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Te Whatu Ora Waitematā
(formerly Waitematā District Health Board)

A Report by the
Aged Care Commissioner

(Case 20HDC02175)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman by Te Whatu Ora Waitematā during two hospital admissions in September and October 2020. During both admissions, the woman was observed to be confused and at times disoriented, requiring a 1:1 watch or 15-minute checks. On her second admission, it was clear that she had suffered a further decline in her cognitive function owing to her Alzheimer's disease, and that her ability to care for herself safely at home was decreasing. At the time of the events, the woman lived alone in the community and was predominantly supported by her friend (who also had dementia) and her friend's daughter-in-law. The woman's daughter (who held an EPOA) was residing overseas at the time. During the course of both admissions, support people raised concerns about how she was coping at home. The woman was discharged home in September following reviews by a Needs Assessor and an occupational therapist, but despite her decline in cognitive function, she was not referred to Older Person's Health (OPH) or Mental Health Services for Older Adults (MHSOA) for assessment. The woman was also discharged without sufficient support in place for monitoring her food intake and medication management. During her second admission in October, the decision to discharge the woman was made prior to an occupational therapy assessment occurring, and her daughter had not been made aware of the results of the occupational therapy assessment prior to her confirming her agreement for her mother to return home. Subsequently, the woman was re-admitted to hospital and remained there until 12 November, when she was discharged to an aged residential care facility.

Findings

2. The Aged Care Commissioner was critical of Te Whatu Ora for failing to consider making a referral to the older persons health service (OPH) during the first and second admissions to hospital and for failing to make a referral to the Primary Options for Acute Care (POAC) service to ensure immediate commencement of cares for the woman after her first discharge from hospital. The Aged Care Commissioner was also critical of the decision to discharge the woman home on 29 October in light of her clear decline in cognitive function, that the decision to discharge was made prior to the occupational therapy assessment, and that the woman's daughter had not been made aware of the results of the assessment prior to her confirming her agreement for her mother to return home. In addition, the Aged Care Commissioner considered that the information supplied by the woman's support people was not acted on appropriately or used in a manner that enhanced the care and discharge planning during both admissions. The Aged Care Commissioner noted that Te Whatu Ora failed to contact the woman's GP to gather further information about her cognitive function.

3. The Aged Care Commissioner found that Te Whatu Ora failed to comply with the Health and Disability Services Core Standards and that cumulatively, the above failings amounted to a breach of Right 4(2) of the Code. The Aged Care Commissioner also found that Te Whatu Ora breached Right 4(5) of the Code for failing to coordinate services to ensure that the woman was discharged home safely on both occasions.

Names have been removed (except Te Whatu Ora Waitematā, North Shore Hospital and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

4. The Aged Care Commissioner recommended that Te Whatu Ora provide an apology to the woman, her whānau and her friend's daughter-in-law for the failings identified in this report; consider the recommendations set out in the independent clinical advice; and update two of its guidelines to provide further guidance to staff.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her friend, Mrs A, by Te Whatu Ora Waitematā (formerly Waitematā District Health Board).[1] The following issue was identified for investigation:

- *Whether Te Whatu Ora Waitematā provided Mrs A with an appropriate standard of care between September and October 2020.*

6. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

7. The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant
Te Whatu Ora Waitematā	Group provider/district
North Shore Hospital	Group provider/hospital

8. Also mentioned in this report:

Ms C	Occupational therapist
Ms D	NASC assessor

9. Independent advice was obtained from Registered Nurse (RN) Richard Scrase and is included as Appendix A.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished and Te Whatu Ora|Health New Zealand being established in their place. All references to Waitematā District Health Board in this report now refer to Te Whatu Ora Waitematā.

Information gathered during investigation

Introduction

10. Mrs A (aged in her eighties at the time of these events) had a history of dementia (Alzheimer's)[2] and was living independently, supported by her elderly sister, her friend (who also had dementia), and her friend's daughter-in-law, Mrs B (complainant). Mrs A's daughter, who held an Enduring Power of Attorney (EPOA),[3] was residing overseas.

11. On 6 September 2020 Mrs A was admitted to North Shore Hospital.[4] During this admission, concerns were raised by Mrs A's support people about how she was coping at home. On 9 September 2020, Mrs A underwent a Needs Assessment[5] and an assessment by an occupational therapist,[6] both of which cleared her for discharge back home. Mrs A was discharged from hospital on 9 September 2020 and went home via taxi.

12. Mrs A was again admitted to hospital[7] on 27 October 2020. During this admission, further concerns were raised by family and friends about her ability to return home. A further assessment was conducted by an occupational therapist, which identified some concerns about Mrs A's cognitive function. Mrs A was discharged home on the afternoon of 29 October, but Mrs B raised concerns with North Shore Hospital (via the occupational therapist and the Needs Assessment and Service Co-ordination (NASC) service) that Mrs A was confused and incoherent on her return. Mrs A returned to hospital that night, where she stayed until 12 November, when she was discharged to an aged residential care facility.

First admission — 6 to 9 September 2020

13. On 6 September 2020, Mrs A was admitted to North Shore Hospital via ambulance and was treated for a UTI. The ambulance summary noted that Mrs A was 'vacant at times, delayed and slow with answers', and that her friend reported that Mrs A had not been herself and had been experiencing some intermittent confusion. The admission note states that on observation, Mrs A was 'not oriented to time/place'.

14. Throughout the first admission, there are various references in the clinical records to Mrs A being disoriented and confused. On 6 September 2020, Mrs A was reviewed by a house officer, who documented: '[Mrs] [is] unable to recollect how she ended up in hospital … Normally functioning independent. Driving until last year. History of Alzheimers.' Later that

[2] A brain disorder that affects memory and thinking skills.
[3] A legal document that sets out who can take care of a person's personal or financial matters if the person is unable to do so. An EPOA comes into effect only if a medical professional or the Family Court decides that the person has become 'mentally incapable'.
[4] Following an acute onset of epigastric pain and two episodes of vomiting. Mrs A was found to have a urinary tract infection (UTI).
[5] A formal process of determining a person's strengths, needs and goals, and identifying the services required to support a person to be independent.
[6] A healthcare profession that helps people to overcome challenges in completing everyday tasks.
[7] Mrs A arrived at North Shore Hospital via ambulance as she was experiencing pain in the back of her head and bleeding near her eye from a suspected fall.

day, a nursing note records that Mrs A was confused, and that she required a hospital 'watch'[8] (which continued throughout her admission).

15. A nursing note on 7 September showed that Mrs A was '[d]isorientated to time and place'. A registered nurse spoke to Mrs A's sister, who raised concerns that Mrs A's dementia had been progressing and that she was not eating and/or drinking properly. Mrs A's sister asked if assistance could be provided to Mrs A on discharge.

16. The nurse sent referrals to NASC, to an occupational therapist, and to a physiotherapist, and noted that multidisciplinary team (MDT) input was required prior to Mrs A being cleared for discharge.

17. On 8 September, Mrs A was again assessed by a house officer, who noted that Mrs A was feeling well and had been eating and drinking without difficulty, and that she was alert and speaking full sentences. Mrs A's notes were reviewed by the physiotherapist, who declined the referral on the basis that Mrs A was mobilising independently on the ward, and there did not appear to be any mobility concerns. The physiotherapist did document that Mrs A would 'likely require cognitive assessment while an inpatient secondary to concerns re progression of confusion as documented in notes'.

Occupational therapist assessment

18. Later that day (8 September), Mrs A was assessed by an occupational therapist, Ms C. The Occupational Therapy Initial Assessment Report noted that previously it had been reported that Mrs A managed her medication independently, but that her sister had reported that blister pack medication was not being taken consistently or at the correct time.

19. Ms C documented the results of the assessment, including that Mrs A was able to safely and independently use the kettle to make a cup of coffee; that she was oriented to her date of birth and year, but that she was disorientated to the month and day and unable to recall the name of where she resided. The occupational therapist noted that Mrs A verbalised that her memory was 'not as good these days', and that she was not able to recall her diagnosis of Alzheimer's.

20. Ms C also had telephone discussions with Mrs A's friend and Mrs B, who reported concerns about Mrs A's safety and her medication management, and said that she was not eating enough nutritious food resulting in weight loss (which, in response to the provisional opinion, Mrs B said was in her view a significant amount), and that she relied heavily on her friend (who also has dementia) to remind her of appointments and where things are located, and that as a result Mrs A was telephoning her friend 6–12 times a day (often for the same thing). Mrs B told Ms C that she felt that Mrs A would benefit from support with supervising her medications, preparing food, and shopping. Ms C documented that she agreed to pass on these concerns to the Needs Assessor and that she discussed with Mrs B that she would send a referral to the Gerontology Nurse Specialist service for follow-up in the community. Ms C also documented that Mrs A had expressed a wish to return home that day.

[8] Careful monitoring of actions and behaviour.

21. Under the 'plan' section of the report, Ms C documented that she was to liaise with NASC about supports for discharge (and that NASC would follow up with Mrs A on 9 September); that she would discuss this with the Community Nurse Manager; and that she would make a referral to the Gerontology Nurse Specialist service for follow-up in the community. Ms C noted that no further occupational therapy input was required, and that she was discharging Mrs A from the Acute Occupational Therapy service.

22. The nursing notes on the evening of 8 September document that Mrs A's watch was being continued as she had been 'wandering about'.

23. On the morning of 9 September, Ms C documented that she had completed the referral to the Gerontology Nurse Specialist service to review Mrs A, 'in particular with regards [to] medication management, nutrition and hydration'. Te Whatu Ora Waitematā told HDC that the referral was triaged on the same day as priority 1.[9] Ms C also noted that Mrs A was awaiting NASC assessment later that day.

Review by NASC assessor

24. At 11.17am on 9 September, Mrs A was assessed by a NASC assessor, Ms D. Ms D conducted an interRAI contact assessment (interRAI-CA).[10]

25. Ms D documented that she obtained relevant background information from the clinical notes and through a discussion with Mrs A's friend and her family. Ms D noted that Mrs A's family and friends were concerned that Mrs A was not eating or drinking adequately, and that she required support from her friend to remind her of appointments and where things were located. Ms D also documented that Mrs B thought that Mrs A would benefit from support with supervising medications and checking the safety of food.

26. The interRAI-CA assessment noted that Mrs A had an Assessment Urgency score of 6/6[11] and a Service Urgency score of 2/4.[12] Ms D documented that Mrs A agreed to have a carer visit daily to oversee her medication management. Ms D noted that she '[s]poke with sister, neighbor/friend informed of assessment and supports'. Te Whatu Ora said that Ms D discussed the support plan with Mrs B, who again raised concerns about meal preparation. Te Whatu Ora stated that Ms D had a discussion with Mrs B about patient choice to decline assistance if they wished.

27. In response to the provisional report, Mrs B said that due to the COVID-19 restrictions in place at the time of Mrs A's first admission, all interactions between Mrs B and hospital staff

[9] Subsequently, Mrs A was seen by a gerontology nurse specialist on 17 September 2020.

[10] A basic screening assessment that provides clinical information to support decision-making about the need and urgency for a comprehensive assessment, support and specialised rehabilitation service. See: https://www.interrai.co.nz/about/interrai-assessments-in-new-zealand/.

[11] When a patient scores 4 or more on the Urgency for Assessment scale in a Contact Assessment, the provider will determine the timeframe for undertaking a Home Care Assessment according to Ministry of Health Guidelines. Patients are prioritised according to the score that signals urgency, with 6 being the highest priority.

[12] A scale that identifies patients who are in urgent need of initiation of community services (support). The higher the score, the more urgent the need for services.

could only be done via phone call. She said that at times it was difficult to get through to staff on the phone.

28. Ms D made a referral for funded personal cares for a total of 3.5 hours a week (for 30 minutes per day) to assist with medication management, to ensure that there was adequate food available, and to check that Mrs A had eaten.

29. Te Whatu Ora acknowledged that there can be a delay in the commencement of long-term services. It stated:

> 'While there can be a delay in long term services commencing, short term services through POAC (Primary Options for Acute Care)[13] were not explored initially as a discharge date had not been confirmed and it was not known if POAC would be required.'

30. At the conclusion of the examination, Ms D documented that she had discharged Mrs A from the Acute NASC service (meaning that she had been cleared for discharge home by the NASC service).

Discharge

31. On the afternoon of 9 September, Mrs A was noted to be 'wandering around wanting to go home' and that she was agitated while waiting for the discharge papers to be completed. In a letter to Mrs B regarding these events, Te Whatu Ora wrote:

> '[B]y 2.30pm [Mrs A] was insisting a taxi be called so she could leave. She reassured the staff she had money to pay for this. The discharging nurse reported that she called [Mrs B] to let [her] know [Mrs A] was coming home in a taxi and that you [Mrs B] said you would check on her later that afternoon.'

32. Mrs A was discharged on the afternoon of 9 September and was escorted to a taxi by a healthcare assistant. In response to the provisional opinion, Mrs B said that Mrs A did not have any money for the taxi. The clinical notes record that telephone calls were made to Mrs A's daughter and Mrs B to advise them of the plan, and that Mrs B advised that she would check on Mrs A that afternoon.

33. Mrs B told HDC that when she spoke to Ms D over the phone on 9 September, she found Ms D to be 'particularly dispassionate', and that when she raised concerns to Ms D about Mrs A's weight loss, Ms D responded: 'When you are her age, you can eat whatever you like.' Mrs B said that the following day she discovered that Mrs A had put something unsafe in her lunch.

34. Te Whatu Ora said that Ms D acknowledged that she did make a statement about Mrs A being able to eat what she wanted but cannot recall exactly how she phrased it. Te Whatu Ora also said that Ms D acknowledged at the time that 'her comments around competency

[13] A service that provides healthcare professionals with access to investigations, care or treatment for their patient, where the patient can be managed in the community safely.

could have been explained better and with more compassion, particularly in light of [Mrs B's] concerns and [Mrs A's] situation at the time'.

