 to 31 September 2016. The Toileting chart has no documentation on 19, 20 and 28 September 2016 and there are regularly periods of five to twelve hours over which there is no documentation, which is significant as this chart relates to pressure area care. Of particular note, there is no documentation for over 50 hours from 27 to 29 September 2016 on the Toileting chart. On the days leading up to Mrs Di Quinzio's 6 October 2016 transfer back to hospital (from 3 to 6 October 2016), there are Toileting chart entries at 2.00am and 5.00am only (aside from one entry at 11.00pm on 3 October 2016). I do not consider that the documentation provided by Ms Chau seemingly in support of her statement that two staff were allocated to assist Mrs Di Quinzio with transfers, general hygiene and toileting every two hours is in any way substantiated by these documents;

(s) Ms Chau appears to attempt to address this lack of documentation by stating that '*[t]he chart was originally located in the medication room which was far away from Mrs Di Quinzio's room that staff did forget to do documentation after toileting and repositioning*';

(t) Ms Chau stated that there were changes to wound care following Mrs Di Quinzio's 'incident', including:

i. once any wound was identified on any resident, Adare SRS would refer such residents to the RDNS for wound care 'straight away' rather than relying on a referral letter from a GP/locum. Ms Chau states that this '*could prevent any delay in management of wound care*';

ii. a file of 'every two hours repositioning' documentation was placed in resident's room together with the RDNS wound care file rather than the medication room (which was located near the main entrance). Ms Chau states that this strategy '*could prevent missing documentation. In another word, it could improve accuracy and quality of documentation*'; and

iii. Adare SRS staff would inform the DHHS on a monthly basis about the number of residents requiring wound care and repositioning. Ms Chau states that the DHHS also conducted unscheduled visits to review the Adare SRS documentation related to 'wound care and repositioning'

(u) Mrs Di Quinzio's pressure injury was reviewed by doctors on 18, 24 and 16 September and 1 and 5 October 2016. Adare SRS staff followed the doctors' instructions to order medications and different dressing types;

(v) following Mrs Di Quinzio's discharge from Maroondah Hospital, Adare SRS staff followed the guidelines of 'Standard 8' of 'Policy and Procedure' entitled 'Health and Wellbeing' in that her GP, locum physicians and physiotherapists were arranged to review her medical condition. Ms Chau stated that Adare SRS staff:

> *have demonstrated to seek for doctors' advice to support her increased care needs. According to doctors' instruction, antibiotics was prescribed and different types of dressings were applied. However RDNS was not referred to by GP until later stage.*

I note that this 'Policy and Procedure' referred to by Ms Chau is a one-page document with headings:

i. *Information*;

ii. *Assisting with appointments*;

iii. *Transport to appointments*; and

iv. *Management of residents' Health Condition*, under which states:

> *When the residents are unwell, their nominated GP will be contacted and arranged to see them. Nurses and staff will follow clinical decision in management of medical conditions instructed by GP.*
>
> *If the residents are required to see specialist, Allied Health or wound management by RDNS, it'll be referred by GP. Nurses will arrange the appointment, transport and follow up with GP.*
>
> *Mobility assessment will be done by Physiotherapy.*
>
> *Podiatry Services will be scheduled by nominated Podiatrist.*

This appears to be the only Adare SRS policy/procedure/training document provided that mentions wound management. I have come to this conclusion as I have specifically asked for any such document and have only been provided with this in response. This document cannot be described as comprehensive documentation relating to the prevention, identification, monitoring and/or management of pressure injuries. As I have specifically asked for such Adare SRS documentation, and have

not been provided with anything beyond this document, I can infer that no such Adare SRS policy/procedure/training document existed;

(w) in relation to documentation, Ms Chau stated:

> *According to our record, there was an ongoing support plan dated 14 Sept 2016 after we received paperwork from Maroondah hospital. On 12 September, there was no discharge summary and medication sent with her to Adare SRS. After we chased up the discharge summary, we received paperwork on 14 September 2016 and therefore it was updated on that day.*
>
> *In year 2016, documentation of deceased residents would usually be removed from the medication room (downstairs of Adare SRS) to filing room situated upstairs of Adare SRS. Usually staff put documentation together before relocating to filing room upstairs, however sometimes some documents or 'loose sheet's would be found in medication room after relocation of the file. When a representative of [t]he DHHS attended Adare SRS and requested to get her documentation for review, staff or myself tried our best to provide the documentation located in filing room for them.*
>
> *In year 2016, documentation of Adare residents was filed in different files in medication room. Since Mrs Di Quinzio's passing, staff and myself have tried to gather her documents from her main file and other files together before relocating to filing room upstairs. However, some of her documents and 'loose sheets' were found in medication room during the period of time 28th April to 4th May 2016, while majority of documents have been relocated to filing room prior [to] 28th April 2016.*

(x) Ms Chau consequently stated, '*I agree the documentation of Mrs Di Quinzio's progress notes was insufficient. I do agree there is lots of room for improvement of the quality of documentation in SRS industry*'.

