Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 21HDC00883)

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Introduction

1. 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.

2. The report discusses the care provided to Mr A at Taranaki Base Hospital, Health New Zealand | Te Whatu Ora (Health NZ) Taranaki (formerly Taranaki District Health Board (TDHB))[1] in 2021.

3. Mr A (aged in his eighties) was admitted to Taranaki Base Hospital for an exacerbation of chronic obstructive pulmonary disease[2] (COPD) and abdominal pain. After being treated with antibiotics and steroids, Mr A was discharged home on Day 5,[3] into the care of his elderly wife, Mrs A.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand | Te Whatu Ora. All references in this report to TDHB now refer to Health New Zealand | Te Whatu Ora Taranaki.
[2] A common lung disease that causes restricted airflow and breathing problems.
[3] Relevant dates are referred to as Days 1–5 to protect privacy.

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4. Mr A was discharged with prednisone,[4] as well as 'back pocket' prescriptions[5] for antibiotics and further prednisone, which he was advised to use if he experienced another flare (eg, shortness of breath, wheezing, cough, or increased phlegm). An outpatient appointment was booked for a flexible sigmoidoscopy,[6] and a semi-urgent outpatient referral was made for him to be seen by a respiratory clinical nurse specialist.

5. On the day of discharge, Mr A was still experiencing shortness of breath on exertion, and he required assistance with mobilising and activities of daily living (ADLs). His daughter, Ms C, stated that he was unable to walk unassisted, and he and Mrs A required help from the public to move him from a wheelchair and into the car to leave the hospital. Ms C told HDC that Mrs A then struggled to get Mr A from the car, up three flights of stairs and into their house, and, sadly, Mr A died within about five minutes of arriving home, and about 40 minutes of leaving the hospital.

6. Ms C raised concerns that Mr A did not receive any physiotherapy or occupational therapy services while admitted as a patient, and that there was minimal consideration of how Mr A would manage at home on discharge.

7. The following issue was identified for investigation:

- *Whether Health New Zealand|Te Whatu Ora provided Mr A with an appropriate standard of care in 2021.*

8. The parties directly involved in the investigation were:

Ms C	Complainant/daughter
Health NZ Taranaki	Group provider

9. Independent advice was obtained from registered nurse (RN) Richard Scrase (Appendix A) and internal medicine specialist Dr Denise Aitken (Appendix B).

Background

10. In 2021, Mr A was admitted to Taranaki Base Hospital for an exacerbation of COPD and acute abdominal pain. In the Emergency Department (ED), Mr A was given salbutamol,[7]

[4] A corticosteroid used to treat conditions such as arthritis, blood disorders, breathing problems, severe allergies, skin diseases, cancer, eye problems, and immune system disorders.
[5] Prescriptions given to the patient with advice not to fill unless symptoms persist or worsen.
[6] A procedure in which a device is used to look inside the rectum and lower colon.
[7] Medication used to relieve symptoms of asthma and COPD, such as coughing, wheezing, and feeling breathless.

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ipratropium[8] nebulisers,[9] and intravenous (IV) hydrocortisone[10] 'with good effect'. Mr A was also started on augmentin[11] and azithromycin.[12]

11. The clinical records show that Mr A was reviewed by a general medicine physician and admitted to the general medicine ward. The physician documented that as well as the abdominal pain, Mr A had some rectal bleeding and weight loss. The physician also documented that Mr A had a long-standing cough, some chest pain in the previous few days when coughing, a history of angina, and swelling of the legs (the left leg more predominantly). The physician noted that Mr A had an exacerbation of his COPD.

12. It is evident from the clinical notes that throughout his admission, Mr A had shortness of breath on exertion and required assistance with his activities of daily living and with mobilising.

13. During admission, Mr A had an ultrasound of his left leg (which was negative for deep vein thrombosis), lumbar X-rays (which showed an old T12 compression,[13] no lesions on the lumbar spine,[14] and prominent bowel gas), and an abdominal ultrasound (noted to be a limited examination that showed gallbladder stones and two cysts in the liver).[15] Mr A received a general surgical review, which did not identify any acute surgical issues, but did recommend that an outpatient flexible sigmoidoscopy[16] be completed and that he resume his anticoagulation medication, which had been stopped temporarily on admission. Mr A also received salbutamol and ipratropium nebulisers, fluid boluses,[17] 40mg prednisone, and doxycycline[18] (in place of the augmentin and azithromycin he was started on in ED), and he was placed on Airvo[19] to treat his COPD exacerbation.

14. Mr A was also reviewed by a speech language therapist, as he was having difficulty swallowing his medications, and by a dietician for his weight loss of 3–4kg 'over a period of months'.

15. On Day 4 a semi-urgent gastrointestinal referral was made to general surgery, and Mr A was triaged for an outpatient CT colonography.[20]

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[8] Medication that dilates the airways.
[9] A nebuliser is a machine that converts liquid medication into a fine mist, which is breathed in through a mask or a mouthpiece.
[10] A corticosteroid.
[11] A type of antibiotic.
[12] A type of antibiotic.
[13] A T12 compression fracture affects the lowest vertebra.
[14] No areas of abnormal tissue on the spinal cord.
[15] The clinical notes do not indicate the actions to be taken as a result of these issues.
[16] An imaging test to view the colon and rectum for the presence of ulcers, polyps, or other abnormalities.
[17] The rapid infusion of fluids over a short period of time.
[18] A broad-spectrum antibiotic.
[19] A device that delivers warmed and humidified air or air and oxygen.
[20] Examination of the inside of the colon by taking a series of X-rays.

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16. On Day 4 and Day 5 semi-urgent referrals were also made for Mr A to be seen by a respiratory clinical nurse specialist. The Day 4 referral noted the referral type as 'complex' and stated that Mr A required assistance with ADLs and mobility. The Day 5 referral noted the referral type as 'non-complex' and stated that Mr A did not require assistance with ADLs or mobility.

17. Mr A was discharged into the care of Mrs A on Day 5. His diagnosis at that time was COPD exacerbation with a secondary diagnosis of 'likely oesophagitis[21]' (causing epigastric[22] pain). The discharge plan noted:

> '1. Discharge home
>
> 2. Continue further 20mg PO prednisone for further 5 days
>
> 3. Back pocket prescription for prednisone and doxycycline
>
> 4. Faecal H Pylori testing[23] — form given, GP to chase please.
>
> 5. Flexible sigmoidoscopy as outpatient.'

18. Mr A was given a back pocket script for more prednisone and doxycycline to be used if needed. The discharge summary also noted follow-up with a respiratory clinical nurse specialist and referral to a pulmonary rehabilitation clinic[24] for further treatment for his COPD.

19. Mr A was given the following advice in his discharge summary:

> 'You were admitted with a flare up of your COPD, which has been treated with antibiotics and steroids, and are now able to go home. Please complete a further 5 days of 20mg of prednisone as prescribed. We have also given you a back pocket script for steroids and doxycycline — an antibiotic — for you to take if you have another flare: shortness of breath, wheezing, cough or increased phlegm.
>
> We have started you on omeprazole once daily for your abdominal pain. Please also take antacids such as gaviscon for this as needed.
>
> If you have worsening shortness of breath, cough, fever, chest pain, bloody or black stools or any other symptoms you are worried about, please see your GP or return to the emergency department.'

