Submission
No 102

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Name: Ms Leigh Adnum

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Partially Confidential

Submission – Health Outcomes and Services in Rural, Regional and Remote NSW

Margaret Annan

6/3/1935 – 30/5/2018

I appreciate the opportunity given to make this submission so I can once again tell my mums story in the hope that someone will listen. I have already gone through the HCCC channel and gained no closure or satisfaction into the reasons why my mother passed away whilst in the care of the Hunter and New England Health Care System. I had almost given up and felt like I had failed my mum until I watched the Liz Hayes story of her father on 60 minutes and this re-ignited my flame again to pursue and hopefully find the answers as to why the system had failed my mum.

My mother left home on the 14th May 2018 to have a hip operation, 82 days later and 10 separate admissions to 4 different hospital in the Hunter New England area, she died on the 30th May 2018

This is her story

1. My mother was 83 and was in good health when she was admitted to Maitland Hospital on the 14th March 2018 to have a hip operation. I was told she would remain in hospital approximately 4 days or until she could get out of bed and take herself to the bathroom on a frame. She would then transfer to Kurri Kurri Rehab to continue her recovery. My mum phoned me the morning of the 16th and told me had told her she was being transferred to the Rehab facility, only 38 hours after leaving the recovery ward. At this stage she had not even put a foot to the floor and was in a degree of pain. I was unhappy with this so I phoned the hospital and was told my concerns would be passed on to the doctor and that he would contact me. My mother phoned me early that afternoon and advised that she had been transferred to Kurri. I never received a call back or was ever informed of my mother's transfer.
2. It was also noted on transfer that my mother had a temperature of 38.7. We later found out at our mediation talk with the HCCC that my mother's observations were not taken the morning of her transfer and if they had of been, her transfer would not have gone ahead. Following transfer my mother's health declined and this was the start to her end. She could not stand, move or weight bare without feeling nauseous, dizzy and in pain. At this stage she became bed ridden and staff used a sling to get her in and out of bed for personal hygiene matters. Approximately 11 days after her operation a medical officer asked if my mother took and medications. I told her yes and gave her a list. It was then brought to my attention that no-one either at Maitland Hospital or Kurri Kurri Rehab facility had charted her normal daily medications. This doctor told me that this was a severe breach and that she would be writing up an incident report. She also told me that this could have made my mother "stroke out". My mother was immediately commenced on her medications and within days her general health started to improve but not her ability to weight bare and start moving. At this stage they also doubled the dose of Rivaroxaban (medication given to patients who have operations to prevent clots).

3. After nearly 3 weeks my mother still could not weight bare without pain and she could not straighten her foot with pain affecting her hip area. The physio approached me and said that he believed that her operation was not a success and that we should ask for a medical review. did not agree and kept saying that we need to encourage mum to try harder with her recovery. She started to go downhill again and on the 2nd April was transferred to John Hunter Hospital to have investigations carried out as she had been passing black tarry stools and was feeling unwell. On discharge it was indicated perhaps a correlation with the increase of rivaroxaban from 10mg to 20mg was the reason. This drug is known for causing gastrointestinal bleeds as well as brain bleeds. After 3 days she was transferred back to Kurri Kurri Rehab and was given an iron infusion. No further investigations were carried out.
4. 4-5 weeks had passed since her operation but still she could not weight bare without pain and her foot turn outwards. Surely after this length of time had passed her medical team would be questioning why there has been no progress and investigating as to why. Her physio was still of the belief that the operation had not been successful and there appeared to be an issue with the alignment. It was only at his insistence that she had x-rays, not , who was adamant that the only thing preventing my mother's recovery was her commitment. I was told that the x-rays were read by a junior radiologist who did not see any issues, however two physiotherapists did. The physio contacted the surgeon and expressed his concerns. The specialist immediately ordered the transfer of my mum back to Maitland Hospital where he performed a second hip operation on Sunday 22nd April (5 ½ weeks since her first operation). All this time she was still on the drug rivaroxaban and was displaying side affects of being on this drug, all warning signs to cease this medication. Some of these being black tarry stools, feeling unwell, dry mouth, feeling nauseous that she did not want to eat, leg swelling, rash and was sleeping way too much. There was even an entry in her nursing notes that highlighted "rivaroxaban", yet not action was taken to reduce or cease the drug. No-one joined the dots or questioned the possible connections to these symptoms and the drug.
5. I spoke to at this point and expressed my disappointment about how unhappy I had been with the professional and medical care given to my mother thus far and that going forward I wanted all boxes ticked to enable her to have the best possible chance for a speedy recovery after this second operation.
6. My mother had her second operation on the 22nd April 2018. Her hip had been out of alignment. She still appeared unwell after the second operation. She was sleeping way too much and was still displaying rivaroxaban warning side effects, even her wound area was showing excessive blood loss and she was experiencing high temperatures. As there were no beds available at Kurri Kurri Rehab she was transferred to Cessnock Hospital to await availability of a bed on the 2nd May 2018. She stayed in Cessnock Hospital for 6 days. During this time no-one checked her wound area or the Pico Insitu Dressing that was applied to her wound area. These dressing have a life span and a light goes out on pump indicating that they need to be changed. This happened in Cessnock Hospital, it was noted in her medical notes. The staff were advised by the NUM that the hospital didn't keep these in stock and that because the patient was transferring back to Kurri Kurri Rehab in the next couple of days that the dressing would be changed on transfer.
7. My mother was transferred back to Kurri Kurri Rehab on the 8th May 2018. She was unwell and expressed that she had a lot of pain and felt like it was radiating throughout her body, she also

had a high temperature. I was in the room when the doctor removed her out of date pico insitu dressing and immediately saw how the area was inflamed, swollen and hot to touch, clearly an infection. I told that no-one during her stay in Cessnock had checked her wound. Because of this my mother had a severe infection, and within 24 hours of being transferred to Kurri Kurri she was transferred back to Maitland Hospital for urgent treatment. She had developed sepsis. Another setback that took time for her to recover and again delayed her recovery from her hip operation, as she was too unwell to continue her rehabilitation. She was put on high doses of antibiotics and after 6 days was transferred back to Kurri Kurri Rehab on the 17th May 2018.