(y) Ms Chau stated that:

> *The management of Mrs Di Quinzio at Adare SRS was relied on advice from various doctors including her GP and a few locum. According to our record, there was no instruction given by those doctors to send her to hospital any earlier than 6th October 2016. During my management at Adare SRS, clinical decision was relied on clinicians/doctors.*

(z) In response to whether Ms Chau considered that Mrs Di Quinzio's death could have been prevented, Ms Chau stated:

> *Since Mrs Di Quinzio discharged from hospital, she had been managed by a few different doctors. As they were the clinicians managing her medical condition, I believe they would be appropriate persons to answer this question.*

(aa) In response to whether Ms Chau considered that the care and management provided to Mrs Di Quinzio was reasonable and appropriate, Ms Chau stated:

> *According to the policy and procedure of Adare SRS, the staff and myself did follow the requirement on Standard 8... Since Mrs Di Quinzio discharged from hospital, she had been managed by her chosen GP and her wound care was reviewed by her GP and also a few different doctors. Besides, her mobility had be[en] accessed by 2 Physiotherapists, and reviewed by them. Unfortunately none of the clinicians told us the level of her medical care was not adequate at Adare SRS, or not appropriate. Otherwise, we would transfer her to any suitable facility for management.*

Further Considerations

Australian Commission on Safety and Quality in Health Care publications

i. National Safety and Quality Health Service – Standard 8

115. The National Safety and Quality Health Service (**NSQHS**) Standard 8: Preventing and Managing Pressure Injuries (2014) (**Standard 8**), developed by the Australian Commission on Safety and Quality in Health Care (**ACSQHC**), sets out criteria to achieve Standard 8. It is part of a raft of 10 Standards developed to reduce the risk of patient harm and to improve the quality of health service provision in Australia. The Standards focus on governance, consumer involvement and clinically related areas to provide a nationally consistent statement of the level of care consumers should be able to expect from health services.

116. The aim of Standard 8 is to prevent patients from developing pressure injuries and effectively manage them should they occur. It cites the *Pan Pacific Clinical Practice Guidelines for Prevention and Management of Pressure Injury* (AWMA, 2012) which outlines the key messages in pressure injury prevention as follows:

    (a) most pressure injuries can be prevented;

    (b) they can occur in any patient, whether that patient has only some of all risk factors;

    (c) best practice in pressure injury prevention includes:

        i. vigilant screening;

        ii. comprehensive assessment;

        iii. implementing pressure injury prevention strategies;

        iv. evaluating the effectiveness of pressure injury prevention strategies; and

        v. engaging patients in their own pressure injury prevention program.

117. Standard 8 states that assessment should occur on admission or when a pressure injury is noted. Ongoing assessment should occur at least weekly, with each dressing change or if there is a change in healing status. Ongoing assessment should include noting the:

(a) location, size and depth of pressure injury;

(b) appearance of wound bed;

(c) condition of wound edges and surrounding skin;

(d) odour, amount and type of exudate; and

(e) level of pain and discomfort.

118. With reference to the management of pressure injuries, Standard 8 refers to patients with pressure injuries being at high risk of developing further pressure injuries and accordingly it is imperative that prevention strategies be implemented, including:

(a) skin protection including minimising exposure to moisture, friction and shear;

(b) optimising nutrition and hydration to assist with wound healing;

(c) provision of support surfaces to assist in reducing and relieving pressure; and

(d) regular patient repositioning.

119. Standard 8 identifies that a pressure injury assessment and management plan must be documented in the clinical record and comprise detailed information regarding:

(a) the type of wound;

(b) the site of wound;

(c) treatment goals;

(d) daily assessment plan; and

(e) evaluation plan.

ii. Selected best practices and suggestions for improvement for clinicians and health system managers, Hospital-Acquired Complication 1 – Pressure Injury'

120. The ACSQH's publication 'Selected best practices and suggestions for improvement for clinicians and health system managers, Hospital-Acquired Complication 1 – Pressure Injury' (March 2018) notes that best practice for pressure injury prevention includes:

(a) that the health service organisation providing services to patients at risk of pressure injuries have systems for pressure injury prevention and wound management that are consistent with best-practice guidelines; and

(b) ensuring that equipment and devices are available to decrease the risk and effectively manage pressure injuries.

Royal Commission into Aged Care Quality and Safety

121. The Royal Commission into Aged Care Quality and Safety (**Commission**) was established on 8 October 2018 by the Governor-General of the Commonwealth of Australia, His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd).