35. In a statement to Waitematā DHB, Ms D said that her hope was to start the initial supports (of medication oversight and checking Mrs A's fridge for food) in the hope that Mrs A would then be open to accepting more support, and that she explained this rationale to Mrs B on 9 September. Ms D said that this was prior to learning that Mrs A had put something unsafe in her lunch. Ms D also stated that on 9 September she advised Mrs B that it might be a few days before Mrs A's medication assistance started. In response to the provisional report, Mrs B said that by this stage, staff had been told several times that Mrs A was not managing her medication independently.

Discussions on 10 September 2020

36. Mrs B said that Mrs A had returned home that afternoon with no support in place, and that she had no keys to enter her home. Mrs B telephoned North Shore Hospital to raise her concerns. Te Whatu Ora told HDC that Mrs B contacted both Ms D and Ms C to advise that she remained concerned about how Mrs A was coping at home, and to ask for additional guidance and support for her. In response to the provisional report, Mrs B told HDC that Mrs A had also returned home with a prescription and a blood test form. Mrs B said that Mrs A did not know what to do with the forms and could not drive to get her prescription filled or the blood tests completed.

37. Te Whatu Ora told HDC that Ms C made a telephone call to the Gerontology Nurse Specialist service to discuss possible assessment dates, and that Ms C was advised that the earliest date for an assessment would be 17 September 2020. However, the record of the telephone call in the clinical notes states that a gerontology nurse specialist advised that there was a waiting list of 6–8 weeks, and they would not be able to visit Mrs A 'this week or probably next week due to case load'[14]. The gerontology nurse specialist recommended to both Ms C and Ms D that either an immediate referral to POAC be made, or that Mrs A be readmitted to hospital. Subsequently, Ms D contacted the Community Nurse Manager and asked for POAC supports to be arranged.

38. Te Whatu Ora told HDC that the purpose of the POAC service is to provide home supports as soon as possible after discharge while the longer-term supports are put into place. Te Whatu Ora stated: 'The lead time for longer term supports (usually 4–5 days) is because an initial environmental health and safety assessment is done to confirm the right level of support.'

39. Te Whatu Ora said that the POAC referral was sent on 10 September, and the request was for 1.5 hours of support per day, split into two visits to supervise medication administration, check that food was available, and support meal preparation for breakfast, lunch and dinner. Supports were to start the following day (11 September 2020) and remain in place for five days until the longer-term supports commenced. The referral also noted that Mrs A might be reluctant to accept the help offered. In response to the provisional report, Mrs B said

[14] Mrs A was seen for assessment on 17 September 2020.

that it was her understanding that the 1.5 hours of support per day was to be split into three visits.

40. Te Whatu Ora stated that Mrs B was advised that POAC supports had been arranged.

41. Te Whatu Ora said that on 11 September, the Community Nurse Manager called Mrs B to apologise for what had occurred following Mrs A's discharge. Te Whatu Ora stated that the Community Nurse Manager explained that Mrs A had presented as 'very credible and that she had not identified the level of impact [Mrs A's] Alzheimers was having on her decision making'.

Gerontology nurse specialist assessment

42. On 17 September 2020, a gerontology nurse specialist visited Mrs A at home to conduct an initial assessment, with both Mrs A's daughter (via video conferencing) and her sister present. A summary of the assessment was sent to Mrs A's general practitioner (GP) on 5 November 2020. The gerontology nurse specialist conducted an Addenbrooke's Cognitive Examination,[15] for which Mrs A achieved a score of 58/100 (indicating moderate dementia with a significant impairment of cognition/ function),[16] which showed 'the greatest deficits in the area of short term memory where she scored 7/26'. However, there were noted deficits across all domains, including language (20/26), fluency (9/14), visuospatial (12/16), and attention (10/18). The gerontology nurse specialist discussed Mrs A's care with a consultant geriatrician. She noted that Mrs A had a moderate neurocognitive disorder that was progressing gradually, particularly in the domain of memory. The gerontology nurse specialist noted:

> 'A daily package of care has been put in place recently by NASC and we will see how well she does with these supports. It is likely that her cognition will slowly deteriorate over time and supports will need to slowly increase around more complex tasks. When this happens a decision will need to be made between [Mrs A] and her family whether she should move into care. She has high care needs that are indefinite.'

43. Te Whatu Ora told HDC that the Gerontology Nurse Specialist Intervention Plan included the recommendation that a driving assessment be conducted by an occupational therapist, and that the idea of Advanced Care Planning be introduced to Mrs A. The plan noted that a copy of the assessment would be forwarded to NASC and that a copy would be available in the community clinical notes section of Clinical Portal (Waitematā's electronic health records) from the date of the assessment on 17 September. However, Te Whatu Ora acknowledged that a copy of the assessment was not available to Mrs A's GP until 5 November, and it was unable to establish the reason for this delay.

[15] A neuropsychological test used to identify cognitive impairment in conditions such as dementia.

[16] See: https://www.healthnavigator.org.nz/media/1707/summary_recommendations_from_dementia__driving_guidelines_2014.pdf. A score of between 35–64/100 indicates moderate dementia with significant impairment of cognition and function, with 'Marked memory loss, Disorientation to time and place, Decreasing ability to make judgements, Decreasing ability to engage socially, Decreasing ability to function independently …'

Referral from GP

44. On 19 October 2020, Mrs A's GP made a referral to Te Whatu Ora's Older Persons Health (OPH) service for an outpatient appointment. The referral noted that the reason for the referral was that Mrs A had had a deterioration in her Alzheimer's, that she had poor social support, and that her carers had suggested a referral to the Vulnerable Adults Resource Group (VARG). The GP requested copies of any recent Gerontology and/or NASC assessments and noted that it was difficult for Mrs A's daughter (EPOA) to get a clear picture of how Mrs A was managing. In response to the provisional opinion, Te Whatu Ora said that the referral was graded by a geriatrician on 21 October, and the plan was for 'GNS clinic review or community. + Forward referral to VARG (Vulnerable Adult Resource Group)'. Te Whatu Ora told HDC that the e-referral system automatically electronically updates a referring GP of the grading outcome and plan. Te Whatu Ora said that at that time, the geriatrician was unaware of the GNS home visit on 17 September due to the delayed sign-off of that document (referred to at paragraphs 42 and 43).

45. On 22 October, NASC received a referral from Mrs A's GP requesting a review of her in-home supports. A face-to-face review was booked for 29 October. However, this did not occur because Mrs A was re-admitted to hospital on 27 October (discussed below).

Second admission — 27 to 29 October 2020

46. On 27 October 2020, Mrs A was admitted to hospital via ambulance as she was experiencing pain in the back of her head and bleeding near her eye. It was suspected that she may have suffered a fall.

47. The clinical notes from this admission contain several references to Mrs A being confused and disorientated. On 28 October, the nursing notes state that Mrs A was wandering around the ward 'trying to go home', that she was confused but easily re-directable, and that she was changing into her own clothes and getting ready to go home 'every now and then'.

48. That same day, during a post-acute ward round, a senior medical officer (SMO) reviewed Mrs A and documented that she had a 'very unclear history', and it was unclear why she had been brought to hospital, but that there were concerns about how she was coping at home. The SMO documented the impression that Mrs A had suffered a fall, and that she '[n]eed[ed] significant MDT input (EPOA [overseas], dementia, closest friend also has dementia, falling and not remembering this)'. Later that day, the nursing notes show that Mrs A was getting 'more and more confused' and that she was wandering around and refusing to go to the ward. The Behaviours of Concern (BOC) Specialty Service nurse was called in to assess Mrs A on the ward.

49. The clinical notes from this assessment show that Mrs A was needing a higher level of observation due to concerns of her wandering off. The nurse documented that Mrs A was confused and thought she was in a circus, and that she voiced that she wanted to go home but was unable to recall her home address. The notes also document that Mrs A was easily distracted by noise, and that she was wandering around the unit looking for exit points.

50. A 1:1 watch was commenced by the BOC nurse from 4pm that day, due to concerns about Mrs A trying to leave the ward. Mrs A's daughter and sister were updated on her status.

51. In response to the provisional opinion, Mrs B said that as well as being very confused and agitated, Mrs A had also been incontinent. Mrs B said that she reported this to staff when she visited Mrs A during her second admission.

Discharge

52. On the afternoon of 29 October, Mrs A was assessed by a registered nurse, who documented that a further NASC referral had been made. Te Whatu Ora said that a NASC assessor was to review the support package the following day (after Mrs A's discharge). Mrs A was also reviewed again by a BOC nurse, who documented that Mrs A was alert to date, but that she was not oriented to place. The BOC nurse documented that ongoing discharge planning was occurring, and that there was no indication to continue the 1:1 watch at that time. However, the nurse noted that strict checks every 15 minutes were to be conducted.

53. At 4.11pm, a house officer documented that Mrs A's care had been discussed with her daughter, who had indicated that she did 'not have concerns with patient being discharged with current package of cares'. Mrs B noted (in response to the provisional opinion) that Mrs A's daughter had not seen her mother since December 2018, and that she was reliant on the verbal information given to her by the hospital staff. The house officer recorded that Mrs A's daughter had advised that Mrs A's friend would be at home to assist her, and that the carers would arrive to assist in the evening. The notes state: 'Daughter believes patient is at baseline cognition according to what we have described to her … patient can be discharged as long as MDT happy.' Te Whatu Ora is unsure whether this was decided prior to or following the occupational therapy assessment (discussed below). However, Te Whatu Ora acknowledged that at 4.11pm the medical team had recorded that Mrs A could be discharged 'as long as MDT happy', but that the occupational therapist documented her review at 4.20pm.

54. The further assessment by the occupational therapist documented at 4.20pm showed that Mrs A was not able to 'plan, sequence or problem-solve throughout the tea-making process'. The occupational therapist documented: 'Anticipate this is the final stint of [Mrs A] managing at home on her own due to deteriorating cognition and increasing need for support.' The occupational therapist recommended that the cares be increased to three times daily due to Mrs A's impaired cognition and noted that NASC was telephoned and advised of the plan.

55. Te Whatu Ora told HDC that the occupational therapist confirmed with the home-care providers that they would be able to assist Mrs A, and the occupational therapist believed that Mrs A could be discharged home as long as the level of support (cares three times daily) was achieved. Te Whatu Ora stated:

> 'Discharge planning involved all of the appropriate services. The challenge for the clinical teams working with [Mrs A] was balancing our responsibility to act in accordance with her requests and preferences, alongside the identified risks, hence the measures put in place to mitigate those risks.'

56. In response to the provisional opinion, Te Whatu Ora said that more considered thought should have been given to whether an urgent inpatient Older People's Health referral should have been made during this admission, and that in hindsight this discharge should not have gone ahead.

57. Mrs B told HDC that when she telephoned the hospital on 29 October to enquire about Mrs A's discharge, she was told that she would be advised when discharge was imminent so that she could arrange to be home at that time. Mrs B said that she was later advised that there had been delays in Mrs A's discharge due to difficulties contacting her daughter and that she told the nurse that a carer was due to be at Mrs A's home at 4.30pm that day. Mrs B said that she told the nurse that if the hospital could not get Mrs A home before that time, then she would need to be kept overnight, as she would have no support in the evening.

58. Mrs B said that she was told by the nurse that she would be called once a taxi had been booked, but she did not hear anything back, so assumed that Mrs A had not been discharged.

59. A letter to Mrs B from Te Whatu Ora Waitematā following these events stated that the nurse recalled informing Mrs B that the discharge papers were complete. The nurse apologised for not recalling that he had advised Mrs B that he would call her back once a taxi had been booked.

60. Mrs A was discharged home that evening. Mrs B told HDC that around 6pm, she received a panicked call from her mother-in-law (Mrs A's friend) asking for help. Mrs B said:

> '[Mrs A] had just arrived home in a taxi, completely disoriented, agitated, unintelligible … Her speech was incoherent and jumbled. We tried to settle her but eventually called the ambulance. The [ambulance officers] agreed [Mrs A] was in no state to stay at home alone and they would admit her back to [North] Shore hospital as a "failed discharge".'

61. In response to the provisional opinion, Mrs B added that Mrs A was discharged in track pants and a jacket but she was wearing 'no underwear or top'.

Subsequent events

62. Mrs A was readmitted to hospital that night, and stayed until 12 November 2020, when she was discharged to an aged residential care facility.

Further information

Mrs B

63. Mrs B expressed concern at the poor communication from Te Whatu Ora Waitematā. She told HDC:

> 'I'm not usually one to complain. I'm doing this so [Mrs A], [Mrs A's friend], or anyone else with dementia in [New Zealand] is well cared for in hospital. Families shouldn't have to rant or complain to receive safe and appropriate care for their loved ones.'

Te Whatu Ora Waitematā

64. Te Whatu Ora told HDC that for older adults who are in a 'convalescent or continuing assessment phase', the hospital environment brings 'not inconsiderable' risks, meaning that '[i]t is the focus of many hospitals internationally to "discharge to assess"' in order to avoid many of the hospitalisation risks.

65. Te Whatu Ora stated:

> 'We acknowledge that there are situations where a patient's desire for continuing independence leads them to make personal welfare decisions that raise valid concerns for their family and with treating clinicians. Services are, and were provided in this case, to support those personal decisions so far as is possible, as that respected the patient's autonomy.
>
> …
>
> In many instances of care in the health sector, when viewed in hindsight, there are opportunities for improvement. That is the case here for [Mrs A] … At the time decisions were made regarding care, we contend they were reasonable.'