20. In her complaint to this Office, Ms C stated that Mr A was 'barely mobile' and unable to walk unassisted. Ms C said that Mr and Mrs A required assistance from a stranger to transfer Mr A from a wheelchair into the car to leave the hospital, and then Mrs A struggled to get Mr A

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[21] Inflammation of the oesophagus (the muscular tube that delivers food from the mouth to the stomach).
[22] The upper central region of the abdomen.
[23] A test to check for infection of *Helicobacter pylori* (a type of bacteria).
[24] Pulmonary rehabilitation clinics provide education and exercise programmes to help people with chronic breathing problems such as COPD.

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from the car, up three sets of stairs, and into their house. Ms C told HDC that Mr A died within about five minutes of arriving home, and about 40 minutes of leaving the hospital. Ms C was not present when Mr A was discharged from the hospital and taken home. However, HDC understands that Mrs A was present for the discharge and that the events outlined in the complaint are based on Mrs A's recollection of the events.

21. Mr A's discharge summary states that normally Mr A's 'ETT' (exercise tolerance test) was about 20–30 metres before he had to stop, but that in the two weeks prior to admission it had been about 5 metres, and he had found showering and toileting 'extremely hard' and had received help twice a week. Mr A's exercise tolerance at discharge is not recorded.

Responses to provisional opinion

Ms C

22. Ms C was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and her comments have been incorporated throughout the report where relevant.

Health NZ Taranaki

23. Health NZ Taranaki was provided with an opportunity to comment on the provisional opinion, and it accepted the recommendations.

Opinion: Health New Zealand | Te Whatu Ora Taranaki — breach

24. I have undertaken a thorough assessment of the information gathered in light of the concerns raised, and I am critical of Health NZ's care of Mr A, particularly the lack of physiotherapy and occupational therapy input, and the discharge planning to ensure that Mr A was transitioned to his home safely. I find that Health NZ Taranaki breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[25]

Admission nursing assessment and follow-up

25. Health NZ's discharge planning procedure in place at the time states that nursing staff should '[e]nsure the patient questionnaire and nursing assessment has been completed with the patient or family/whānau as soon as practicable following admission', and 'initiate appropriate action/referrals from information gained'.

26. The 'nursing assessment and care planner' was only partially completed. In particular, the admission planning section for Mr A contained only the date of admission, preferred language, and 'initial screening tool'. The information about recent weight loss was incomplete. The discharge planning section (which starts at admission) was also largely incomplete, noting only that Mr A lived with his wife. The discharge checklist includes important information such as whether the patient is likely to have any difficulties with self-care on discharge (eg, walking, dressing), whether they are concerned about returning

[25] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

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home, the level of support services they currently receive, and their arrangements for transport on discharge. None of this information was included.

27. An initial 'nursing care plan' completed at admission identified that Mr A required assistance and use of a stroller to mobilise. However, the 'initial screening tool', 'falls risk assessment', 'pressure injury risk assessment', and 'delirium assessment' are dated Day 2, the day after Mr A's admission.

28. Health NZ told HDC that the admission assessments should be undertaken within 24 hours of admission to the ward. Mr A arrived at the ward at approximately 2.15pm, but the times of the assessments completed on Day 2 are not documented, so it is unclear whether these were done within 24 hours of admission to the ward.

29. Health NZ stated that the two registered nurses responsible for Mr A's assessment no longer work in the acute medical ward and therefore Health NZ is unable to seek commentary from them. Health NZ said that both were experienced nurses, and both had 'negative trendcare variances' over the relevant shifts, which meant that the patient demand outweighed the nursing availability.[26]

30. The 'initial screening tool' identified that Mr A was at risk of falls and required aids to mobilise. Further, the 'falls risk assessment' identified that Mr A's risk of falling was high, which required interventions including mobilising with assistance, initiating discharge planning, a toileting assessment and plan in place, and completion of 'appropriate multi-disciplinary team referrals'. Health NZ stated that the outcome of Mr A's 'falls risk assessment' indicated that a physiotherapy and/or occupational therapy referral should have been made, and Health NZ confirmed that this did not happen.

31. Mr A was also assessed as unlikely to have delirium and being at a low risk of pressure injuries.

32. Health NZ stated:

> 'Unfortunately we did let [Mr A] down on this occasion … His admission documentation was incomplete and a baseline assessment pertaining to his activities of daily life (ADLs) and home situation was not assessed. This is a nursing responsibility.'

33. I sought advice from registered nurse (RN) Richard Scrase, who advised:

> 'It is my professional view that a fundamental aspect of good nursing care is quality assessment which is completed in a timely manner and then appropriate actions taken … In addition, it is important for health professionals to understand an individual's functional and physical baseline in order that the interventions required to safely discharge that person back home have been fully understood and considered.'

[26] Health NZ can determine this by an acuity system as opposed to speaking directly with staff.

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34. RN Scrase identified that the initial assessment on admission had 'significant gaps', particularly in the discharge planning. RN Scrase advised:

> 'In my experience, the risk of any unfilled section of an assessment is that it may be interpreted as not relevant or not important to the next person reading it and consequently matters may never be followed up.'

35. RN Scrase stated that one of several important parts of the discharge planning that was not completed was the question about whether this patient had any formal supports being provided at home. RN Scrase acknowledged that the clinical notes for the evening of admission refer to Mr A 'living at home and being independent'. However, RN Scrase considers that the discharge planning is key in terms of ascertaining an individual's baseline level of function and dependency and deciding what, if any, additional supports may be required on discharge. RN Scrase advised:

> 'In my professional view, what was missing from the assessment at admission was an understanding of the patient's home situation apart from the fact that he lived at home with his wife.'

36. RN Scrase said that it would be reasonable to assume that Mr A being assessed as a high falls risk should necessitate a physiotherapy and occupational therapy assessment, particularly given the reference in the assessment form for a need for a toileting assessment. RN Scrase advised:

> 'Given the significant gaps in the initial nursing assessment and the lack of follow up with respect to his clearly identified falls risk at the point of admission, I consider that there has been a severe departure from accepted practice.'

37. I accept RN Scrase's advice that the significant gaps in the initial nursing assessment and lack of follow-up regarding Mr A's identified falls risk constituted a severe departure from accepted practice. I also note that Health NZ has acknowledged that the incomplete assessments and lack of follow-up fall below its expected standard. I am concerned by the inadequacy of the initial nursing assessments and follow-up in relation to Mr A's falls risk. The oversights in the initial assessment meant that subsequent staff did not have appropriate information available to them about Mr A's functional and physical baseline and the interventions required during his admission or for safe discharge home.

38. RN Scrase acknowledged that acute hospital settings, and ED in particular, are extremely busy and high-pressure environments, and that this may be a reason why the documentation was incomplete. However, RN Scrase stated:

> '[T]he highly clinically complex and frail nature of so many of our older clients is one of the fundamental reasons why documentation needs to be fully completed accurately and assessments followed up on despite other pressures, so that nothing is missed and patients like Mr [A] can be given the most appropriate clinical input.'