122. The Letters Patent for the Royal Commission, which formally appoint the Royal Commissioners, also outline the Commission's terms of reference.

123. The Commission delivered an interim report on 31 October 2019 and are required to provide a final report by 12 November 2020.

124. To date, the Commission has received 7,747 submissions.[3] In the Commissions' Interim Report 'Neglect', the Commission notes:

> *We have been told about people who have walked into an aged care residence, frail but in relatively good spirits and mentally alert, only to die a few months after suffering from falls, serious pressure injuries and significant pain and distress...*[4]

125. The Commission further notes:

> *A little over 1000 providers responded to our Service Provider Survey. They self-reported 274,409 instances of substandard care over the five year period to June 2018, including almost 112,000 occasions of substandard clinical care and close to 69,000 occasions 2 of substandard medication management. They also reported 79,062 complaints about substandard care. Of these complaints, 15,700 were about personal care, 8800 were about compromises to an older person's dignity, and 7500 were about a lack of choice and control for the people receiving aged care services.*
>
> *Expert evidence on clinical and personal care has also contributed to our understanding of the extent of substandard care:*
>
> > *the Dietitians Association of Australia use current research to estimate that 22-50% of people in residential aged care are malnourished...*
> > *recent Australian research reveals that pressure injuries occur in a third of the most frail aged care residents at the end of their lives...*[5]

126. The Commission heard from a number of experts specifically in relation to pressure injuries, who emphasised that implementation of preventative measures is a key to wound management, and preferable to reactive treatment of pressure injuries.[6]

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[3] https://agedcare.royalcommission.gov.au/Pages/default.aspx access 24 January 2020.
[4] *Royal Commission into Aged Care Quality and Safety* (Interim Report 'Neglect', October 2019) Volume 1, pages 4-5.
[5] *Royal Commission into Aged Care Quality and Safety* (Interim Report 'Neglect', October 2019) Volume 1, pages 6-7.
[6] Transcript, Catherine Sharp, Darwin and Cairns Hearing, 11 July 2019 at T3301.01-47; Transcript, Hayley Ryan, Darwin and Cairns Hearing, 11 July 2019 at T3330.09-15; Transcript, Geoffrey Sussman, Darwin and Cairns Hearing, 11 July 2019 at T3330.17-37 as cited in *Royal Commission into Aged Care Quality and Safety* (Interim Report 'Neglect', October 2019) Volume 2, pages 258-260.

COMMENTS

127. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

128. According to the findings of the DHHS authorised officers, Mrs Di Quinzio's support plans were inadequate and not updated following her 12 September 2016 return from hospital. In April 2017, the DHHS authorised officers documented that they counselled Ms Chau about the need to update on-going support plans, expressed concerns about the level of care provided and advised Ms Chau of the need to consider moving residents to another care facility where an assessment suggested that their needs could not be met.

129. Based on the available information, I am unable to assess to a level of comfortable satisfaction:

    (a) the number and skills of staff rostered to work on any given shift during the period when Mrs Di Quinzio required high care;

    (b) the policies, procedures and/or guidelines (and relevant training) employed by Adare SRS in relation to pressure area monitoring and management at the time of Mrs Di Quinzio's residency or since; and

    (c) the precise elements of care that were actually delivered to Mrs Di Quinzio by Adare SRS upon her 12 September 2016 discharge from hospital and the timing of any such care delivery. This uncertainty is created by a lack of comprehensive documentation, a possible lack of reliable documentation and an apparent lack of comprehensive specificity in the statements provided by Ms Chau.

130. With reference to the 'Health and Wellbeing, Standard 8: choice of access to health care providers' document provided by Ms Chau, it is unclear why this 'policy' requires RDNS referrals to be completed by General Practitioners when RDNS holds no such requirement currently or at the time of Mrs Di Quinzio's residency.[7]

131. I note in respect of Adare SRS's capacity to care for residents that in DHHS' April 2017 visit, when the DHHS authorised officers reviewed the support plans of six residents who were immobile, find that four of these residents had sacral pressure sores, it was determined that staffing levels were insufficient to adequately support the needs of residents in relation to the care of pressure sores.

[7] https://www.betterhealth.vic.gov.au/health/serviceprofiles/rdns-service accessed 28 January 2020.

132. I note the lack of adequate (or possibly reliable) documentation regarding the timing of implementation of pressure care management strategies and Mrs Di Quinzio's regular position changes following Adare SRS staff observing the sacral pressure injury. I note Ms Chau's concession in this regard and hope Ms Chau, if still working in the residential aged care industry, and the new proprietors of Adare SRS commit to establishing a system of documentation (if this has not already been done) that is consistent with best practice, that current Adare SRS staff are trained in this system and that such a system is monitored and enforced.