<u>POAC support</u>

66. Te Whatu Ora told HDC that initially it did not arrange for POAC support prior to Mrs A's discharge on 9 September 2020, as usually the short lead time in arranging long-term supports (following referral) is acceptable, 'particularly where the patient has informal supports available to bridge that gap which was the understanding of the team in relation to Mrs A's neighbor'.

<u>MDT input</u>

67. Te Whatu Ora told HDC that during Mrs A's second admission, MDT input was obtained by way of the occupational therapist, NASC, and the Social Work service. It said that the occupational therapist was involved to determine Mrs A's functional ability and her likely care needs 'to enable her to manage at home as this was Mrs A's expressed wish'. A social worker was involved in conversations with Mrs A's daughter around her EPOA, and NASC was involved to assess care needs and help to determine appropriate care options.

68. Te Whatu Ora said that it connects with GPs and other healthcare providers when assessing patients' cognitive state 'as required'. However, in relation to Mrs A's second admission, it advised:

> '[A]s the [gerontology nurse specialist] and Gerontology Consultants assessment of [Mrs A's] cognitive state was clear/unambiguous, we did not feel we needed additional information from the GP. If there had been any uncertain[t]y or lack of clarity about her cognitive state, we would have certainly sought information from the GP.'

<u>Referral to Mental Health Services for Older Adults (MHSOA)</u>

69. Te Whatu Ora told HDC that Mrs A's admission on 6 September 2020 was for an 'acute surgical event which resolved over three days'. It said that on a review of the clinical records

of this admission, 'there is no indication from any of the health care professionals (medical, nursing or allied health) that a referral to MHSOA was required'.

70. Te Whatu Ora told HDC that Mrs A was referred to Liaison Psychiatry by the General Medicine house officer on 4 November 2020, with the request for confirmation that Mrs A's cognitive impairment was thought to be permanent/irreversible. Te Whatu Ora advised that this referral was declined by Liaison Psychiatry on 4 November and forwarded to MHSOA on 5 November 2020, but a decision was made that Mrs A did not meet the criteria for assessment by a specialist mental health service. In response to the provisional opinion, Te Whatu Ora clarified that this referral was for the purposes of requesting a 'level of care assessment' for dementia, and that feedback was given to the referrer that a Geriatrician can complete a level of care assessment for dementia (meaning that a consultation with a specialised Psychogeriatrician was not required).

71. Te Whatu Ora told HDC that no referral was made to MHSOA during Mrs A's inpatient stays as the criteria for referral to the service were not met, as detailed in its Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA). Te Whatu Ora said that '[Mrs A] did not have such complex and challenging symptoms', and it does not consider that earlier referral to MHSOA would have been clinically appropriate as there was no indication that behavioral and psychological symptoms of dementia (BPSD) were present.

72. Te Whatu Ora said that confusion is not a reason for referral to MHSOA, and that most in-patients with delirium and dementia are cared for by General Medicine, as 'General Medicine doctors hold specialist expertise in the management and treatment for the majority of delirium and dementia cases'.

Policies

73. Te Whatu Ora provided HDC with its Referral to Specialist for Advice and Care Review guideline, and the Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) guideline.

74. Section 3.1 (Complex Needs) of the Referral to Specialist for Advice and Care Review guideline states:

> 'Where patient care needs are complex it is important that there is regular complex case review … Decisions made to seek specialist input [nursing, medical, allied health] are documented and actioned.'

75. Section 4.2 (Response to Referrals) outlines how the specialist accepting the referral should communicate with the referrer.

76. The Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) outlines the entry criteria for MHSOA referrals, and how the referrals are to be managed between the services (including how to progress them when required).

77. The Referral to Specialist for Advice and Care Review guideline does not contain a definition of what constitutes 'complex' patient needs, but Te Whatu Ora advised that to document what constitutes 'complex' across multiple domains would not be possible. It stated:

> 'Health care professionals are trained to assess, think critically and synthesise a body of knowledge into a customised care plan. This includes the ability to exercise and apply judgement where multiple factors (complexity) exist.'

78. Te Whatu Ora said that declining to accept a referral is normal practice in any clinical specialty, and the clinician 'grading' the referral has the opportunity to provide advice to the referrer to assist them in the ongoing care of their patient. It stated: 'That is the clinician's professional choice and should not be restricted or mandated by a specific policy.'

Responses to provisional opinion

Mrs B

79. Mrs B was given the opportunity to comment on the 'information gathered' section of the provisional report and her comments have been incorporated into this report where appropriate.

80. In addition, Mrs B said that during Mrs A's final hospital admission, it seemed that staff were not sure what to do with her. Mrs B said that she was the one who suggested the residential care facility to which ultimately Mrs A was discharged.

81. Mrs B stated that she made it very clear to hospital staff on numerous occasions (as had Mrs A's sister) that Mrs A had 'poor informal supports' and that her friend and neighbour who was supporting her also had moderate dementia and 'could not cope'.

82. Mrs B told HDC that Mrs A remains at the residential facility, and that unfortunately she is no longer able to have a conversation and rarely participates in any of the activities offered. However, Mrs B reported that Mrs A is still mobile.

Te Whatu Ora Waitematā

83. Te Whatu Ora disagreed with the proposed findings and the independent clinical advice.

84. Te Whatu Ora referred to a study[17] that highlights that hospitalisation rates in elderly patients 'rise exponentially in a 6-month period immediately prior to placement in a long-term care facility'. Te Whatu Ora said that it is not realistic or achievable to seek specialist inpatient assessment from OPH for such a large number of patients. It stated that the limited inpatient consultation resources of the service are mainly prioritised to assessing which patients are suitable for inpatient rehabilitation and assisting with decisions regarding the level of care required when a patient is being placed in a long-term care facility. In relation to the MHSOA service, Te Whatu Ora said that this is a 'small inpatient service with no routine inpatient referral assessment capacity', and that it is focused on high-risk and complex older patients with mental and cognitive health disorders.

[17] Boyd M et al. *Age and Aging* (2016) 45: 558–563.

85. Te Whatu Ora said that Mrs A was similar to the majority of hospital inpatients in her age group in North Shore Hospital (in relation to cognitive impairment) and that this is due to the transient cognitive decline that often occurs with acute illness and the environment of a hospital, 'which frequently improves when patients are well and in their home environment'. Te Whatu Ora said that this further complicates the prediction of which patients can successfully return home, 'as many will in fact be a good deal better out of the ward and acute medical situation'. Te Whatu Ora told HDC that hospital staff sought to respect Mrs A's wishes, but that in retrospect it 'erred too much on the side of patient autonomy and did not sufficiently recognise [Mrs A's] vulnerability'. However, Te Whatu Ora submitted that it does not agree 'that the clinical situation would have been as clear prospectively as it is in hindsight'.

86. Te Whatu Ora also acknowledged that there were opportunities to improve communication with Mrs A's support people during both the September and October admissions. However, it advised that there is clear evidence that the concerns of Mrs A's support people were listened to during the Needs Assessment summaries of both 10 September and 15 September 2020.

87. In relation to contact with Mrs A's GP, Te Whatu Ora advised that while it is often helpful to gather additional information from the patient's GP, in the context of the COVID-19 pandemic in 2020 most primary care visits with vulnerable older people were kept to a minimum. It said that there was no reference in the GP referral of 19 October of any direct contact between the GP and Mrs A, 'as the details given are all third hand from support persons, which the MDT team in the hospital were already well aware of'.

88. In response to the proposed recommendations, Te Whatu Ora agreed to consider the recommendations made by RN Scrase but said that its response would be determined by the availability of the specialist staffing resources within both the OPH and MHSOA services. It said that there are current staff shortages, and any decisions made on referral criteria and acceptance will 'necessarily prioritise those patients with the highest clinical need'.

Relevant standards

Health and Disability Services Standards

89. The NZS 8134.1:2008 Health and Disability Services (Core) Standards enable consumers to be clear about their rights, and providers to be clear about their responsibilities, for safe outcomes.

90. NZS 8134.1(b) stipulates that '[c]onsumers receive timely services which are planned, coordinated, and delivered in an appropriate manner'.

91. NZS 8134.1: 2008 Standard 3.10.2 (Continuum of service delivery) relating specifically to the transition, exit, discharge, or transfer from services, provides:

> 'Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.'

Opinion: Te Whatu Ora Waitematā — breach

Introduction

92. Te Whatu Ora Waitematā had a responsibility to ensure that Mrs A was provided with services that complied with the Code of Health and Disability Services Consumers' Rights (the Code), and for ensuring that it planned and coordinated Mrs A's discharge from hospital appropriately and safely. This was particularly important given that Mrs A lived alone at the time of these events, and predominantly was supported by a friend (who also had dementia), and her next of kin (her daughter and EPOA) was residing overseas.

93. During both admissions to hospital, Mrs A was observed to be confused and at times disoriented, requiring a 1:1 watch or 15-minute checks. On her second admission, it was clear that she had suffered a further decline in her cognitive function owing to her Alzheimer's disease, and that her ability to care for herself safely at home was decreasing. It was the responsibility of Te Whatu Ora Waitematā to facilitate appropriate supports for Mrs A on discharge to ensure her safety.

94. As part of my assessment of this complaint I sought independent clinical advice from a registered nurse, RN Richard Scrase.

95. RN Scrase advised:

> 'As with all investigations of this nature, I have drawn my conclusions from documentation provided. At the beginning of my initial report I stressed that I would be examining events at the time they were documented as occurring rather than with the benefit of hindsight. In my professional view, [my] documented comments provided are highlighting potential risks at the time events occurred and hindsight or a retrospective view of events was not a factor.'

First admission — 9 September

Referral to specialist health services for older persons (Mental Health Service Older Adults (MHSOA) or Older Persons Health Team)

96. On 9 September, Mrs A underwent an interRAI-CA assessment (conducted by NASC assessor Ms D). Mrs A was noted to present well, and she reported that she was able to manage her meals at home. Te Whatu Ora said that prior to the assessment Ms D reviewed Mrs A's clinical notes, which did not identify any concerns around cognition, and that Mrs A had completed a 'hot drink assessment' with the occupational therapist.

97. Further, Te Whatu Ora told HDC that Mrs A's admission on 6 September was for an acute surgical event, which resolved over three days, and that on review of the clinical records,

'there is no indication from any of the health care professionals (medical, nursing or allied health) that a referral to MHSOA was required'. Te Whatu Ora said that the Entry Criteria and Referral Process for MHSOA had not been met, and there was no indication that behavioral and psychological symptoms of dementia were present.

98. RN Scrase advised that the interRAI-CA is not a comprehensive assessment tool but rather an evidence-based tool that highlights areas that may need further assessment, follow-up or support. RN Scrase said that there can be challenges associated with trying to ascertain someone's normal level of function in a hospital environment, but that Mrs A's documented presentation and the concerns raised by her family and friends highlighted that she required further follow-up. RN Scrase advised that it would have been appropriate for Mrs A to be referred to the Older Persons Health Team or the MHSOA service.

99. RN Scrase stated:

> 'Whilst respecting the clinical decision making of those directly involved with this patient's care, the fact remains that she was confused during the course of the admission. In addition, her confusion was documented on the day of discharge and she was aided to her taxi by the watch. All of this indicates to me a significant degree of ongoing cognitive impairment.'

100. I acknowledge Te Whatu Ora's comments in response to the provisional opinion that it is not realistic or achievable to seek specialist inpatient assessment from the Older Persons Health Team when many patients of a similar age will have significant cognitive impairment during their hospital stay. However, in my view there were several concerning factors in this case that warranted consideration of referral to OPH. In particular, the interRAI assessment identified that Mrs A had an Assessment Urgency score of 6/6, and her friend and Mrs B raised significant concerns about Mrs A's ability to manage at home alone. Accordingly, I accept RN Scrase's advice that it would have been appropriate for Te Whatu Ora to have considered a referral to the Older Persons Health Team or MHSOA during Mrs A's first admission to hospital.

Request for home support

101. Following the interRAI-CA assessment on 9 September, Ms D made a referral for funded personal cares to assist with Mrs A's medication management and food oversight. Te Whatu Ora acknowledged that there can be a delay in commencement of long-term services because an initial environmental health and safety assessment needs to be done to confirm the correct level of support.

102. Te Whatu Ora said that the purpose of the POAC service is to provide home supports as soon as possible after discharge while the longer-term supports are put into place. Te Whatu Ora stated that in this case, POAC options were not explored prior to discharge because a discharge date had not been confirmed, and it was not known whether POAC would be required. Te Whatu Ora also noted that usually the short lead time in arranging long-term supports (following referral) is acceptable 'particularly where the patient has informal

supports available to bridge that gap which was the understanding of the team in relation to [Mrs A's] neighbor'.

103. RN Scrase told HDC that it was not unusual for long-term support not to begin immediately on discharge. He advised:

> 'While in some circumstances this may be acceptable, in the case of someone that live[s] alone, had known cognitive impairment, and where concerns were expressed about eating and medication management in particular, an immediate response was required.'

104. RN Scrase considered that any community follow-up should have occurred on the day of discharge, particularly given that there was no inpatient specialist review (by way of referral to the Older Persons Health Team or MHSOA) and in light of the concerns raised by Mrs A's support people. RN Scrase advised that the failure to refer Mrs A for an inpatient specialist review, in conjunction with the failure to make a referral to POAC once the discharge date had been confirmed, represents a severe departure from accepted practice.

105. RN Scrase acknowledged that the ward was a busy and acute setting that would have had many areas of expertise but not specifically that of older people, which is a specialist service in its own right. He said that the challenge is for health professionals to identify the signs that indicate that an individual requires additional input. He advised:

> 'When supporting clinically complex patients the key is not about having all the answers but being aware of all the questions and identifying the appropriate people when you can't answer these questions … [T]here were too many unanswered questions and too many uncertainties about [Mrs A's] level of function at the point of discharge.'