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Interventions and investigations during admission

39. On admission, Mr A was documented to have abdominal pain, some rectal bleeding, and weight loss. It was also documented that Mr A had a long-standing cough, some chest pain in the previous few days when coughing, a history of angina, and swelling of the legs (the left leg more predominantly). An ultrasound was performed on the left leg and abdomen. Mr A received a general surgical review, which did not identify any acute surgical issues but recommended an outpatient flexible sigmoidoscopy.

40. Mr A continued to receive treatment for his COPD exacerbation. He was reviewed by a speech language therapist owing to his difficulty swallowing medications, and by a dietician due to his weight loss. On Day 4 a semi-urgent gastrointestinal referral was made to general surgery and Mr A was triaged for an outpatient CT colonography. On Days 4 and 5 referrals were also made for Mr A to be seen by a respiratory clinical nurse specialist and to a pulmonary rehabilitation clinic.

41. I sought advice from internal medicine specialist Dr Denise Aitken, who stated:

> '[I]t is clear that objective measures of [Mr A's] symptoms of chronic airways disease improved over the course of his admission. These are, recordings of oxygen levels, blood pressure, respiratory rate and heart rate. Similarly, it appears that his abdominal pain settled and important pathology such as aortic dissection and gallbladder infection are appropriately ruled out.'

42. Dr Aitken considered that appropriate tests and investigations were carried out during Mr A's admission, with the exception of occupational therapy and physiotherapy referrals.

43. RN Scrase stated that it is important to acknowledge that during Mr A's admission, there were 'numerous examples of good quality interventions and assessments'. For example, RN Scrase noted that on several occasions Mr A's Early Warning Score was high and warranted medical review, which occurred in a timely manner, and the documentation indicates that he was monitored appropriately by nursing staff. RN Scrase also said that the assessments and referrals for both a dietician and a speech and language therapist were examples of good nursing interventions, and he acknowledged that a referral was made for outpatient services on discharge. However, RN Scrase advised that these interventions were largely about addressing the issues that presented in the hospital at the time, rather than taking a more holistic view that considered the individual's home environment.

44. I accept this advice. The issue of occupational therapy and physiotherapy referrals is discussed separately below, but I consider that appropriate tests and investigations were carried out during Mr A's admission, and there was no departure from the accepted standard of care in this area.

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Physiotherapy and occupational therapy input, and community supports

45. There is no evidence of physiotherapy or occupational therapy input into the care Mr A received during his admission, nor was any referral made for physiotherapy or occupational therapy input to discharge planning.

46. Health NZ stated that on many occasions during Mr A's admission it was noted that he required at least one-person support for his ADLs and mobility, and usually this would correlate to nursing staff undertaking a referral to physiotherapy and occupational therapy.

47. Health NZ also said that 'a large number of individuals' were involved in Mr A's care over his admission, and there were multiple opportunities for staff (including nursing, medical, and allied staff) to refer Mr A for physiotherapy or occupational therapy during his admission.

48. The discharge planning procedure that was in place at the time states: 'All patients admitted to TDHB have an inter-disciplinary discharge plan initiated on admission and completed by discharge.' The discharge planning procedure includes early assessment and identification of inter-disciplinary needs, with referrals actioned immediately once the need is identified, and patients with complex needs should be referred to a case manager and have a care plan discussed at weekly inter-disciplinary team meetings.

49. In response to the provisional opinion, Ms C queried whether the discharge plan had been completed, signed off, or even reviewed at her father's discharge.

50. Health NZ's discharge planning procedure stated that medical staff held responsibility to initiate inter-disciplinary team referrals on admission, and that the inter-disciplinary team held responsibility for any referrals for community support if needed.

51. Health NZ noted that '[p]hysiotherapy coverage over the weekend is limited and this contributed to this lack of service provision'. However, Health NZ also stated that methods of referral included a telephone call within business hours, discussion and referral during a daily multi-disciplinary team meeting on the ward, and 24/7 online electronic referrals.

52. In response to the provisional opinion, Ms C said that Health NZ has not provided a satisfactory explanation as to why her father never received physiotherapy or occupational therapy input before he was discharged, other than stating that physiotherapy coverage is limited over the weekend. Her father was admitted on Friday and was discharged on Tuesday, and there has been no explanation as to why physiotherapy or occupational therapy input was not sourced on either of these two workdays, or why those involved in her father's care did not make these referrals.

53. Health NZ has a Complex Discharge Coordinator role, which is a 'Monday to Friday role' that was established in October 2020 to 'assist complex patients and their families in the discharge process and ensure a seamless transition from inpatient care to the primary place of residence'. The Complex Discharge Coordinator is expected to coordinate patient care across the continuum 'from pre-hospital admission to discharge from hospital services'. Expected outcomes include early identification of patients with complex care needs;

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collaboration with all disciplines to develop a plan of care at the time of acute admission; and planning and management of patients' complex discharge needs using the entire patient care team.

54. Health NZ stated:

> 'Unfortunately during this period the Complex Discharge Coordinator was on annual leave and this position was not covered (as at the time we had not finished recruiting into the casual role). Normally this role would have picked up patients like [Mr A] at the 11am [multi-disciplinary team meeting].'

55. In response to the provisional opinion, Ms C said that she is concerned that this position was unfilled at the time and that Health NZ had not arranged for this position to be covered, particularly given the nature of the role.

56. RN Scrase advised that when it is identified through assessment that the input of a particular discipline is required, a registered nurse should refer to an appropriate member of the multi-disciplinary team. RN Scrase stated:

> 'In this context, in very broad terms, physiotherapy input would be important if there were concerns about an individual's mobility which might require additional walking aids, exercises, rehabilitation, education or as is often the case, a combination of all of these to varying degrees. Occupational therapists frequently work closely with Physiotherapists and again in this context would be most likely to be assessing and supporting, often with additional equipment, how an individual performs various activities of daily living, such as using the toilet, getting in and out of bed, dressing and eating.'

57. RN Scrase advised that he was surprised to see no reference to physiotherapy or occupational therapy input when reviewing the clinical notes, and he is not sure that the absence of the Complex Discharge Coordinator is an acceptable reason for this omission. RN Scrase acknowledged that this coordinator role is a 'valuable and skilled one which would benefit both the consumer and the service as a whole'. However, he advised:

> '[T]he risk of any specialist nursing role can be … an expectation by the nursing staff that the specialist will do everything that comes under their scope, including tasks which could reasonably be expected to be completed by nurses on the floor.'

58. On review of the clinical notes, RN Scrase identified numerous instances where Mr A required assistance to mobilise, largely due to his shortness of breath. RN Scrase also noted that on the day prior to discharge, Mr A needed assistance with washing and walking and required a wheelchair to help him return to bed after visiting the toilet.

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59. RN Scrase advised:

> 'In my professional opinion both physiotherapist and occupational therapist input was required during the course of this patient's admission. Given this did not occur, I consider that there has been a severe departure from accepted practice.'

60. RN Scrase also stated that critical thinking is a fundamental part of being a registered nurse, and, given that there were 'many very good examples of this occurring during the course of this admission', he found it particularly surprising that nobody considered making a physiotherapy or occupational therapy referral during Mr A's admission, despite the information available.