133. This case highlights the importance of matching the needs of aged people with their requirements of care. The failure to recognise that a patient's needs exceed the aged care facility's service capability can lead to a failure to escalate care to match residents' needs and ultimately, to possible poor outcomes. The genesis of the apparent confusion regarding Mrs Di Quinzio's residential accommodation care level remains unclear as between Adare SRS, Maroondah Hospital and those others involved in her care. The importance of this factor should be balanced however against Adare SRS's apparent representations made to the hospital that they could accommodate Mrs Di Quinzio's care needs upon her discharge.

134. Following Mrs Di Quinzio's 12 September 2016 discharge from Maroondah Hospital, I recognise the number of occasions on which medical practitioners were contacted and referrals executed to specialist services, as well as the apparent prompt response of the Adare SRS staff in the documentation. In this respect, I note that treating medical practitioners did not suggest that Mrs Di Quinzio be transferred to hospital at any earlier time. I further note that there was a lack of continuity of care in that there were many medical practitioners who consulted with Mrs Di Quinzio upon her September 2016 discharge from hospital, and that this lack of continuity may have impacted upon the medical practitioners' ability to consider her clinical pathway in a more ideal contextual manner.

135. There is however evidence of gaps in care that appear suboptimal. Consequently, under different circumstances, the pressure injury may not have occurred, or had it been treated more promptly, Mrs Di Quinzio's death may have been preventable. I note in this respect however that no more can be said in this regard due to a lack of direct evidence capable of being adduced regarding the timing of the pressure sore development, and further, that on the evidence before me, no single causative factor leading to the pressure sore development can be established to a level of comfortable satisfaction. I further note that Professor Ibrahim found no evidence of neglect that would warrant further investigation and/or referral.

136. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

137. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Adele Di Quinzio, born on 26 October 1929; and

    (b) Ms Di Quinzio died on 17 October 2016 from 1(a) sepsis complicating sacral decubitis ulceration in the setting of recent surgical correction of fractured neck of femur (secondary to fall);

    (c) in the circumstances described above.

138. I find that Adare SRS, with the benefit of hindsight, was not an adequate facility to manage Mrs Di Quinzio's level of care needs following her 12 September 2016 discharge from Maroondah Hospital.

139. I find that the Adare SRS written policies/procedures/guidelines relevant to pressure area screening, care and management available at the time of Mrs Di Quinzio's residency and provided to me in the course of my investigation were inadequate and did not comply with relevant best practice.

140. I further find that had Mrs Di Quinzio been cared for in a facility that was more suitable to meet her care needs following her 12 September 2016 discharge from Maroondah Hospital, that her death may have been prevented.

141. I wish to express my sincere condolences to Mrs Di Quinzio's family, I acknowledge the grief and devastation that you have endured as a result of your loss.

RECOMMENDATIONS

142. Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

    RECOMMENDATION ONE:

    I recommend that the Mr Jinson Thomas, Proprietor of Adare SRS develop and implement a policy, procedure or guideline about the prevention, identification and management of pressure injuries in their residents (and train staff accordingly).

RECOMMENDATION TWO:

I recommend that the Ms Kym Peake, Secretary of DHHS regularly monitor Adare SRS in relation to their service delivery to their residents relevant to the prevention, identification and management of pressure injuries in their residents.

RECOMMENDATION THREE:

I recommend that the Ms Kym Peake, Secretary of Department of Health and Human Services develop and distribute educational material to Supported Residential Services with the aim to inform them about the importance of the prevention, identification and management of pressure injuries in their residents.

RECOMMENDATION FOUR:

I recommend that Adjunct Professor David Plunkett, Chief Executive Officer of Eastern Health, Maroondah Hospital arrange to provide refresher training to staff responsible for admitting and discharging patients to ensure that they are aware of the differences in types of aged care facilities; such as the difference between a nursing home and supported residential service and their respective levels of care.

143. Pursuant to section 73(1) of the Coroners Act 2008, I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- The family of Ms Di Quinzio;
- Mr Jinson Thomas, Proprietor of Adare SRS
- Ms Kym Peake, Secretary of the Department of Health and Human Services;
- Adjunct Professor David Plunkett, Chief Executive Officer, Eastern Health
- Ms Kris Chau
- Ms Vicky Mutiba, DHHS
- Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

- Dr Bashir Ahmed, General Practitioner
- Professor Joseph Ibrahim, Victorian Institute of Forensic Medicine
- Mr Gerard Mansour, Commissioner for Senior Victorians;
- Professor Euan Wallace, Safer Care Victoria;
- AHPRA;
- Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 30 January 2020