106. I agree. I acknowledge Te Whatu Ora's comments that a referral to POAC was not made as a discharge date had not been confirmed, and that once concerns were raised by Mrs B on 10 September, POAC support was commenced. However, I do not consider that these are mitigating factors. Mrs A was particularly vulnerable in that she had declining cognitive function, lived alone, and relied on support from her friend, who also had dementia. For these reasons, I am also not satisfied with Te Whatu Ora's submission that it is usually acceptable for informal supports (in this case, Mrs A's neighbour and Mrs B) to 'bridge the gap' between discharge and formal supports starting. Accordingly, I am very critical of Te Whatu Ora in this regard.

Decision to discharge

107. Te Whatu Ora told HDC that for older adults who are in a 'convalescent or continuing assessment phase', the hospital environment can present risks, and that many hospitals will 'discharge to assess' in order to mitigate those risks. Te Whatu Ora also said that it was Mrs A's expressed wish to return home, and she was discharged from both the Acute Occupational Therapy service and the NASC service.

108. However, RN Scrase advised:

> '[Mrs A] did appear to present credibly when discharge was discussed with her and … she passed her [occupational therapy] assessment by making a cup of coffee. However, in my professional opinion the evidence based InterRAI assessment and her clinical presentation on the ward on the day of discharge raised enough concerns to clearly show that the discharge process needed to be more robust.'

109. RN Scrase considered the decision to discharge Mrs A on 9 September to represent a severe departure from accepted standards.

110. I agree. I acknowledge Te Whatu Ora's comments that it was Mrs A's expressed wish to return home and that she was discharged from both the Acute Occupational Therapy service and the NASC service. Despite these factors, it was clear that Mrs A's cognitive ability was declining, and her home situation was fragile. I consider that the decision to discharge Mrs A was inappropriate and required further consideration and specialist input.

Second admission — 29 October 2020

Referral to specialist health services for older persons

111. During Mrs A's second admission, despite Mrs A's decline in cognition, Te Whatu Ora did not make a referral to the Older Persons Health Team or to MHSOA. Te Whatu Ora advised that confusion is not a reason for referral to MHSOA, and that most in-patients with delirium and dementia are cared for by General Medicine, as staff hold specialist expertise in the management and treatment of the majority of delirium and dementia cases. Te Whatu Ora also advised that the Entry Criteria and Referral process for MHSOA had not been met.

112. However, RN Scrase advised that referral to MHSOA would have been appropriate on this admission, particularly in light of Mrs A's presentation and the consistent references in the clinical notes to her confusion and disorientation. RN Scrase said that this referral would have been particularly relevant during Mrs A's second admission, as it had been identified by the occupational therapist that it was likely to be Mrs A's final opportunity to live at home on her own. RN Scrase advised that if Mrs A did not meet the criteria for MHSOA referral, then a referral to the Older Persons Health Team would have been entirely appropriate given her clinical presentation.

113. RN Scrase considered that this was a further missed opportunity to have Mrs A reviewed by a specialist service, and that the failure to do so in light of her vulnerability at home and her clinical presentation represented a severe departure from accepted standards.

114. I agree. I acknowledge that a referral was sent to MHSOA on 5 November (following the failed discharge on 29 October) for the purposes of requesting a 'level of care assessment' for dementia, and that this was declined by the service (as a consultation with a specialised psychogeriatrician was not required for this assessment). However, in my view this was a missed opportunity to gain valuable input from a specialty service to aid in the discharge planning for Mrs A, who had been admitted to hospital twice in the space of six weeks when previously she had been unknown to the service. In the case that Mrs A did not meet the

criteria for entry into the MHSOA service, it is my opinion that she should have been referred to the OPH service. I find the failure to do so particularly concerning when coupled with the fact that the decision to discharge Mrs A was made prior to the results of the occupational therapy assessment being known.

Discharge

115. Te Whatu Ora told HDC that it discussed Mrs A's planned discharge with her daughter (EPOA), who indicated that she was happy for Mrs A to return home with an increased package of care. However, as noted above, this was prior to the occupational therapy assessment, which raised significant concerns about Mrs A's cognitive ability and her safety at home. It is also relevant that at the time of these events, Mrs A's daughter was living overseas and may not have been able to judge Mrs A's wellbeing and cognitive ability.

116. Te Whatu Ora advised that in its view, Mrs A's discharge planning involved all of the appropriate services. Te Whatu Ora said that the challenge for the clinical teams working with Mrs A was balancing the responsibility to act in accordance with Mrs A's requests and preferences, 'alongside the identified risks, hence the measures put in place to mitigate those risks'.

117. However, RN Scrase advised that the issues raised in the occupational therapy assessment warranted reconsideration of the discharge plan. He said that the issues with the discharge on 29 October were similar to those identified with the previous discharge, 'except that they were more apparent not least because there was more of a history'.

118. I agree. I am particularly concerned about the decision to discharge Mrs A on 29 October for the following reasons:

- There was a clear decline in cognitive function from her first admission;
- The decision to discharge Mrs A was made prior to the occupational therapy assessment; and
- Mrs A's daughter (her EPOA) was not made aware of the results of the occupational therapy assessment prior to her confirming her agreement for her mother to return home.

Consideration of concerns of whānau

119. RN Scrase advised that informal support is an important and often undervalued aspect when it comes to the support of older adults. He stated:

> 'Carer stress is also an important contributor to vulnerable older adults [no] longer being able to live safely at home. Carer stress is never a judgement on the carers but an acknowledgement of the physical, emotional and mental toll that the role can take on individuals … It therefore follows that when an individual or individuals in this role express concerns as was the case here, it should be listened to and fully considered prior to discharge.'

120. Throughout the clinical documentation there are several references to Mrs A's support people (including her friend, Mrs B, and her daughter) being consulted about her discharge.

121. RN Scrase advised:

> '[I]t would be unreasonable to say that the friends and family were not listened to because the documentation would suggest they were. However, it is my professional opinion that the implications of what they were saying was not fully considered and acted on, otherwise services and supports as mentioned above would in my view have been better instigated.'

122. RN Scrase advised that the failure to consider the concerns of Mrs A's friends and family represents a severe departure from the accepted practice in relation to the first discharge on 9 September, and a moderate departure in relation to the second discharge (owing to the lack of documentation around concerns raised by whānau in relation to this discharge).

123. I accept that Mrs A's support people were contacted and communicated with about the plan for Mrs A's care. However, I also accept RN Scrase's advice that the information supplied by Mrs A's support people (who knew Mrs A and her cognitive baseline) was not acted upon appropriately, or used in a manner that enhanced the care and discharge planning provided to Mrs A.

Input from general practice

124. Te Whatu Ora told HDC that it connects with GPs and other healthcare providers when assessing patients' cognitive state 'as required'. In relation to Mrs A's second admission, Te Whatu Ora advised that as her cognitive state was 'clear', it did not feel the need to obtain additional information from her GP. Te Whatu Ora said: 'If there had been any uncertain[t]y or lack of clarity about her cognitive state, we would have certainly sought information from the GP.'

125. On 19 October 2020, following Mrs A's first admission to hospital, her GP made a referral to Older Person's Health (OPH) because of the deterioration of her Alzheimer's and because she had poor social support. The referral also noted that it had been difficult for Mrs A's daughter to get a clear picture of how her mother was managing. The GP requested copies of any recent Gerontology and/or NASC assessments. On 22 October, the NASC service received a further referral from Mrs A's GP requesting a review of her in-home support. A face-to-face review was booked for 29 October.

126. I also note that the results of the gerontology nurse specialist assessment on 17 September were not made available to Mrs A's GP until 5 November, but that the records had been requested on 22 October. Te Whatu Ora was unable to explain why the assessment was not made available to the GP until this date.

127. In relation to the lack of contact with Mrs A's GP, RN Scrase advised:

> 'In the case of both hospital admissions the single most important source of information that was overlooked was in my view General Practice. In my professional experience

> because of the lack of connectivity in our health systems respective electronic records, it is unlikely that General Practice would have been aware of [Mrs A's] admission unless someone specifically told them and therefore they would have no reason to contact the hospital themselves. In the case of the second admission in particular given that the GP had sent in a referral for review of supports it would be reasonable to assume that they had concerns. In my professional opinion, a discussion with General Practice would have been appropriate and may well have better guided the discharge process on this occasion.'

128. RN Scrase considered this omission to represent a severe departure from accepted standards.

129. I agree. It is evident from the comments from Te Whatu Ora that staff did not contact Mrs A's GP to gather further information about her cognitive function. I consider this a significant oversight given that the GP saw Mrs A in the community/home environment, and therefore may have had valuable information to provide in relation to her baseline cognitive function. I acknowledge Te Whatu Ora's comments that the GP referral of 19 October did not suggest any direct contact with Mrs A by her GP, and that due to the COVID-19 pandemic, primary healthcare providers were limiting face-to-face visits with vulnerable older people (meaning that Mrs A's GP may not have seen her face-to-face for some time). However, I do not consider these to be mitigating factors. Regardless of whether or not Mrs A's GP reviewed her in person prior to the referral being made on 19 October, it is clear that the GP had concerns about Mrs A's cognitive function and ability to care for herself at home (whether through a consultation with her or through feedback from her support people) based on the information before them. This indicates that Mrs A's cognitive state at that time was not 'usual' for her, and as such, her GP should have been consulted by Te Whatu Ora as part of the MDT.

Conclusion

130. As a provider of healthcare services, Te Whatu Ora had a responsibility to provide services to Mrs A that complied with the Code. Under Right 4(2)[18] of the Code, Te Whatu Ora also had a responsibility to provide services that complied with relevant standards.

131. Health and Disability Services Core Standards (NZS 8134.1(b) noted above) provides that '[c]onsumers receive timely services which are planned, coordinated, and delivered in an appropriate manner'. In my view, by failing to ensure that Mrs A had appropriate support in place following her discharge on 9 September, and by failing to refer Mrs A for specialist input prior to both discharges, Te Whatu Ora did not provide timely, planned and coordinated services to Mrs A.

132. Standard 3.10.2, also noted above, stipulates that '[s]ervice providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives'. In my view, Te Whatu Ora failed to identify and plan appropriately

[18] Right 4(2) of the Code states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.'

for the risks associated with Mrs A's discharge on both occasions, for the reasons I have discussed above.

133. In my view, Te Whatu Ora failed to provide services to Mrs A that complied with the Health and Disability Services Core Standards, for the following reasons:

- Te Whatu Ora failed to consider making a referral to a specialist older persons health service during Mrs A's first admission to hospital.
- Te Whatu Ora failed to make a referral to POAC for immediate commencement of cares during Mrs A's first admission, once the discharge date had been confirmed.
- Te Whatu Ora failed to refer Mrs A to a specialist older persons health service during her second admission to hospital given her clear deterioration in cognitive function and that the occupational therapist had identified that it was likely to be Mrs A's last opportunity to live at home on her own.
- The decision to discharge Mrs A home on 29 October in light of her clear decline in cognitive function from her first admission was inappropriate. In addition, the discharge decision was made prior to the occupational therapy assessment, and Mrs A's daughter was not made aware of the results of the assessment.
- The information supplied by Mrs A's support people was not acted on appropriately or used in a manner that enhanced the care and discharge planning.
- During both admissions, Te Whatu Ora failed to contact Mrs A's GP to gather further information about her cognitive function.

134. Cumulatively, I consider that these failings amount to a breach of Right 4(2) of the Code.

135. Right 4(5) of the Code provides that every consumer has the right to co-operation among providers to ensure quality and continuity of services. Mrs A was particularly vulnerable at the point of discharge on both 9 September and 29 October. This is evidenced by her requiring an escort to take her to the taxi on 9 September, and the distressed state in which she returned to her home on the evening of 29 October. I note Te Whatu Ora Waitematā's comments that for older adults who are in a 'convalescent or continuing assessment phase' many hospitals will 'discharge to assess' in order to mitigate the risks associated with the hospital environment. While that may be appropriate in some cases, it is evident that this was not one of them. Mrs A lived alone and was largely supported by her friend who also had dementia. On both occasions, she was discharged home alone via taxi, with no immediate supports in place for her return. In my view, by failing to coordinate services to ensure that Mrs A was discharged home safely on both occasions, Te Whatu Ora Waitematā also breached Right 4(5) of the Code.

Policies and procedures — adverse comment

136. Te Whatu Ora provided HDC with several documents relevant to the care provided to Mrs A, including the Referral to Specialist for Advice and Care Review guideline, and the Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) guideline.

Referral to Specialist for Advice and Care Review guideline

137. Section 3.1 (Complex Needs) of the Referral to Specialist for Advice and Care Review guideline states:

> 'Where patient care needs are complex it is important that there is regular complex case review … Decisions made to seek specialist input [nursing, medical, allied health] are documented and actioned.'

138. However, the guideline does not define 'complex needs'.

139. Section 4.2 (Response to Referrals) outlines how the specialist accepting the referral should communicate with the referrer. However, it does not include a section detailing what should be considered if the referral is declined by the specialist service.

140. RN Scrase advised that 'complexity' can be a combination of a number of factors, including those that are clinical, social or physical in nature. Therefore, he considered that a clear definition of what 'complex' means would be helpful. He advised: 'A clear definition would help reduce subjectivity and ensure a more standardised and equitable approach.'

141. However, Te Whatu Ora advised that to document what constitutes 'complex' across multiple domains would not be possible, and that healthcare professionals are trained to apply judgement when multiple factors (complexity) exist. In response, RN Scrase said that he was referring to complexity of care provision rather than strictly clinical complexity, such as is utilised for the purposes of a Standardised Assessment Tool.

Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA)

142. RN Scrase also advised that clarity in the guidelines around what to do when a referral is declined would be of benefit. He said: 'Guidelines around this important area may have been very helpful during this case given the fact that the MHSOA declined the referral made to them on 5 November 2020.' The Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) outlined the entry criteria for MHSOA referrals, and how the referrals are to be managed between the services (including how to progress them when required).

143. Te Whatu Ora advised that declining a referral is common practice, and that the clinician 'grading' the referral has the opportunity to provide advice to the referrer to assist them in the ongoing care of their patient, and that this should not be restricted or mandated by a policy.

144. In any event, RN Scrase advised that it was his view that this document also did not outline what steps were to be taken when a service declined a referral. He advised:

> '[T]he subsequent process or action needs to be clearer for the user particularly given that they won't necessarily be a specialist themselves … The fact that the presenting concerns do not meet the threshold for MHSOA involvement does not necessarily make the issues any less valid or concerning, and an alternative action or intervention was required.'

145. I agree. However, I note that the document also contains a section titled 'Dispute Resolution', which outlines the steps that could be taken if a referral was declined. It stipulates that there is scope for review of the decision and outlines the process for this.

Conclusion

146. Overall, RN Scrase advised that although the policies and guidelines were adhered to, they could have been more robust for the reasons outlined above. He considers that the shortcomings in the policies represented a moderate departure from the accepted standard of care.

147. I accept RN Scrase's advice, and I agree that the Referral to Specialist for Advice and Care Review guideline could have been enhanced by providing clarity to the meaning of 'complex needs' and that the Entry Criteria and Referral Process — MHSOA could have been improved to support staff when a referral was declined. However, I also note the mitigating factor that the Entry Criteria and Referral Process — MHSOA did contain a section on how to dispute a declined referral. In any event, I consider that some guidance on where staff can turn following a declined referral from MHSOA would be helpful. This is particularly important given that the referrer may not be a specialist.

Changes made

148. Te Whatu Ora Waitematā told HDC that as a result of these events it introduced Winscribe for gerontology nurse specialists in the Health of Older Adults Service. Te Whatu Ora advised that this means that letters can now be dictated soon after the assessment and, once approved, are automatically sent to the GP so that delays in the process are now trackable.

Recommendations

149. I recommend that Te Whatu Ora:

a) Provide a written apology to Mrs A, her whānau, and Mrs B for the failings identified in this report. The apology is to be sent to HDC for forwarding within three weeks of the date of this report.

b) Consider the recommendations set out in RN Scrase's advice, and report back to HDC with the results of its consideration. In particular, Te Whatu Ora is to consider the recommendations that it:

   i. Consider ensuring that patients are referred to OPH or MHSOA when issues around cognition and confusion arise.

ii. Develop a process that identifies when patients should be referred to OPH, to help ensure that referrals rely less on a single person's subjective view.

iii. Ensure that primary care (in particular general practice) have input in the MDT, particularly when assessing someone who is new to the service.

iv. Ensure that staff involved in the discharge process are in regular contact with the community-based services to ensure that the availability of resources is assessed and POAC supports can be arranged if required.

v. Consider family/whānau meetings when issues arise concerning baseline cognitive function and a patient's ability to be discharged home safely.

c) Update the Referral to Specialist for Advice and Care Review guideline to include a definition of 'complex needs', and update the Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) guideline, to include further guidance for staff on how to proceed when a specialist referral has been declined. The updated policies are to be provided to HDC.

150. Te Whatu Ora is to provide HDC with the information requested in recommendations (b) and (c) within three months of the date of this report.

Follow-up actions

151. A copy of this report with details identifying the parties removed, except Te Whatu Ora Waitematā, North Shore Hospital, and the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Richard Scrase:

'Thank you for the request to provide clinical advice regarding the care provided by Waitematā District Health Board to [Mrs A] from September 2020 until October 2020. In preparing the advice on this case, I am not aware of any personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I started my nursing career in 2000 as a Nursing Auxiliary at Torbay Hospital in Devon, UK. After completing my Nursing Diploma, I began working as a Registered Nurse on an acute surgical ward at Torbay Hospital in the UK in 2005. In 2006 I moved to New Zealand and worked at Christchurch Hospital on an acute colorectal and general surgical ward. I transferred to Older Persons Health in 2009 and worked as Registered Nurse on a rehabilitation ward before moving across to the Community Team at Older Persons Health in Christchurch which included working as an RN in a newly formed early supported discharge team as well as completing interRAI assessments and organising and coordinating formal supports for older adults returning to their own homes.

Following this I became a Gerontology Nurse Specialist in 2013 in a role that supported Aged Residential Care Facilities with areas such as clinically complex residents, education, and care planning support. In 2018 I was appointed as Nursing Director Older People — Population Health for Canterbury and West Coast DHBs. This role focuses on supporting nursing in both the Community and Aged Residential Care settings whilst continuing to be direct Line Manager for the Gerontology Nurse Specialist Team. It also involves investigating and reporting on any complaints and concerns raised to the Canterbury DHB and West Coast DHBs about care provided in local Aged Residential Care Facilities. In addition to this I have completed my post graduate diploma in Gerontology Nursing, and I have been an author on five published peer reviewed articles focussing on health-related issues in New Zealand's frail older population. I am currently part of the national group that has been formulating the ARC Covid Response Plan for New Zealand. I am also currently Chair of the HQSC National ARC Leadership Group.

The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] was reasonable in the circumstances and why.

I have specifically been asked to provide comment on:

1. Whether referrals to NASC, Older Persons Mental Health, and the Gerontology nursing team:
   - Were made when indicated.
   - Were prioritised correctly.
   - Were followed up by the respective services within the timeframe expected.

2. During each of [Mrs A's] discharges from hospital (on 9th September 2020 and 29th October 2020) was sufficient discharge planning carried out? Did discharge planning involve input from the services which you would expect?
3. Were concerns about [Mrs A's] cognitive health, raised by her friends and family, followed up and acted upon appropriately?
4. Was communication and co-ordination with community health services consistent with what you would expect as standard practice in organising care for someone with [Mrs A's] clinical presentation?
5. Were cognitive assessments carried out sufficient and consistent with standard practice? Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?
6. Are there any other matters in this case which you think warrant further comment or amount to a departure from the standard of care or accepted practice?

For each question I have been asked to advise:

- The standard of care/accepted practice
- If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?
- How would it be viewed by my peers?
- Recommendations for improvement that may help to prevent a similar occurrence in future.

In preparing this report I have reviewed the clinical notes for the specific admissions, the letters of complaint and the response from the DHB. As required by the Commissioner, I have endeavoured to provide an objective opinion on the questions posed from the documented information made available to me.

When quoting relevant passages from documentation, I will not have quoted every passage relating to a specific issue, but in my professional opinion what I have quoted captures the essence of a specific issue as it appears in the documentation.

In reviewing this case, I have considered the fundamental documents relating to the standards of care throughout to be the Ministry of Health, Health and Disability Services Standards (1) and in particular those relating to the Continuum of Service Delivery (Standard 8134.1.3:2008), which outline that:

"Consumers receive timely services which are planned, coordinated and delivered in an appropriate manner" (2).

Furthermore, with respect to discharge or transfer of care, (Standard 8134.1.3.10) I have carefully considered the specific Service Standard which states that:

"Service providers identify, document and minimise risks associated with each consumer's, transition, exit, discharge or transition including expressed concerns of the consumer and if appropriate, family, whānau of choice or other representatives" (2).

Finally, in reviewing this case I have undertaken to view the events as they unfolded rather than with the benefit of hindsight, because the outcome was not known at the time that decisions were made. This being the case, I have in most cases intentionally investigated matters as two events that occurred one after the other when answering the specific questions that have been put to me.

Background

[Mrs A] was initially admitted to hospital with a UTI on 6th September 2020. During this admission [Mrs A's] family and a friend raised concerns about the consumer's ability to care for herself at home. [Mrs A] underwent a Needs Assessment on 9th September 2020. The Needs Assessor observed her to be well kept and [Mrs A] reported that she was able to manage preparation of her meals. Occupational Therapy and NASC cleared [Mrs A] for discharge.

[Mrs A] was discharged and sent home in a taxi on 9th September 2020. Waitematā DHB comment that this was at [Mrs A's] own insistence. Waitematā DHB comment in their response that [Mrs A] reassured their staff that she had money to pay for the taxi, and staff ensured that the driver knew her address. The family disagree that [Mrs A] was sufficiently capable to be discharged and return home without assistance.

Formal supports were organised to check that [Mrs A] was taking her medications correctly and to check that she was eating meals. This was initially at a frequency of three times daily which were then planned to taper down to twice daily.

[Mrs A] was then admitted to hospital again on 27th October 2020 after a suspected fall. During this admission there were concerns raised about her ability to return home.

[Mrs A] was discharged at 6pm on 29th October 2020. Waitematā DHB comment that appropriate discharge planning was complete and they respond that [Mrs A's] discharge was late in the day as they wanted to ensure that the EPOA (at that stage unactivated) was aware. [Mrs A's] friend reports that [Mrs A] was confused and incoherent when she arrived home. An ambulance was called and she was returned to hospital.

1. Whether referrals to NASC, Older Persons Mental Health, and the Gerontology Nursing team:

- **Were made when indicated.**
- **Were prioritised correctly.**
- **Were followed up by the respective services within the timeframe expected**

<u>Discharge on 9th September 2020</u>

Review of notes

On reviewing the notes, it needs to be acknowledged that I did not have access to any notes or referrals from Primary Care and in particular [Mrs A's] General Practice in relation to any concerns about her decline in cognitive function. I note that [Mrs A] visited her GP the day for a blood test, after her discharge according to the OT notes

written on 10th September 2021, but there is no other documentation available as to any concerns or issues raised during this visit.

The hospital notes highlight that [Mrs A] was confused for the duration of her admission and required a hospital watch (a staff member allocated to monitor and support patients that are confused and may be at risk of falls or wandering). She still required this watch on the day of discharge and indeed the hospital notes state that this watch assisted [Mrs A] to her taxi when she was going home.

The hospital documentation notes that [Mrs A] was able to successfully make a cup of coffee in an OT assessment which is a good indicator of successful problem solving in a new environment. She was also largely independently mobile, could dress and wash herself independently and all the indicators are that [Mrs A] answered questions appropriately and was able to state on several occasions that she could manage well at home. I note also that according to her interRAI-CA assessment on September 9th 2020, [Mrs A] visited the Memory Clinic during her admission although the details of this consultation were not available. However, throughout her admission there was also frequent reference to [Mrs A's] poor short-term memory and confusion.

Although there were many reassuring aspects of [Mrs A's] interRAI-CA, it also highlighted that:

- She was disorientated to month and day.
- Likely required oversight of medication management
- May need encouragement with diet and hydration

When looking specifically at the day of discharge, the clinical notes highlighted the following:

Wednesday 9th September. Nursing notes 06.25 *"Confused. Shared watch present"* Wednesday 9th September 14.52. Nursing notes 14.52.*"Pt wandering around wanting to go home. Pt looks agitated because of waiting for the papers and wanted to go home straight away. Assisted by watch to get taxi home."*

On Wednesday 9th September 2020 [Mrs A] was discharged with long term supports organised by NASC and on the same day a referral was sent to the GNS (Gerontology Nurse Specialist) for follow up at home. This referral included a summary of concerns and specifically medication management. It also stated "*Uncertainty about how she is coping in relation to nutrition, hydration and managing her medications please review this pt and her safety in her own home."*

On Thursday 10th September 2020 there was contact from the neighbour's daughter who was concerned about how [Mrs A] was managing post discharge. POAC commenced (although I haven't seen a role description, my understanding is that this would be an early supported discharge service). OT contacted GNS who advised that they have a 6–8 week waitlist.

Thursday 17th September 2020. Date of "urgent GNS visit" to review [Mrs A] and to include daughter [overseas] by conference call.

What is the standard of care/practice?

Although appropriately used in this instance**,** it is important to understand that the interRAI Contact Assessment (interRAI-CA) is not a comprehensive assessment tool but rather an evidenced based tool that highlights areas that may need further assessment, follow up or support. The interRAI-CA is:

"*A basic screening assessment that provides clinical information to support decision making about the need and urgency for a comprehensive assessment, support and specialised rehabilitation service" (3).*

As a result of utilising the interRAI-CA it may be that a more thorough assessment needed to be completed, in which case the interRAI Homecare (interRAI-HC) tool would be utilised most likely in the individual's home environment. The interRAI-HC is described as:

"A comprehensive clinical assessment that informs and guides the planning of care and services in community based settings"(3).

In my professional opinion, one of the challenges for the Clinical Assessor when using the interRAI-CA in an acute hospital environment is that they are endeavouring to ascertain someone's normal level of function when they are away from their normal environment and given they are in hospital the patient is also likely to be unwell. It therefore requires a degree of critical thinking and interpretation when asking the questions, particularly when the person being assessed may have a degree of cognitive impairment.

That said, my professional view is that the assessment appears thorough and well completed particularly in terms of the additional notes. My concern is with how this information was interpreted and subsequently utilised.

The interRAI-CA completed in September highlighted that [Mrs A] had an Assessment Urgency score of 6/6 and a Service urgency score of 2/4. The interRAI-CA outcomes, her documented presentation and the concerns raised by her informal support highlighted that she required further follow up.

In my professional opinion, [Mrs A's] presentation right up to the point of discharge (given it is documented that she still required a hospital watch and this watch took her to the taxi) warranted a referral to the Older Persons Health team or Older Persons Mental Health (OPMH). The former would have the professional skills and experience to address [Mrs A's] issues but in any event they would have referred onto OPMH if it was felt that specific skill set was needed.