61. I accept RN Scrase's advice that the lack of physiotherapy/occupational therapy input in Mr A's care amounted to a departure from accepted practice. I note that Health NZ has also acknowledged that the lack of physiotherapy/occupational therapy input fell below its own expected standard of care. Clearly, physiotherapy/occupational therapy input was indicated in this case, and I am concerned that despite many different staff attending to Mr A over his four-day admission, nobody recognised that he required such input and had not received it. I agree with RN Scrase that this indicates a lack of critical thinking among staff.

62. I am also concerned about the inadequate cover that was available whilst the Complex Discharge Coordinator was away on leave. This role had been designed to assist with complex cases such as Mr A's. Given that no cover was available, this created a risk of other clinicians not taking steps that were part of the Complex Discharge Coordinator's role.

Safety of discharge

63. Mr A was discharged into the care of his wife. His diagnosis at that time was COPD exacerbation with a secondary diagnosis of 'likely oesophagitis'. He was reported to have needed assistance getting from the wheelchair into the car to leave the hospital. Ms C told HDC that Mr A died within about five minutes of arriving home, and about 40 minutes of leaving the hospital.

64. Dr Aitken considers that it is the responsibility of the whole multidisciplinary team to ensure that discharge is safe, with the identification of concerns, appropriate referrals, and assessment being a shared responsibility. This requires robust processes and communication in addition to adequate knowledge and capacity of staff, with 'medical clearance' being only one aspect of a safe discharge. In this case, Mr A was improving medically and discharge planning was appropriate. However, his safe discharge depended on all members of the multidisciplinary team agreeing that he was ready for discharge, which did not occur.

65. Dr Aitken stated that it appears that Mr A's functional ability was not addressed in the ward notes by doctors. In my view, the medical team should have been aware of Mr A's decreased mobility, given that this was documented in his records. Dr Aitken also noted that no safety-netting advice was documented as having been given to Mr A on discharge.

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66. Dr Aitken advised:

> 'This discharge was not safe, as [Mr A] is reported to have required bystander assistance to get into his vehicle and to struggle to get into his own home. This is of concern. The responsibility for this is shared by all. From a medical perspective this was not best practice and would be viewed by my peers as a mild departure from accepted practice given the shared responsibility.
>
> The failure to ask, versus failure for [the] problem to be raised makes it difficult to direct responsibility to any group. It is perhaps a reasonable expectation of a medical team that as [Mr A's] exacerbation of airways disease improved, it is likely his exercise tolerance would improve. I note that the night prior to discharge [Mr A] expressed concern about his planned discharge. The next day it is documented that he mobilised with minimal assistance in nursing notes.'

67. I accept this advice. Despite the differing observations of Mr A the night before discharge and on the day of discharge, I am concerned that a lack of critical thinking and communication resulted in an unsafe discharge. I am also concerned about the lack of documentation of a formal assessment of Mr A's functional ability and any safety-netting advice provided and that no consideration was given to the age and health status of Mrs A and her ability to assist Mr A at his discharge. I take this opportunity to remind staff of the importance of good clinical documentation of a patient's functional abilities and any safety-netting advice given.

Community supports at discharge

68. Health NZ's discharge planning procedure states that the nurse performing the discharge is responsible for ensuring that all documentation is present and the patient care is complete, and that the inter-disciplinary team holds responsibility for any referrals for community support if needed.

69. Health NZ stated that the individual who was responsible for the discharge of Mr A no longer works for Health NZ and is no longer in the nursing profession. The individual was a surgically trained and experienced registered nurse, and Health NZ noted that due to staffing shortages on the ward, this individual was removed from their normal role to take a patient load for the afternoon shift.

70. In response to the provisional opinion, Ms C queried who would have been responsible for her father's discharge if this position was unfilled at the time.

71. Health NZ stated:

> 'Upon discharge there was minimal consideration for how [Mr A] would manage at home, evidenced by the lack of documentation. [Mr A] was discharged for follow up with the Respiratory clinical nurse specialist (CNS), however this was of no benefit for assistance at home with cares or mobility.'

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72. RN Scrase advised:

> '[T]his patient was not at his functional baseline at the point of discharge. This in itself need not be cause for concern in part because some individuals unfortunately never return to their base line level of function whereas others require more time, and the home environment can often be the best and preferred place for this to happen. However, … what is important is that the individual is offered the necessary support if they are being discharged back to their own home. Given this patient's clearly documented challenges with mobility and with managing his personal cares, some formal support with showering and dressing alongside community physiotherapy and occupational therapy input would in my professional view and experience be a clear expectation. I could not identify any documented evidence that this had been offered or discussed.
>
> …
>
> As with any health touch point, this admission should have been an opportunity to assess, to change things as necessary, and to provide the necessary available supports. In terms of the discharge my view is that this did not occur, and I believe my peers would agree with my conclusion.'

73. RN Scrase concluded: 'In view of the lack of community support offered to [Mr A] when he was being discharged, I consider there to have been a severe departure from accepted practice.'

74. I accept RN Scrase's advice that a lack of community support offered to Mr A when he was discharged was a departure from accepted practice. Clearly, Mr A required assistance with mobility and ADLs at the time of discharge, and I am concerned by the lack of community support offered. The follow-up plan in place was an appointment with a respiratory clinical nurse specialist, and the discharge summary was sent to Mr A's GP. RN Scrase noted that the respiratory specialist would not have been seen for several weeks, and the GP was unlikely to have seen the discharge letter for some time following discharge. Therefore, given Mr A's presentation, in my view these were not appropriate immediate supports.

Discharge planning procedure

75. RN Scrase reviewed the district's discharge planning procedure document that was in place at the time of events. He noted that on reading the discharge planning flow diagram, it was not clear what defined a patient with 'complex needs'. RN Scrase acknowledged that complexity is to an extent a matter of perspective and experience. However, he advised:

> 'In my professional view and experience someone that is clinically complex is not necessarily the same as somebody that has complex needs on discharge. For example, an older adult that has been admitted with a relatively straight forward clinical issue such as a chest infection which has been resolved but is of no fixed abode and has no family, and therefore has nowhere to go but doesn't meet the threshold for aged residential care, could be a very complex discharge.'

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76. Further, RN Scrase noted that the two flow diagrams in the document were written in different ways, one using a series of questions (for discharge to aged residential care) and the other a series of stages (for community discharges). RN Scrase suggested that a similar style for both may be easier to follow, and that the ARC discharge process was more useful because it asked a yes/no question at each stage, which would be more likely to elicit an action. RN Scrase also noted that the flow diagram that relates to individuals living in aged care villages or villas could equally relate to people living in the community, as essentially they are the same group of people (ie, in terms of the degree of support available to them) and therefore, he questioned whether these people should be under the ARC discharge process.

77. RN Scrase advised that the primary issue was not that there were no procedures, but that they were not followed or that individuals were not fully aware of them. RN Scrase considered that in this case, a lack of critical thinking was the primary issue, but clear and visible policies and procedures should aid and guide this thinking and make the process in question objective whilst still keeping it person centred.

78. RN Scrase advised:

> 'In my professional opinion, the procedures were there but they lacked clarity and visibility. For this reason, I consider that there has been a moderate departure from accepted practice with respect to the policies and procedures.'