8. My mother was starting to feel better and finally felt well enough to work with physio, making good progress with her movements and looking forward to coming home, scheduled for the 28th May 2018.
9. On the 24th May 2018 I went to visit my mother. I found her with a nurse complaining of a bad headache. She said to me, I never get headaches, I wish this would go away. The nurse informed me that she had been given paracetamol at 12 noon and that she could not have anything else but would see doctor to chart an endone and get her a cold cloth to put on her head. She also had a ticklish cough, and I was told by nursing staff that they did not chart cough medicine, but I could run up to the chemist and buy some for her. I left and went to the chemist, I was away maybe 20 minutes. On my return I saw a doctor in the hallway and asked if he could see my mother as she was unwell. We both walked into her room and found her slumped in bed unconscious. An ambulance was called, and she was transferred to the John Hunter Hospital.

   As if this was not unsetting enough I also had to witness that whilst a medical team were working on my mother and transferring her from the hospital bed to ambulance bed, 2 nurses from the facility were putting all her possessions into plastic bags and then walked outside and placed them next to our car whilst my mum was being put into the ambulance. I reflected after how callous, disrespectful and lacking compassion this act was.
10. The medical team at JHH spoke to me and because prior to her admission to hospital for her hip operation, my mother had been in good health, they decided to give her a chance and operate on her to relieve the pressure and blood surrounding her brain. She had had a subdural hemorrhage.
11. After 48 hours after my mother's operation the doctors told us that they didn't think even if she recovered from the operation that she would be the same person and most likely a person that would need full time care in a nursing home, maybe not ever walking, or able to feed herself etc. She would not have wanted this to be the case, so we decided to allow them to start palliative care and she passed away on the 30th May.

Summary

My mum went into hospital on the 14th March 2018 in good health, 82 days later and having 10 transfers between 4 hospitals, she died on the 30th May 2018.

From the time she walked through the revolving doors of the Hunter New England Health System, she was a number. My mother still should be with us today......she is not because of poor decision making, incompetence of medical staff not doing their job properly and negligence of others. My mother had a voice, but was not heard, we her family had voices, but no one wanted to listen, this also demonstrated a total lack of respect and compassion to all parties concerned.

We were given the opportunity to have my mothers story told through a mediation discussion organized by the HCCC. Whilst appreciative of the opportunity it achieved nothing. We were listened to, we were given an apology, however it was hollow. I later tried to follow up my disappointment with the General Manager of the Hunter New England Health System, I was given the opportunity to speak to her about my mother. The day she phoned me she had not even read my mothers file and therefore had no background into the history of the case. This woman also sent me a letter, the contents of which had no bearing into the complaint about my mother's care. This is the person running our areas health care system and what was displayed by her and how she conducted herself was disgraceful.

When someone dies in our health care system, and if the reason for their passing, is contributed largely due to the negligence and lack of duty of care towards the patient, then it should be up to the hospital and the treating staff members to prove that they were not negligent.....it should not have to be up to the family of the deceased to prove that they were negligent.

I am sure even today that the staff that forgot to take my mothers temperature prior to transfer, the staff that failed to document her medications at both hospitals, the staff that failed to connect the symptoms she was experiencing related to bad side effects of rivaroxaban, the staff that failed to hear and listen to the pain she was experiencing when she tried to walk, the staff that failed to read the x-ray properly, the staff that failed to check her wound for days that led to her getting sepsis, and the staff that just didn't listen.... would probably not even be aware that my mother passed away.

My mother died from a subdural hemorrhage, chronic not acute.....which means that the bleed could have commenced weeks before her passing. It was noted on her death certificate that she had been on the drug rivaroxaban. My mother was unnecessarily on this drug for much longer than she should have been. The reason was because of all the unnecessary delays to her rehabilitation after her operation due to poor decision making, incompetence, negligence and a lack of respect and compassion shown to her by members of the medical and nursing staff at the hospitals she was admitted to.

This has never been a witch hunt by us, as nothing will bring my mother back, however, we need some form of closure.....why did my mother die ? no-one can tell me that, no-one wants to admit that there may have been negligence, no-one wants to be accountable. My mother deserved better. She should not have had to endure all that unnecessary pain and suffering in the last months of her life. All this was totally unavoidable. My mother had a face, she was a mother, grandmother, sister, friend to many, losing her has shattered and broken our hearts, losing her in such a manner is unforgivable.

The system and how these matters are conducted need to change. Hospitals and staff need to be held accountable for their negligent actions. They need to stand up and accept responsibility of same. The involved staff members should be involved in the process, they need to be made aware of the mistakes that were made and the consequences that resulted from their lack of duty of care. How else can improvements be made if they are not made aware of what their actions caused. What price are we putting on the lives of individuals, surely life is not that cheap.

Additional Notes

My name is Leigh Adnum, daughter of Margaret Annan.

I have no issues with the information provided to you being made public, nor do I have any issues with my name being made public. I am willing to participate in any form of discussion relating to these issues.