From a clinical perspective, [Mrs A] would have been at high risk of developing a delirium during the course of her hospital admission (4, 5) and either of the aforementioned specialist services would have considered this and completed a delirium screen as appropriate. Regardless of whether [Mrs A] had a delirium or not, the advice may well have been to discharge [Mrs A] home to a familiar environment with the opportunity for further support and assessment if she was clinically well enough to be discharged.

However, regardless of whether [Mrs A] was reviewed by a specialist service, and particularly in view of the concerns highlighted in the assessment and her presentation on the ward the ensuing discharge on the 9th September needed to be done safely and with follow up and support done in a timely manner. 6–8 weeks which was stated as being the GNS waitlist is in my professional opinion too long to wait in order to review someone after discharge from hospital in the circumstances described.

It did not surprise me that the long-term supports were documented as being likely to take 2–3 days before they started. The reason for this is likely to be a matter of resources and planning for the services involved. While in some circumstances this may be acceptable, in the case of someone that lived alone, had known cognitive impairment, and where concerns were expressed about eating and medication management in particular, an immediate response was required. It is therefore my professional opinion that any community follow up should have occurred on the day of discharge by utilising the POAC service and that the Gerontology Nurse Specialist service was utilised within a couple of days of discharge particularly given there was no inpatient specialist review. Given the concerns raised by the family and other informal support, this responsive approach would have been significantly more proactive than was the case and would have been more in line with the Disability Standards requirements mentioned in my introduction.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

In considering this question with respect to the first admission and discharge from hospital, I have again looked at it from the perspective of "at the time the events occurred". When considered against the requirements of the relevant Service Standards, I consider there to have been a severe departure from accepted practice in terms of the timing of any referrals to additional services and supports, and their subsequent follow up.

How would it be viewed by my peers?

I acknowledge that my professional view is based on that of someone whose area of expertise is Older Persons Health and that I am very familiar with the service from both an inpatient and community perspective. The ward in question was a busy acute setting that would have had many areas of expertise but not specifically that of the older person which is a specialist service in its own right. However, the same applies to other specialist services such as cardiology and the challenge is for health professionals to

identify the signs that indicate that an individual requires additional input. When supporting clinically complex patients the key is not about having all the answers but being aware of all the questions and identifying the appropriate people when you can't answer these questions. Ultimately it is my view that there were too many unanswered questions and too many uncertainties about [Mrs A's] level of function at the point of discharge and this is what concerned me.

Discharge on 29th October 2020

Review of notes

22nd October 2020. NASC referral received from GP requesting review of supports. Face to face review planned for 29th October 2020.

27th October 2020. Admitted following what was believed to have been an unwitnessed fall at home.

28th October 2020. 11.06 Post-acute ward round. *"Concerns around coping at home with cognitive decline". "Needs significant MDT input (EPOA [overseas], dementia, closest friend has dementia, falling and not remembering this."*

28th October 2020. 11.40. Nursing notes. *"Patient is getting more unsettled. Was trying to find way out to home every now and then".*

28th October 2020. 16.33. Behaviour of Concern Speciality Service input. Recommended 15/60 checks overnight and 1:1 watch in morning. To keep ward doors locked.

28th October 2020. 21.38 Nursing Notes "*PRN lorazepam given as pt got agitated*".

29th October 2020. 05.46. Nursing notes "*Confused ++"*

29th October 2020. 14.23. Nursing notes. "*Nil behavioural issues noted."*

29th October 2020. 16.11. Doctors Note. "*Discussed with daughter [overseas]. Does not have concerns with pt being discharged with current package of care"*. 29th October 2020 16.20 OT assessment. Kitchen assessment *"unable to make cup of tea".* Recommendations/Plan. "*Refrain from going out on roads independently, driving to be assessed. Disconnect Oven. Recommend increasing current POC to 3x daily supports due to impaired cognition +++ Aware that pt is discharging tonight. POC tonight. Anticipate this is the final stint of pt managing at home on her own due to deteriorating cognition and increasing need for support."*

29th October 2020 21.13 (late entry). "*d/c papers on hand. Informed friend" "Taxi chit given and taxi booked, d/c with papers."*

What is the standard of care/practice?

In my professional opinion, one of the most important aspects of supporting the frail older adult particularly when they live alone is IDT input. This brings a multidisciplinary

approach with differing areas of expertise allowing for better opportunities for a successful discharge. The importance of this was highlighted by the statement that was made on the post take ward round on the 28th October 2020 when it was identified that [Mrs A] would require significant MDT input. Although there was clear evidence that [Mrs A] was reviewed by the Behaviour of Concern Speciality Service and there was also an OT assessment, the latter appears to have occurred after it had already been decided that [Mrs A] was being discharged as indicated by the OT note 29th October 2020 16.20 above. Again, referring to the specific Service Standards concerning Continuum of Service Delivery, it is not clear to what extent this assessment was considered as part of the discharge process given that [Mrs A] was identified as not being able to make a cup of tea, which was very different to her first admission.

Throughout this second admission there was frequent reference to [Mrs A's] cognitive score from 2019 being 22/30. As previously mentioned, I can appreciate that it may not be appropriate to undertake a cognitive assessment, and, in many respects, it had already been established that [Mrs A] was very confused, so it might be argued that a cognitive test would add little new information. However, it would in my professional view have been appropriate to contact the GP who is an important and frequently forgotten part of the IDT in the broadest sense of the term. They may have also completed a cognitive assessment in their home environment which, if this was the case would have been very useful as a new baseline. Therefore, robust involvement of the IDT and a preparedness to alter plans based on their assessment outcomes is an important aspect of successful discharge planning.

In terms of referrals to specific services, it would appear from the documentation that there were no referrals to Older Persons Health or Older Persons Mental Health. In my professional opinion, referral to either of these services would have been appropriate given [Mrs A's] presentation during this admission. This referral is particularly relevant in my view because of the clearly identified fact that this was likely to be [Mrs A's] final opportunity to live at home on her own. It would therefore be reasonable to ensure that the discharge was as robust as possible and this specialist input would have aided this.

It would appear that [Mrs A] was referred to the GNS service for further follow up following the GP request on 22nd October. The proposed date of the visit on 29th October, which didn't occur because of the hospital admission would appear a reasonable time frame given the information known at the time of the referral.

The clinical notes also identify that supports were increased to 3 times a day from the day of discharge. However, given the documented challenges in terms of providing adequate supports in a timely and regular fashion following the previous discharge it was surprising that the POAC service were not involved.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

Although there were referrals made to support services at the point of discharge and immediately prior to admission, there was no referral made to Older Persons Health or Older Persons Mental Health during this admission. Given [Mrs A's] well documented vulnerability at home and her clinical presentation I consider this to have been a severe departure from accepted practice.

How would it be viewed by my peers?

I acknowledge that my peers would consider that there was frequent reference to discussing the discharge with the EPOA which at that time was inactivated. The clinical notes indicate that they were comfortable with the discharge process although the letter of complaint has a different perspective on this. However, it would still be my professional opinion that while as health professionals we must consult the EPOA and other primary supports and closely consider their views and preferences particularly if a safe discharge depended on them, we must also use clinical judgement, assessment skills and professional experience to guide the discussion appropriately to best support the patient and these primary informal supports. My peers may also consider that this patient was considered to have mental capacity at the time of discharge by virtue of the fact that the EPOA had not been activated. However, it is my professional opinion that a referral to a specialist service such as OPMH may well have put a different perspective on this.

Recommendations for improvement that may help to prevent a similar occurrence in future.

- Ensuring that patients are referred to OPH or OPMH or the delirium service if there is one when issues around cognition and confusion arise.
- Develop a process that identifies when patients should be referred to OPH service. There will always be a significant element of clinical judgement but this may help ensure that it relies less on a single person's subjective view.
- Ensure that Primary Care and in particular the GP are involved in the discussion particularly when assessing someone that is new to the service as was the case here with respect to the first admission.
- Ensure that there is an environment where discharges can be discussed, and concerns raised. This doesn't necessarily have to be an IDT but staff need to have the opportunity to safely raise potential risks. There is no evidence to suggest any obvious concerns in this regard, but I am aware from my own experiences that in a busy ward environment where patient flow is imperative there can be a risk that flow could take precedent over robust discharge planning.
- In hindsight, it would appear that there was an unrealistic expectation as to time scales with respect to the GNS service in particular but also what the community teams were able to offer in terms of the number of visits each day. Therefore, it may be helpful for there to be closer communication on a regular basis between the acute hospital system and the community services so that expectations can be better matched with available resources.

2. During each of [Mrs A's] discharges from hospital (on 9th September 2020 and 29th October 2020) was sufficient discharge planning carried out? Did discharge planning involve input from the services which you would expect?

Discharge on 9th September 2020

What is the standard of care/practice?

The summary of notes and issues highlighted above have in my professional opinion clearly identified most of the issues here and that there was a significant lack of discharge planning as required under the Health and Disability Service Standards referred to in the introduction.

It is clear from the documentation that the team discussed concerns with family and friends. The documentation also highlighted that the neighbour was herself elderly and had a diagnosis of dementia and that a lot of the support came from the neighbour's daughter. In my professional opinion, this indicates a very fragile home situation particularly as [Mrs A] was living alone.

It is clear that there are differing views on the degree of comfort that friends had with the discharge home on the 9th September 2020. However, I will put the differing views aside and view this objectively from what was clearly known at the time as identified in the documentation supplied. [Mrs A] had a diagnosis of dementia, she was confused at the point of discharge, she lived alone, she went home alone in a taxi. [Mrs A] did appear to present credibly when discharge was discussed with her and that she passed her OT assessment by making a cup of coffee. However, in my professional opinion the evidence based interRAI assessment and her clinical presentation on the ward on the day of discharge raised enough concerns to clearly show that the discharge process needed to be more robust.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

In view of the concerns outlined above, I consider there to have been a severe departure from accepted practice with respect to discharge planning. This failing in terms of discharge planning was in my professional view the key issue throughout when reviewing this case.

How would it be viewed by my peers?

I accept that there may be a view that [Mrs A] was relatively unknown to the hospital system at least in terms of home supports and services and that she presented as credible when discussing discharge on September 9th 2020. However, like anyone, the fact that there is limited history doesn't mean that their problems are less concerning than someone for whom more history is immediately available and has lots of supports already in place.

Discharge on 29th October 2020

What is the standard of care/practice?

In my view the issues with respect to the discharge planning were similar to those that I identified for the first discharge except that they were more apparent not least because there was more of a history. In many respects it was my opinion the elements of good discharge planning were there, but they weren't connected, or they weren't fully considered. This connectivity and consideration are fundamentally important in good practice, otherwise assessments are at risk of becoming part of a process rather than an invaluable tool in decision making and clinical risk assessment. However, given the resource limitations that were already identified with respect to the community providers and the GNS service, a referral to the Older Persons Health or Older persons mental health would have been entirely appropriate and in my view necessary. In my professional opinion this was the key aspect of the planning that was missing with respect to this second discharge and it would be reasonable to expect this input for someone of this age and clinical presentation.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

I consider there to have been a severe departure from accepted practice with respect to discharge planning for the second discharge from hospital.

How would it be viewed by my peers?

In my professional opinion, my peers would agree with the views outlined above.

Recommendations for improvement that may help to prevent a similar occurrence in future. Recommendations would be as outlined above for question 1.

3. Were concerns about [Mrs A's] cognitive health, raised by her friends and family, followed up and acted upon appropriately?

Discharge on 9th September 2020.

What is the standard of care/practice?

In my professional opinion, informal support is an important and often under valued aspect when it comes to the support of older adults at home particularly when they have a diagnosis of dementia. Carer stress is also an important contributor to vulnerable older adults no longer being able to live safely at home. Carer stress is never a judgement on the carers but an acknowledgment of the physical, emotional and mental toll that the role can take on individuals in this role. It therefore follows that when an individual or individuals in this role express concerns as was the case here, it should be listened to and fully considered prior to discharge. Again, this is in line with the Health and Disability Service Standards relating to discharge planning and family/whānau involvement. (2) There would not be an expectation that the concerns raised by friends and family be listened to without considering other aspects of the admission, her presentation and other assessments, as well as of course the wishes of the patient

themselves. However, there would in my professional opinion be an expectation that these views be considered alongside other evidence that would be cause for concern particularly when the individual lives alone as was the case here. At the end of the day though, the family and friends knew [Mrs A] better than anyone else in her care and therefore their views were invaluable.

As already mentioned, as is often the case with dementia and indeed delirium there were some inconstancies in terms of [Mrs A's] level of function. So while on the one hand [Mrs A] could make a hot drink and was walking her dogs twice a day when at home and apparently wanted to continue driving her car, on the other hand she required medication management, she was according to her interRAi-CA assessment, *"phoning her neighbour several times at night often for the same thing",* and the same assessment documented a decline in decision making in the last 90 days and as having "*very poor short term memory*". Also, as previously mentioned the clinical notes state that she required a hospital watch for the duration of her admission. This is important as it indicates concerns about clinical safety and risk to the patient.

In my professional opinion, it would be unreasonable to say that the friends and family were not listened to because the documentation would suggest they were. However, it is my professional opinion that the implications of what they were saying was not fully considered and acted on, otherwise services and supports as mentioned above would in my view have been better instigated.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

In view of the concerns outlined above, I consider there to have been a severe departure from accepted practice with respect to discharge planning.

How would it be viewed by my peers?

My peers would rightly state that it would both be correct and reasonable to consider the views of the patient in this matter, and the evidence would certainly suggest this was the case here. This is an important consideration particularly when the individual was seen as having mental capacity (although a referral to OPH may have found otherwise). To an extent, people are allowed to make what others might consider poor choices and furthermore, having reduced mental capacity is not the same as having no mental capacity. However, given the documented evidence it is my view that my peers would be of the opinion that greater consideration should have been given to the concerns raised by family and friends as primary informal supports in this case.