79. I accept RN Scrase's advice that the lack of clarity and visibility of the discharge planning procedure amounted to a departure from accepted practice and agree that the procedures outlined in the document lack clarity. I also note that the discharge planning procedure states that it was 'last reviewed' in May 2014 and the 'review by date' was May 2017. I am concerned that this version of the discharge planning procedure was still in place at the time of Mr A's admission in 2021. In particular, this did not take into account the role of the Complex Care Coordinator, which was created in October 2020. It is clear from the position description of the Complex Care Coordinator that the creation of this role would have had a significant impact on discharge planning procedures. I am therefore also concerned about the accuracy of what was documented in the discharge planning procedure document at the time compared to the actual expected process and consider that this may have created some confusion for staff.

Conclusion

80. Health NZ had a responsibility to provide Mr A with care of an appropriate standard. I consider that several areas of care fell short of appropriate standards:

- There were significant gaps in the initial nursing assessment, and there was a lack of follow-up with respect to Mr A's clearly identified falls risk at the point of admission.
- There was a lack of both physiotherapist and occupational therapist input during Mr A's admission.

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- There was a lack of community support offered to Mr A when he was being discharged.
- The discharge planning procedures lacked clarity and visibility.
- There was no cover for the Complex Care Coordinator role whilst the Complex Care Coordinator was on leave.
- There was a lack of communication within the multidisciplinary team, which resulted in an unsafe discharge for Mr A.

81. I am concerned that Mr A was discharged from hospital in an unsafe manner. The impact of this on Mr A and his wife, given the events that unfolded shortly after discharge, cannot be overstated. I consider that Health NZ is responsible at a systems level for the aspects of Mr A's care and discharge that did not meet acceptable standards, given that multiple staff members across different teams and roles were involved in his assessment and discharge planning during his admission. Therefore, I consider that Health NZ did not provide Mr A with an appropriate standard of care and breached Right 4(1) of the Code.

Changes made since events

82. Health NZ decided to train a senior ward registered nurse to undertake the role of Complex Discharge Coordinator during times of leave, so that the service on the acute medical ward is covered Monday to Friday from 8am until 4.30pm.

Recommendations

83. I recommend that Health NZ Taranaki:

a) Provide a written apology to Mr A's family for not providing Mr A with an appropriate standard of care during his admission and at discharge. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Conduct an audit of the completion of admission documentation, including the nursing assessment and care planners over the past six months. A summary of the audit findings with corrective actions implemented/to be implemented should non-compliance be identified is to be provided to HDC within six months of the date of this report.

c) Complete a survey with nursing staff on their understanding of the falls risk form and expectations if someone is identified as a moderate or high falls risk. A summary of the results/findings with any corrective actions implemented/to be implemented should any issues be identified is to be provided to HDC within six months of the date of this report.

d) Complete a review of the process of the 'Ward Huddle' to ensure that referrals are initiated independent of any individual staff member being present. A summary of the review and any corrective actions identified is to be provided to HDC within six months of the date of this report.

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e) Undertake the following, within six months of the date of this report:

   i. Use this case as a basis for developing education/training on the importance of discharge planning, critical thinking and speaking up, and when an interRAI[27] assessment and referral to Older Persons Health could be beneficial.

   ii. Provide education for staff on the above issues using the newly developed education/training as well as the discharge screening tool.

   iii. Provide evidence of the above education/training having occurred, in the form of education material and staff attendance records.

f) Undertake the following, within six months of the date of this report:

   i. Review and update the discharge planning procedure and provide a copy of this to HDC (including a clear definition of what a complex patient/complex discharge is, and the role of the Complex Care Discharge Coordinator) and include a patient-centred standard that incorporates that the patient and whānau understand what is meant by safe discharge, and their concerns have been addressed and their questions answered.

   ii. Conduct an evaluation of the effectiveness of this new documented procedure two to three months following its introduction, via an audit of compliance, and provide HDC with a report that includes any corrective actions implemented/to be implemented.

g) Consider the most useful key times for physiotherapy and occupational therapy staff to be on the ward and provide HDC with a summary of what has been considered, and any changes implemented/to be implemented, within six months of the date of this report.

Follow-up action

84. A copy of this report with details identifying the parties removed, except Taranaki Base Hospital, Health NZ Taranaki, and the advisors on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[27] A tool that provides a clinical assessment of medical, rehabilitation, and support needs and abilities, and self-care for clients who require home and community support services.

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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 to [Mr A] at Taranaki Base Hospital in 2021.
>
> In preparing the advice on this case, I am not aware of any personal or professional conflict of interest. I confirm that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> **Career Summary**
> I started my nursing career in 2000 as a Nursing Auxiliary at Torbay Hospital in Devon, UK. After completing my Nursing Diploma, in 2005 I began working as a Registered Nurse on an acute surgical ward at Torbay Hospital in the UK. 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 a Registered Nurse on a rehabilitation ward before moving across to the Community Team at Older Persons Health in Christchurch. This included 3 years being a Liaison Nurse for a newly established early supported discharge team for complex patients that were returning to their own homes. Following this, in 2013 I became a Gerontology Nurse Specialist 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 what were then the Canterbury and West Coast DHBs. This role focused 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 and the CNSs in the early supported discharge team. 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 left my Nursing Director position in April 2022, and I am currently involved in further research writing in addition to training to be a health auditor.
>
> **Background**
> The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] by Taranaki DHB was reasonable in the circumstances and why.
>
> I have specifically been asked to provide comment on:
>
> - The adequacy of relevant assessments upon [Mr A's] admission to hospital on [Day 1].
> - Whether physiotherapy and/or occupational therapy input was required during [Mr A's] inpatient stay in [2021].
> - The adequacy of [Mr A's] discharge planning.

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- The adequacy of the relevant policies and procedures in relation to the discharge process at the time of events.
- Any other matters in this case that I consider warrant comment or amount to departure from the accepted standard of care.

For each question, I have been asked to advise on:

a) The standard of care/accepted practice.

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

c) How would it be viewed by my peers?

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

In reviewing this case on behalf of the Health and Disability Commissioner, I have examined all the documentation supplied to me which includes:

- The letter of complaint dated [2021].
- Taranaki DHB's response dated [2021] and attachments.
- Clinical records from Taranaki DHB.

When answering the questions raised above, I have considered matters at the time the events occurred as opposed to viewing them with the benefit of hindsight. In addition, I have been mindful that the focus should be on the intervention or action and not the outcome. This is because, we may have good quality care and input but a poor outcome and conversely poor care and input but still have a good outcome for the patient in question.

Summary of the case
On [Day 1], [Mr A] aged [in his eighties] was admitted to hospital for an exacerbation of COPD and acute abdominal pain. He was discharged home on [Day 5] with prednisone and a referral was made to see a respiratory CNS. A referral was also made for an outpatient general surgery clinic. His family have raised concerns about [Mr A's] discharge planning.

1. The adequacy of relevant assessments upon [Mr A's] admission to hospital on [Day 1].

The standard of care/accepted practice.
Fundamental to the standard of care throughout are the NZ Nursing Competencies. In addition, when considering all the matters raised in this case the overarching guiding document is the Ngā Paerewa Health and Disability Service Standard (NZS 8134:2021). These supersede the previous Service Standards, NZS 8134:2008, NZS 8181:2007 and NZS 8158:2012.

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Although Ngā Paerewa came into effect after the case in question, it is my view that the fundamental principles remain the same between this new version and earlier service standards, particularly with respect to the referral and discharge process.

It is my professional view that a fundamental aspect of good nursing care is quality assessment which is completed in a timely manner and then appropriate actions taken. Assessments need to be formative and constructive, and thereby they should inform the relevant health professionals reading it next what the necessary actions should be.

In addition, it is important for health professionals to understand an individual's functional and physical baseline in order that the interventions required to safely discharge that person back home have been fully understood and considered. Section 3.2.3 (c) of Ngā Paerawa states that:

"comprehensive assessment includes consideration of people's lived experience"

Furthermore, section 3.2.3 (h) of the standards requires that:

"people's care or support plan identifies wider service integration as required"

However, it is also important to recognize that assessment is ongoing and not simply something that occurs at a moment in time with no re-evaluation.

Section 3.2.4(d) *"… needs and risk assessment are an ongoing process …"*

If there has been a departure from the standard of care or accepted practice, then how significant a departure (mild, moderate or severe) do you consider this to be?
It is important to acknowledge that during [Mr A's] admission to hospital, there were numerous examples of good quality interventions and assessments. For example, there were a number of occasions when the patient's Early Warning Score (EWS) was high and warranted medical review. This occurred in a timely manner and the documentation indicates that he was monitored appropriately by the nursing staff. In addition, there was assessment and then referral for both a Dietician and a Speech and Language Therapist which again are examples of good nursing interventions. Furthermore, there was a referral made for outpatient services on discharge.

Although entirely appropriate, these interventions were however largely about addressing the issues that presented themselves to staff in the hospital at the time. In many respects it was about what they saw from the end of the bed rather than with a more holistic view that considered the individual's home environment. In my professional view, what was missing from the assessment at admission was an understanding of the patient's home situation apart from the fact that he lived at home with his wife.

In addition, on admission the initial assessment had significant gaps particularly on the discharge planning screen tool (page 4 on Admission Plan). In my experience, the risk of

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any unfilled section of an assessment is that it may be interpreted as not relevant or not important to the next person reading it and consequently matters may never be followed up. One of several important parts of this was the question about whether this patient had any formal supports being provided at home, although I acknowledge that the clinical notes for the evening of admission refer to [Mr A] being "living at home and being independent". However, despite this piece of information, the discharge planning screening tool is in my view key in terms of ascertaining an individual's baseline level of function and dependency and deciding what if any additional supports may be required on discharge.

However, what was recorded was that [Mr A] was identified as being at risk of falls, and that he required aids to mobilise. He was also identified as a high risk of falls, according to the hospital falls assessment and although it didn't explicitly say so in the assessment outcomes, it would be reasonable to assume that this should include a physiotherapy and occupational therapy assessment, particularly given the form's reference for a need for a toileting assessment. Referring to my introductory statement that the focus here is on the action and not the outcome, the fact that [Mr A] didn't have a fall doesn't make the falls assessment any less relevant or important. Given the significant gaps in the initial nursing assessment and the lack of follow up with respect to his clearly identified falls risk at the point of admission, I consider that there has been a severe departure from accepted practice.

How would it be viewed by my peers?
When answering this question for each of the points under investigation, I have endeavoured to consider other perspectives, which the Commissioner may find useful when considering my findings.

Acute hospital settings and ED in particular are extremely busy and high-pressure environments, and it might be considered that this would be a reason why documentation was incomplete at times particularly when they need to focus on the acute issues at hand. However, the highly clinically complex and frail nature of so many of our older clients is one of the fundamental reasons why documentation needs to be fully completed accurately and assessments followed up on despite other pressures, so that nothing is missed and patients like [Mr A] can be given the most appropriate clinical input. I believe that my peers would support this view.

Recommendations for improvement that may help to prevent a similar occurrence in future
It may be useful to complete an audit on admission documentation to establish whether this issue of poor documentation was a one off or something more widespread. In addition, I personally found the falls risk form difficult to follow in terms of the recommended outcomes. There may be value in getting the view of nursing staff on this form and their understanding of expectation if someone is identified as a high falls risk (Bundle C on the form).

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Finally, further education about the importance of the Discharge Screening Tool may be beneficial. This was largely incomplete, but if it had been filled in correctly it would almost certainly have meant that he was highlighted at the Rapid Round and input to further MDT input made.

2. Whether physiotherapy and/or occupational therapy input was required during [Mr A's] inpatient stay in [2021]

The standard of care/accepted practice
I refer again to Ngā Paerewa Health and Disability Service Standard (NZS 8134:2121) in addition to the NZ Nursing Council Nursing Competencies.

In summary a Registered Nurse should refer to an appropriate member of the MDT when it is identified through assessment that the input of that particular discipline is required. On review of the documentation supplied I could not identify any written evidence of a physiotherapy or an occupational therapy referral. Both Physiotherapists and Occupational Therapists are skilled and valued members of the multi-disciplinary team. In this context, in very broad terms, physiotherapy input would be important if there were concerns about an individual's mobility which might require additional walking aids, exercises, rehabilitation, education or as is often the case, a combination of all of these to varying degrees. Occupational therapists frequently work closely with Physiotherapists and again in this context would be most likely to be assessing and supporting, often with additional equipment, how an individual performs various activities of daily living, such as using the toilet, getting in and out of bed, dressing and eating.

The question I therefore need to answer was whether there was documented evidence that referrals would have been appropriate. In my professional view both physiotherapy and OT input was identified as being required at the point of admission, but that this did not happen. It is possible though that the patient's condition improved with clinical interventions and that this input although overlooked, was now no longer required. I have therefore considered this possibility when reviewing the notes.

For clarity I have summarized what I consider key aspects of the nursing clinical notes from which I have based my opinion. Where necessary I have written any abbreviations used in full for ease of understanding.

[Day 1] 10.06 hrs. *1 x support with mobility up to toilet*

[Day 2] 16.50 hrs. *Patient independently mobilised to toilet. Upon returning back to bed, nursing staff assisted. Noted increased shortness of breath distressing for pt.*

[Day 3] 03.20 hrs. *Advised to ring bell if mobilizing*

[Day 3] 03.35 hrs. *Mobilised to toilet x 1 assist*

[Day 3] 06.20 hrs. *Said he had walked to end of bed and become very short of breath*

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[Day 3] 14.00 hrs. *1 x assist with mobility and ADLs (activities of daily living) due to shortness of breath*

[Day 3] 20.30 hrs. *Limited mobility secondary to shortness of breath on exertion.*

[Day 4] 14.10 hrs. *Needs encouragement with one assist to wash. Walking with stick and one assist. Not voicing an interest to mobilise.*

[Day 5] 06.10 hrs. *Up to toilet with health care assistant. Very short of breath on exertion. Commode chair back to bed.*

[Day 5] 13.30 hrs. *Minimal assistance required. Remains short of breath. Discharged at 15.30.*

If there has been a departure from the standard of care or accepted practice, then how significant a departure (mild, moderate or severe) do you consider this to be?
The documentation summarized above highlights that there were numerous times during the course of this patient's admission when he required assistance to mobilise largely due to his shortness of breath. On the day prior to his discharge he required assistance with washing and walking, and on the morning of his discharge a wheelchair was required to help him return back to his bed after visiting the toilet. The admission documentation records [Mr A] as being independent prior to admission. This documentation also identified that he was a falls risk.