Discharge on 29th October 2020.

Review of notes

28th October 2020 16.33 *"sister reports that [Mrs A's] memory has significantly declined and that she has significant concerns about her managing at home".*

29th October 2020 15.07. *"Discussed with daughter [overseas]. Does not have concerns with patient being discharged with current package of care."*

What is the standard of care/practice?

As discussed with respect to the first admission, consideration of the concerns of friends and informal supports is important particularly when it is known that someone is vulnerable and is living alone.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

The documented evidence of discussion around this is limited. However, as well as having the history of the concerns raised during the previous relatively recent admission the concerns raised by the sister would have been consistent with [Mrs A's] clinical presentation at the time of her admission. In my professional opinion the presenting areas of concern were clear at the time and required further assessment as an inpatient as mentioned above. However, in answering this specific question for this specific admission, because the documented evidence of concerns raised by family was limited I consider that there was a moderate departure from accepted practice for this specific admission.

How would it be viewed by my peers?

It is my view that the view of my peers would be in line with those I have outlined for the first admission.

Recommendations for improvement that may help to prevent a similar occurrence in future

In the event that there are two conflicting opinions on a family member's cognitive function it is important to reach an understanding as to why this might be. A family meeting by Zoom may have been very beneficial in the case of both admissions in order to reach consensus and a shared understanding.

4. Was communication and co-ordination with community health services consistent with what you would expect as standard practice in organising care for someone with [Mrs A's] clinical presentation?

Review of notes

Review of the documentation submitted highlighted that there was communication with community health services with respect to both hospital admissions. In the case of the first admission a referral was sent to the GNS team with what I would consider a reasonable degree of detail. In the case of the first admission, the POAC team were referred to after the informal support had contacted the ward after discharge and had expressed her concerns. At the point of discharge during the second hospital admission [Mrs A] was discharged home with an increased package of care.

What is the standard of care/practice?

As previously identified though the issue was really concerning the timeliness of follow up and to an extent the degree to which [Mrs A's] issues were fully communicated. In particular I refer to the referral to the GNS which identified that she was to get medication supervision but it appeared to be acknowledged in the notes that this wasn't going to start for about 3 days. Given that it had been decided that [Mrs A] would be going home and that it was known she lived alone, the most important aspect of any community coordination would have been to involve the POAC team and this didn't happen until concerns were raised by the family friend after discharge.

In terms of the second hospital admission, there was again documented communication with the community provider that was delivering supports whereby there was to be an increase in the package of care. However, it is my view that this didn't really address the issues at hand namely that [Mrs A's] cognitive state would appear to have declined between admissions as indicated by the fact that in the first admission she could make a hot drink and in the second she couldn't during the OT assessments.

In the case of both hospital admissions the single most important source of information that was overlooked was in my view General Practice. In my professional experience because of the lack of connectivity in our health systems respective electronic records, it is unlikely that General Practice would have been aware of [Mrs A's] admission unless someone specifically told them and therefore they would have no reason to contact the hospital themselves. In the case of the second admission in particular given that the GP had sent in a referral for review of supports it would be reasonable to assume that they had concerns. In my professional opinion, a discussion with General Practice would have been appropriate and may well have better guided the discharge process on this occasion.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

Again, I believe that there has been a severe departure from accepted practice in respect of this specific concern.

How would it be viewed by my peers?

I believe that my peers would be in agreement with this view.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I believe that as mentioned above, more regular contact with General Practice should be considered when supporting frail older adults as inpatients.

5. Were cognitive assessments carried out sufficient and consistent with standard practice? Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?

Review of notes

During the course of both admissions, the clinical notes make frequent reference to a MOCA score of 22/30. In addition there were numerous references to [Mrs A] being confused, wandering and showing behaviours consistent with significant cognitive impairment either as a result of dementia or a delirium. During the course of her second admission there was evidence that [Mrs A's] cognitive function had declined as evidenced by her inability to successfully make a hot drink independently.

What is the standard of care/practice?

The Montreal Cognitive Assessment is a well established cognitive assessment tool (6) and a score of 22 would be interpreted as indicating mild cognitive impairment. The MOCA tool states that:

In MCI, there is some memory or other cognitive impairment. However, it is mild and does not significantly impair social or occupational functioning i.e., activities of daily living are preserved and complex functions are intact or only minimally impaired.

However, as always, a degree of clinical judgement is required and furthermore this test was documented as having been completed in 2019, approximately a year prior to these admissions.

Were cognitive assessments carried out sufficient and consistent with standard practice?

An acute hospital setting is not always the most appropriate place to carry out a cognitive assessment particularly on someone that already has a degree of cognitive impairment. Furthermore, the individual may have a delirium which would clearly impact on the MOCA score. Importantly though, an Older Persons Health or Older Persons Mental Health review could have determined the value of such an assessment at a given time. If it wasn't appropriate in an inpatient setting then a planned cognitive test once home would have been extremely useful in determining the degree if any of [Mrs A's] cognitive decline not least when compared with the one that was completed in 2019. The detail of this test rather than just the final score of 22/30 would also have been helpful in indicating specific areas of decline. However, for a cognitive assessment to be completed in the home environment it required timely follow up by the appropriate services, which did not occur in this instance.

Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?

The clinical signs and assessment outcomes outlined previously strongly suggest to me that an opportunity was missed. The opportunity was not so much to identify that [Mrs A's] dementia had progressed because we don't know that at this stage, but rather the opportunity was missed to get her reviewed by a specialist service such as Older Persons Health. It is the assessment from a specialised service that was missing particularly given

that [Mrs A] was documented as being confused at the point of discharge on both occasions. The review by OPH or OPMH may have determined that [Mrs A] would be best served returning home with appropriate supports and an assessment completed in her own environment. However, they may also have recommended that she be transferred to a rehab ward for further assessment.

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do I consider this to be?

In view of the fact that [Mrs A] was still requiring a hospital watch at the point of departure, and her ongoing clinical presentation, I consider there to have been a severe departure from accepted practice.

How would it be viewed by my peers?

Given our Ageing in Place policy it could be argued that there are a significant number of older adults living at home with significant cognitive impairment and that at the time the events occurred it might be reasonable to assume that [Mrs A] would equally be able to manage once home. However, it is my firm belief that her clinical presentation, the fragile informal home supports and the fact that [Mrs A] lived alone warranted further assessment as an inpatient by a specialist service.

Recommendations for improvement that may help to prevent a similar occurrence in future

Recommendations are really to focus on robust discharge planning and to have a greater awareness of when to refer to OPMH or OPH for specialist advice.

6. Are there any other matters in this case which you think warrant further comment or amount to a departure from the standard of care or accepted practice?

I do not consider there to be any other matters in this case which warrant comment on my part.

References

1.Ministry of Health. 2008, *Health and Disability Services (General) Standards NZS 8134.0:2008*, Wellington, MOH

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3. interRAI.NZ. Retrieved from. https://www.interrai.co.nz/about/interrai-assessments-in-new-zealand/

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5. HQSC, Frailty Care Guides, Delirium. Retrieved from: https://www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Delirium_.pdf

6. Montreal Cognitive Assessment (MOCA). Retrieved from: https://www.nzgp-webdirectory.co.nz/site/nzgp-webdirectory2/files/pdfs/MoCA-Test-English_7_1.pdf

Richard Scrase RN. 23rd August 2021'

The further following advice was obtained from RN Scrase:

'Thank you for the opportunity to review this case, particularly in view of the significant further information and documentation provided by Te Whatu Ora — Waitematā, previously known as Waitematā DHB at the time the initial concern was raised.

As was the case with my initial report, I have followed the HDC guidelines, and I have considered matters based on the documentation provided to me. In addition, I have examined events with a focus on the action rather than the outcome as there may be poor actions by health professionals that still result in a good outcome for the patient but also conversely, excellent actions by clinicians and staff that unfortunately result in a poor outcome for the patient. In addition, I have reviewed documentation objectively, at the time they occur rather than considering them with the benefit of hindsight.

When considering all the questions raised by the Commissioner, context is of course important, and many older adults with cognitive impairment or a significant diagnosis of dementia remain living safely at home. However, it is the supports, both formal and informal, and the planning, coordination and review around these supports that improves the likelihood of a successful outcome for this potentially vulnerable cohort. An important consideration in this case was that this individual lived alone, and although she had two daughters, they both lived abroad. In addition, she had a supportive friend and neighbour, but my understanding is that this person had a diagnosis of dementia and was finding her supportive role challenging. This is all information I identified from the documentation provided by Te Whatu Ora — Waitematā.

The Commissioner requested that I review the information provided by Te Whatu Ora Waitematā and consider whether this information caused me to amend my previous advice. As was the case with my initial advice, the specific questions I have considered were:

1. Whether referrals to NASC, Older Persons Mental Health, and the Gerontology nursing team:
    - Were made when indicated.
    - Were prioritised correctly.
    - Were followed up by the respective services within the timeframe expected.

2. During each of [Mrs A's] discharges from hospital (on 9th September 2020 and 29th October 2020) was sufficient discharge planning carried out? Did discharge planning involve input from the services which you would expect?

3. Were concerns about [Mrs A's] cognitive health, raised by her friends and family, followed up and acted upon appropriately?

4. Was communication and co-ordination with community health services consistent with what you would expect as standard practice in organising care for someone with [Mrs A's] clinical presentation?

5. Were cognitive assessments carried out sufficient and consistent with standard practice? Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?

In addition, I was asked to consider the adequacy of the policies and guidelines in place at Te Whatu Ora — Waitematā at the time of these events, and whether they were adhered to in this instance.

Review of initial report and new documentation

1. Whether referrals to NASC, Older Persons Mental Health, and the Gerontology nursing team:

- **Were made when indicated.**
- **Were prioritised correctly.**
- **Were followed up by the respective services within the timeframe expected.**

This patient had two admissions to hospital during the period under investigation. The first admission was on 6 September 2020 with discharge on 9 September 2020. The second admission was on 27 October 2020 with discharge on 29 October 2020.

The response from Te Whatu Ora — Waitematā provides information that confirms that a referral to MHSOA was made on 4th November 2020, initially to Liaison Psychiatry which was then forwarded to MHSOA. However, they declined the referral on the basis that it did not meet the entry criteria. However, no referral appears to have been made to MHSOA during the course of her hospital admissions although as stated in my initial report there appeared to be a number of flags that indicated that this would have been appropriate.

In Te Whatu Ora — Waitematā's letter dated 9th February 2023, I note the comment that there was no indication during the first admission that a referral to MHSOA was required. Whilst respecting the clinical decision making of those directly involved with this patient's care, the fact remains that she was confused during the course of the admission. In addition, her confusion was documented on the day of discharge and she was aided to her taxi by the watch. All of this indicates to me a significant degree of ongoing cognitive impairment. This may have resolved by returning home (which I also note the patient wanted to do) but even with family and friends being able to support during parts of the day, professional support was in my view required sooner than was initially planned. A period of 48 hours without supervision holds significant risk if

medication supervision is required in a home environment even with the use of blister packs.

The response from Te Whatu Ora — Waitematā clarified the time frame regarding the Gerontology Nurse Specialist (GNS) referral and subsequent follow up. The assessment which was in my view thorough and well considered took place on 17th September 2020, but the documented findings were not available to other clinicians including the GP until 5th November 2020. The reasons for this were unclear but earlier communication with the GP may have been helpful given the circumstances and identified clinical vulnerability of the patient.

I noted from Te Whatu Ora — Waitematā's letter dated 9th February 2023, that following the first discharge on 9th September 2020, the patient was referred for services under Long Term Community Supports. As is common with these services, they did not start immediately and after concerns were raised by a friend or family member, the Primary Options Acute Care (POAC) service received a referral on 10th September 2020. They began services on 11th September 2020, which was two days following discharge from hospital.

The issue of competence and the right to decline services was raised in the letter of response to the family dated 28th September 2020. However, an individual can remain competent and still be clinically vulnerable and consequently the appropriate services still need to be offered or offered in a manner that may be acceptable to the client in question. At the point of the first discharge in September 202, this did not occur with respect to the POAC service.

In reviewing this case again given the further documentation provided, my opinion is that what was missing and what could reasonably be expected at the time the events occurred were:

a) A referral to MHSOA, given the patient's presentation immediately prior to discharge and during both admissions.

b) A referral to POAC once a discharge date had been confirmed for the first discharge in order that services could be set up knowing the patient's vulnerability and the fact that long term supports would take several days to start.

I acknowledge that reasonable actions were taken by the services and individuals involved to provide appropriate supports once concerns had been highlighted. However, that is not the question I was asked, and planned pre-emptive involvement of services mentioned above may well have eliminated the need for this firefighting. As a result, I stand by my original finding that there has been a severe departure from accepted practice.

2. During each of [Mrs A's] discharges from hospital (on 9th September 2020 and 29th October 2020) was sufficient discharge planning carried out? Did discharge planning involve input from the services which you would expect?

In my initial report, I expressed concerns about what I saw as poor discharge planning for someone that was identified as having cognitive loss and for whom family and friends had expressed documented concerns. I concluded that there had been a severe departure from accepted practice with respect to both the discharge on the 9th September 2020 and 29th October 2020.

I have covered a significant part of this question in reviewing the previous query. I acknowledge the new documentation sent by Te Whatu Ora — Waitematā including the letters sent to the family dated 28th September 2020 and 30th November 2020. I also note that discussion was had with a daughter [overseas] just prior to the discharge on 29th October 2020 and that it would appear that she did not have concerns about her mother being discharged with the current package of care. However, this conversation was prior to the OT assessment the same afternoon (29th October 2020, 16.20) which stated:

"Unable to make cup of tea". Recommendations/Plan. "*Refrain from going out on roads independently, driving to be assessed. Disconnect Oven. Recommend increasing current POC to 3x daily supports due to impaired cognition +++ Aware that pt is discharging tonight. POC tonight. Anticipate this is the final stint of pt managing at home on her own due to deteriorating cognition and increasing need for support".*

This patient was discharged home after this assessment was completed. In my professional view the points raised in this assessment warranted reconsideration of the discharge plan. From the documentation that I have available, this does not appear to have occurred.

There were in my view other red flags which were identified in my initial report particularly around this patient's cognition which I do not think were fully considered when planning her discharge. I therefore remain of the view that there has been a serious departure from accepted practice with respect to the discharge process.

3. Were concerns about [Mrs A's] cognitive health, raised by her friends and family, followed up and acted upon appropriately?

I have reviewed this question both with respect to the original documentation and that which has since been provided. In my original report I stated that:

"In my professional opinion, it would be unreasonable to say that the friends and family were not listened to because the documentation would suggest they were. However, it is my professional opinion that the implications of what they were saying was not fully considered and acted on otherwise services and supports as mentioned above would in my view have been better instigated".

However, the team did talk and listen to the daughter prior to the second discharge when she appeared comfortable with her mother going home, but they didn't follow up on the OT review that occurred after this.

Viewing this matter in its entirety, the views and feedback from family and other informal supports are an important part of the discharge process which was in itself deficient. It is not just about listening to family concerns but about acting appropriately. I stand by my initial finding with respect to this question.

4. Was communication and co-ordination with community health services consistent with what you would expect as standard practice in organising care for someone with [Mrs A's] clinical presentation?

The concern for me here was that someone with identified and documented cognitive issues was being discharged home with formal supports that in the case of the first discharge, were not going to commence for several days. Direct verbal communication with the General Practice would, in my view have been a reasonable expectation. This may have occurred, but I was unable to find any documentation confirming this. The referral to the GNS service was reasonable and well executed albeit that a letter to the GP does not appear to have been available for reading by them for approximately two weeks, (17th September–5th November). However, having identified a concern and knowing the time frame before this service could visit, there needed to be some other services going in at the point of discharge. At the time of the first discharge in particular, this did not occur until concerns were raised by friends or family members at which point the POAC service was initiated. I therefore consider that my initial finding of a severe departure from accepted practice remains appropriate.

5. Were cognitive assessments carried out sufficient and consistent with standard practice? Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?

When reviewing documentation for my initial report, I did not have access to the GNS assessment which took place on 17th September 2020. The GNS completed an Addenbrookes Cognitive Assessment in which the patient scored 58/100, with the greatest deficit being in short term memory. As stated in my initial report, an inpatient setting is often not the best location in which to undertake a cognitive assessment, because of unfamiliar environment, disorientation, a possible delirium and of course the fact that people are generally unwell when in hospital. That said, although a cognitive assessment during a hospital admission may not give a true reflection of that individual's baseline it would be an opportunity to formally assess that person's level of understanding, problem solving and any confusion at that moment in time. This would then add useful information when considering the discharge process, and if the person improves rapidly once in a familiar environment, then any supports can be tapered down accordingly.

I remain of the view that there was a severe departure from accepted practice.

Do you consider that an opportunity was missed to identify that [Mrs A's] dementia had progressed, or that she required a higher level of support than her admission of 29th October 2020?

I raised some of the key documented events in my initial report. However, for clarity I think it is useful to revisit these concerns about this patient coping at home and her documented cognitive decline during her second hospital admission.

28th October 2020. 11.06 Post acute ward round. *"Concerns around coping at home with cognitive decline. Needs significant MDT input. EPOA [overseas], dementia, closest friend has dementia, falling and not remembering this".*

28th October 2020. 11.40 Nursing notes. *"Patient is getting more unsettled. Was trying to find way out to home every now and then".*

28th October 2020 16.33. Behaviour of Concern Specialist Service input. Recommended 15 minutes checks overnight and a one-to-one watch in the morning and to keep ward doors locked.

28th October 2020 21.38. Lorazepam given for agitation.

29th October 2020. 05.46 Nursing notes. *"Confusion ++"*

29th October 2020 16.20 OT assessment during which patient was unable to make a cup of tea. Advice was to disconnect oven and to refrain from driving independently. It could have been challenging to implement both of these recommendations given the patient lived alone.

29th October 2020 Patient discharge home after OT assessment with increased package of care.

I acknowledge that there was documented evidence of this patient being settled on the morning of the 29th October and that a conversation was had with a daughter [overseas] who is documented as having no concerns about discharge under the current package of care. However, given she lived alone and given the points raised above concerning her confusion (which may fluctuate) and her inability to make a hot drink would in my view be reasonable grounds to at least delay discharge and do a more comprehensive review of this patient's cognition and ability to remain living safely at home. Clarity around her safety at night when I understand she would have been alone would have been beneficial. In view of this I consider that there was a severe departure from expected practice.

6. The adequacy of the policies and guidelines in place at Te Whatu Ora — Waitematā at the time of these events, and whether they were adhered to in this instance.

I am grateful to Te Whatu Ora Waitematā for sending a number of brochures and policies and procedures which are pertinent to this case, including the Escalation of

Concern Pathway, NASC Trifold Brochure, and Operational Interface Guideline for Te Whatu Ora — Waitematā.

Two key documents were the Referral to specialist for Advice and Care Review, and the Entry Criteria for MHSOA.

While reviewing the document, Referral to Specialist for Advice and Care Review, my view was that a clear definition of what "complex" means would be helpful as this term can be interpreted in several different ways. Complexity can be a combination of a number of factors including those clinical, social or physical in nature. Therefore, a clear definition would help reduce subjectivity and ensure a more standardised and equitable approach. In addition, clarity in this document on what happens if a referral is declined would be beneficial. Guidelines around this important area may have been very helpful during this case given the fact the MHSOA declined the referral made to them on 5 November 2020.

The document titled, Entry Criteria and Referral Process — Mental Health Services for Older Adults (MHSOA) was also of importance in this case. The process in this document was in my view reasonable, and it was made clear that a diagnosis of dementia was not in itself a reason for them to accept a referral from another service. However, as with the previous document, if it is considered that a patient requires specialist input, but that service disagree and declines, the subsequent process or action needs to be clearer for the user particularly given that they won't necessarily be a specialist themselves. The fact that the presenting concerns do not meet the threshold for MHSOA involvement does not necessarily make the issues any less valid or concerning, and an alternative action or intervention was required.

In terms of accepted practice, it is important that all policies and procedures are not only up to date and in line with current guidelines and best practice, but also accessible to all appropriate staff members so that staff know where to locate them.

My view is that policies and guidelines were adhered to but that they could have been stronger for the reasons given above. I therefore consider there to have been a moderate departure from accepted practice and I believe that my peers would hold the same view.

This concludes my review of this case, but please contact me if you require any further information or clarification.

Richard Scrase
Registered Nurse

21 March 2023'

The following further advice was received from RN Scrase on 19 May 2023:

> 'Thank you for giving me the opportunity to review the response letter from Te Whatu Ora — Waitematā dated 5 May 2023 relating to this case. While considering the points raised in this response, I have reread my initial report and findings dated 23rd August 2021, in addition to the follow up report dated 21 March 2023, as well as relevant clinical documentation initially sent to the Commissioner by Te Whatu Ora — Waitematā.
>
> In this report I have responded to specific points raised by Te Whatu Ora — Waitematā rather than revisiting each question in detail again.
>
> - *Te Whatu Ora — Waitematā's position that no referral to Older Persons Mental Health Services (MHSOA) was completed because the individual didn't meet the criteria.*
>
> I acknowledge that I wasn't entirely clear in my response dated 21 March 2023. However, I stated in my initial investigation dated 23rd August 2021 that:
>
> *"In my professional opinion, [Mrs A's] presentation right up to the point of discharge (given it is documented that she still required a hospital watch and this watch took her to the taxi) warranted a referral to the Older Persons Health team or Older Persons Mental Health (OPMH). The former would have the professional skills and experience to address [Mrs A's] issues but in any event, they would have referred onto OPMH if it was felt that specific skill set was needed."*
>
> I maintain my position that if the individual did not meet the criteria for OPMHS referral then a referral to OPH would have been entirely appropriate given her clinical presentation which included the following also taken from my initial report:
>
> *"The hospital documentation notes that [Mrs A] was able to successfully make a cup of coffee in an OT assessment which is a good indicator of successful problem solving in a new environment. She was also largely independently mobile, could dress and wash herself independently and all the indicators are that [Mrs A] answered questions appropriately and was able to state on several occasions that she could manage well at home. I note also that according to her interRAI-CA assessment on September 9th 2020, [Mrs A] visited the Memory Clinic during her admission although the details of this consultation were not available. However, throughout her admission there was also frequent reference to [Mrs A's] poor short-term memory and confusion.*
>
> *Although there were many reassuring aspects of [Mrs A's] interRAI-CA, it also highlighted that:*
>
> - *She was disorientated to month and day.*
> - *Likely required oversight of medication management*
> - *May need encouragement with diet and hydration."*

I would agree with the point raised that many older adults in medical wards have a diagnosis of dementia or acquire a delirium although both of course need managing appropriately. However, the issue for me is that this patient presented with documented symptoms of confusion and was going home alone when it was known that home support services would not be commencing for approximately two days. I agree that the concept of discharging to assess is entirely appropriate as long as the patient has been correctly assessed and appropriate interventions put in place immediately on their return home which can be scaled up or down as necessary. The documentation provided by Te Whatu Ora — Waitematā for the day of discharge highlighted the following:

Wednesday 9th September. Nursing notes 06.25 *"Confused. Shared watch present."*

Wednesday 9th September 14.52. Nursing notes 14.52. *"Pt wandering around wanting to go home. Pt looks agitated because of waiting for the papers and wanted to go home straight away. Assisted by watch to get taxi home."*

At the beginning of my report I have stressed that the focus is on the action rather than the outcome (as you may have poor practice and a good outcome and vice versa), and therefore the fact that apparently there were no adverse events between the date of discharge and the start of services does not in my view necessarily justify the decision. The risk is of normalisation of deviance, whereby bad practice becomes acceptable practice because there was not a poor outcome in any particular situation.

The response from Te Whatu Ora — Waitematā states that they provided evidence that specialist geriatric care was provided (page 2), but from an inpatient perspective it wasn't clear to me what this was.

I therefore maintain my view that a referral to either Older Person's Health Service or OPMHS would have been reasonable and appropriate for the reasons highlighted above and in my previous reports.

- *Te Whatu Ora — Waitematā's suggestion that there was a degree of retrospective bias on my part.*

As with all investigations of this nature, I have drawn my conclusions from documentation provided. At the beginning of my initial report I stressed that I would be examining events at the time they were documented as occurring rather than with the benefit of hindsight. In my professional view, the documented comments provided above and in more detail in both previous reports are highlighting potential risks at the time events occurred and hindsight or a retrospective view of events was not a factor.

- *Te Whatu Ora — Waitematā's comments referring to the OT assessment on 29th October 2020, and the patient's second discharge from hospital on the same day on page 4 and 5 of their response.*

I acknowledge that this patient was discharged with an increased package of care. However, she was returning to live alone at home, (the daughters lived abroad and her

main support was a neighbour who was recorded as having dementia) and during the course of her OT assessment she could not make a cup of tea. She was also given Lorazepam the night prior to discharge for agitation and was documented as being very confused the morning of discharge. Ultimately any services would visit three or possibly four times a day and not at all during the night which can reasonably be considered to be at least 12 hours (8pm to 8am). I would therefore continue to maintain that there was a significant discharge risk which was not fully addressed.

- *Te Whatu Ora — Waitematā's statement that they disagree that a clear definition of what is "complex" is reasonable (page 9 of their letter).*

In terms of complexity, I was referring to complexity of care provision rather than strictly clinical complexity (although this is by the impact of disease on function a factor) such as utilised for the purposes of a SAT or Standardised Assessment Tool. An interRAI assessment can provide the necessary information for this. The interRAI-CA completed during the first hospital admission highlighted that [Mrs A] had an Assessment Urgency score of 6/6 which would again indicate that prompt and appropriate integrated interventions were required prior to or at the point of discharge.

- *Te Whatu Ora — Waitematā's statement that no meaningful evidence is provided that our policy for entry and referral to MHSOA is a moderate departure from accepted practice, (final page of response).*

In response, I refer to my report dated 21 March 2023 and the comments on pages 6 and 7 relating to policies. I have considered this issue throughout from the basis of how any change or improvement can be of benefit to the individual using it which is ultimately the true test particularly given this individual is likely to be a patient facing employee. The question I raised was what happens if a referral to MHSOA or any other service is declined? This is the area which I believe could be stronger, and which I have seen in other health services, in terms of any review of the policy documentation. If this direction was visible, it may have been helpful to the discharging team and prompted a different approach with respect to the patient in question.

Points raised about this patient making informed decisions and wanting to go home.

Although it appears to have been accepted that the patient had mental capacity, she was presenting as confused and agitated. Consequently, any desire by her to go home as soon as possible and herself not having any concerns, needs to be considered in the context of this documented confusion. Moreover though, the issue is not so much about keeping her in hospital but ensuring that all possible in-patient interventions (Older Persons Health) and on discharge, all appropriate community services (Primary Options Acute Care, POAC team) are in place to support her.

Thank you for the opportunity to review this case again and for the opportunity to fully consider the further response from Te Whatu Ora — Waitematā. I can confirm that after due consideration I have not changed my view on the matters first raised by the Health and Disability Commissioner in 2021.'