In my professional opinion both physiotherapist and Occupational therapist input was required during the course of this patient's admission. Given this did not occur, I consider that there has been a severe departure from accepted practice.

How would it be viewed by my peers?
As mentioned above, it is possible that despite at the very least physiotherapy input being identified on admission (because he was seen as a falls risk) his level of function may have improved to the extent that this was no longer required. However, the evidence above highlights that this was not the case. In addition it may have been possible that services were offered to [Mr A] and he declined them. However, I was unable to identify any documented evidence of such a discussion and consequently I am confident that my peers would agree with my view that there has been a severe departure from accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.
I was surprised that I could not see any reference to physiotherapy or occupational therapy input when I was reviewing the clinical notes and I am not sure that the absence of the Complex Discharge Coordinator is an acceptable reason for this omission. I can see that this Coordinator role is a valuable and skilled one which would benefit both the consumer and the service as a whole. However, in my view, the risk of any specialist nursing role can be that there may be a risk of there being an expectation by the nursing

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staff that the specialist will do everything that comes under their scope, including tasks which could reasonably be expected to be completed by nurses on the floor. It may be useful to revisit the terms of reference so that there is a shared understanding of its purpose and expectations.

Although there was no physiotherapy or occupational therapy referral the lack of any input from these disciplines indicates to me that they weren't present on the ward at key times such as handovers and ward rounds. If they were then they would almost certainly have realized that this patient required their input. Therefore, examining the most useful key times for these and other disciplines to be on the ward may be valuable in the future.

In addition, critical thinking is a fundamental part of being a Registered Nurse and there were many very good examples of this occurring during the course of this admission. It is therefore particularly surprising that nobody considered making the referral discussed here despite the evidence that they faced from the end of the bed. I noted that on the evening prior to discharge the RN wrote that the patient was "hesitant for discharge" and "please review in the morning". Although I acknowledge that this is only my interpretation, this indicates to me some concern on the part of the nurse. Worded slightly differently and with more conviction may have allowed an opportunity for the medical team to reconsider their discharge plans. Some education on both critical thinking and speaking up may therefore be of value.

3. The adequacy of [Mr A's] discharge planning.

The standard of care/accepted practice.

The guiding document with respect to this question is again Ngā Paerewa and in particular section 3.6.5 which states that:

"Service providers shall ensure people obtain the support they need and that this is documented in the transition, transfer or discharge plan."

In my professional view it can be more useful to consider actions such as those discussed here in the context of a transfer of care rather than a discharge, as the latter phrase can have a degree of finality and closure about it, when in actual fact care is generally continuing, albeit in a different setting and in a different manner.

On reviewing the discharge documentation, it is clear that there had been a number of clinical investigations and that there were referrals made for further input including the respiratory services, although the latter was triaged as semi urgent and so is unlikely to have occurred for some weeks following discharge.

It was also clear to me from reading the clinical notes that this patient was not at his functional baseline at the point of discharge. This in itself need not be cause for concern in part because some individuals unfortunately never return to their base line level of function whereas others require more time, and the home environment can often be

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the best and preferred place for this to happen. However, as the clause above highlights, what is important is that the individual is offered the necessary support if they are being discharged back to their own home. Given this patient's clearly documented challenges with mobility and with managing his personal cares, some formal support with showering and dressing alongside community physiotherapy and occupational therapy input would in my professional view and experience be a clear expectation. I could not identify any documented evidence that this had been offered or discussed.

If there has been a departure from the standard of care or accepted practice, then how significant a departure (mild, moderate or severe) do you consider this to be?
In view of the lack of community support offered to [Mr A] when he was being discharged, I consider there to have been a severe departure from accepted practice.

How would it be viewed by my peers?
This admission was just one part of this individual's health journey and in theory there could have been other opportunities for appropriate interventions to be made. However, the respiratory specialist would not have been seen for several weeks and the GP is unlikely to have seen the discharge letter for some time following discharge. Therefore, neither would have been in a position to organise any supports immediately upon discharge. As with any health touch point, this admission should have been an opportunity to assess, to change things as necessary, and to provide the necessary available supports. In terms of the discharge my view is that this did not occur, and I believe my peers would agree with my conclusion.

Recommendations for improvement that may help to prevent a similar occurrence in future
Given this patient's presenting issues and his level of physical function at the time of his admission, an interRAI assessment (https://www.interrai.co.nz/) may have given an opportunity for the MDT to better understand the ongoing needs for this man. An interRAI assessment is mandated throughout New Zealand for home and community services, and is a comprehensive clinical assessment which focusses on an individual's function. It is designed to show the assessor opportunities for improvement and any risks to the person's health, which then form the basis of a care plan. Either the shorter and relatively quick Contact Assessment or the more in depth Home Care assessment could have been used. Education as to when this might be necessary could be beneficial.

Furthermore, there may have been benefit in involving Older Persons Health in this instance. It could be helpful to ensure the nursing staff are aware of how and when such a referral can be made so that this can be suggested to the medical team in the busy acute setting.

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The adequacy of the relevant policies and procedures in relation to the discharge process at the time of events

The standard of care/accepted practice
In their response letter dated [2021], Taranaki DHB stated that they did not have any specific policies or procedures relating to the Complex Discharge Coordinator Role.

I have reviewed the Taranaki Discharge Planning Procedures document during the course of this investigation and note that discharge planning is intended to be part of orientation for ward staff as would be expected. It also states that the discharge plan is initiated on admission which again aligns with the thinking that discharge planning starts at the point of admission. I note that this document was due for review in May 2017.

On reading the discharge planning flow diagram, it wasn't clear to me what a patient with complex needs was defined as. To an extent complexity is a matter of perspective and experience on the part of the individual making the decision. However, in my professional view and experience someone that is clinically complex is not necessarily the same as somebody that has complex needs on discharge. For example, an older adult that has been admitted with a relatively straight forward clinical issue such as a chest infection which has been resolved but is of no fixed abode and has no family, and therefore has nowhere to go but doesn't meet the threshold for aged residential care, could be a very complex discharge.

If there has been a departure from the standard of care or accepted practice, then how significant a departure (mild, moderate or severe) do you consider this to be?
In my professional opinion, the primary issue was not that there were no procedures but that they were not followed or that individuals were not fully aware of them. The lack of critical thinking is in my view the primary issue in this case. That said, clear and visible policies and procedures aid and guide this thinking and make the process in question objective whilst still keeping it person centred.

In my professional opinion, the procedures were there but they lacked clarity and visibility. For this reason, I consider that there has been a moderate departure from accepted practice with respect to the policies and procedures.

How would it be viewed by my peers?
I believe that my peers would agree with my views.

Recommendations for improvement that may help to prevent a similar occurrence in future
There are opportunities for improving and clarifying the discharge procedures as outlined below. As already discussed though, I would also recommend that greater clarity is given to defining what a complex patient is. In addition, I would be inclined to clarify how aware staff were of the discharge procedure given that the nursing assessment was incomplete, and that the algorithm indicated that they may need to

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refer to the complex case manager. If they were not considered complex though, it wasn’t clear to me what the next steps should be.

Although there always needs to be opportunities for clinical reasoning that go beyond an algorithm, having clearly defined what a complex discharge is with specific questions so that it is objective could be useful. For example. Do they live alone? Do they have a mental health history? Do they have a diagnosis of dementia? Has carer stress been identified? Do they require assistance at night? Are they a falls risk? Questions like these might help define complexity which goes beyond the important issue of clinical diagnosis alone.

I would also recommend review of the discharge planning procedure document as again not every aspect of this was clear and intuitive. The two flow diagrams were written in different ways. One was a series of questions (ARC) and the other a series of stages (Community discharges). A similar style for both may be easier to follow and to use. I thought that the ARC discharge process was more useful because it asked a question at each stage (Yes/No) which in my view would be more likely to elicit an action. Also, the flow diagram that relates to those individuals living in aged care villages or villas could equally relate to people living in the community as essentially, they are the same group of people and therefore I would question whether it should be under the ARC discharge process.

Any other matters in this case that I consider warrant comment or amount to departure from the accepted standard of care
As briefly mentioned above there may have been value in referring this patient to Older Persons Health for their expert advice. They may have recommended further in-patient rehabilitation or additional supports if returning home.

Richard Scrase
Registered Nurse 10/10/22’

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Appendix B: Independent clinical advice to Commissioner

The following advice was obtained from internal medicine specialist Dr Denise Aitken:

‘**Complaint:**	**Health New Zealand Te Whatu Ora Taranaki formerly Taranaki DHB**
Our ref:	**21HDC00883**
Independent advisor:	**Dr Denise Aitken**

I have been asked to provide clinical advice to HDC on case number 21HDC00882. I have read and agree to follow HDC’s Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	BSc MBChB FRACP Clin. Dip palliative care
Documents provided by HDC:	1. Letter of complaint dated [2021] 2. Health New Zealand Te Whatu Ora’s response to the family dated [2021]. 3. Clinical records from Health New Zealand Te Whatu Ora Taranaki covering the period [Day 1] to [Day 5] 4. Discharge planning procedure Health New Zealand Te Whatu Ora Taranaki, medical certificate of cause of death, discharge summary PDF, referrals made to the Health Integration Centre dated [Day 4]. Referral made to the General Surgery gastroenterology service [Day 4]. [2021] letter to HDC regarding this complaint. 5. Other provided documents, admission document (DATE), radiology records related to the admission [Day 1]–[Day 5]. Laboratory results related to the admission [Day 1]–[Day 5].
Referral instructions from HDC:	I have been asked to review the provided documents and advise whether I consider the care provided to [Mr A] by Health New Zealand Te Whatu Ora Taranaki was reasonable in the

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	circumstances and why. In particular, I was asked to comment on the following. 1. Whether it was appropriate to give medical clearance for [Mr A] to be discharged? 2. Whether all the appropriate tests/investigations were carried out prior to discharge? 3. Whether the safety net advice and follow up plan was adequate?

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	I do not have access to the email correspondence referred to between … and … The documented complaint on the inwards correspondence record dated … is a description of events. That is, that [Mr A] was admitted by ambulance to Taranaki Base Hospital with back and stomach pains. That he was discharged on [Day 5]. This document describes his presentation and the reason for his admission. It goes on to say that "our dad was discharged from hospital even though he was unable to walk unassisted. On the day that dad was discharged, our [elderly] mother had to get two passers-by to help transfer dad from the wheelchair into their car. When they arrived home mum struggled to get dad from the car up three stairs into the house. Within five minutes of arriving home our father suddenly passed away". After [Mr A's] death the family requested access to the discharge papers and the physiotherapy and occupational therapy reports. The discharge summary was available but there was no occupational therapy or physiotherapy report. In communication with Taranaki District Health Board, it became clear that he had not received assessment from those members of the multidisciplinary team. The family point out that he had required assistance with activities of daily living during this admission and that this should have correlated with a referral to these services. The complaint is predominantly about the lack of referral to appropriate members of the multidisciplinary team and the distress thus caused at the transfer home when [Mr A] was unable to independently get out of hospital or get into his own home.

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List any sources of information reviewed other than the documents provided by HDC:	I have not reviewed other sources of information.
Advisor's opinion:	I have been asked whether it was appropriate to give medical clearance for [Mr A]. On review of the notes it is clear that objective measures of his symptoms of chronic airways disease improved over the course of his admission. These are, recordings of oxygen levels, blood pressure, respiratory rate and heart rate. Similarly, it appears that his abdominal pain settled and important pathology such as aortic dissection and gallbladder infection are appropriately ruled out. The contemporaneous nursing notes describe that he requires assistance to mobilise. This is different to what is documented in his admission note where he is reported to have been previously independently able to mobilise a short distance, suggesting that prior to discharge he is not back to baseline. During the period of admission, the Doctor's ward round notes do not address his functional ability, ie his ability to walk or self-care. The discharge planning procedure policy provided by Health New Zealand Te Whatu Ora Taranaki states that it the responsibility of all members of the multidisciplinary team to ensure that a person is safe to discharge. Nursing staff responsibilities are addressed fully in this document. Medical staff responsibilities are documented as "initiate interdisciplinary team referrals on admission". "Ward huddles" take place week days apparently, these are a form of rapid round I understand and as such are an opportunity to ensure appropriate assessment and referrals are in place.

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<table>
<tr><td></td><td>In my opinion it is the responsibility of the whole MDT (Multidisciplinary team) to ensure discharge is safe.

Essentially identification of concerns, appropriate referral and assessment is a shared responsibility. In practise this is complex and requires

1 Robust process and communication
2 Adequate knowledge and capacity of staff.

It appears the medical teams were not aware of [Mr A's] decreased mobility despite this being documented. It is not possible to ascertain if this was raised at the ward huddle. In the absence of awareness, no safety net advice was given.

Throughout this admission appropriate tests/investigations were carried out and respiratory referral was completed and advice given. I do note that referrals were made for Speech/Language Therapy because of difficulty with swallowing medications, and to the Dietitians because of [Mr A's] weight loss. Both of these referrals were appropriately initiated.</td></tr>
<tr><td>Was there a departure from the standard of care or accepted practice?

• No departure;
• Mild departure;
• Moderate departure; or
• Severe departure.</td><td>The standard of care is to ensure safe discharge.

This discharge was not safe, as [Mr A] is reported to have required bystander assistance to get into his vehicle and to struggle to get into his own home. This is of concern. The responsibility for this is shared by all. From a medical perspective this was not best practice and would be viewed by my peers as a mild departure from accepted practice given the shared responsibility.

The failure to ask, versus failure for problem to be raised makes it difficult to direct responsibility to any group. It is perhaps a reasonable expectation of a medical team that as [Mr A's] exacerbation of airways disease improved, it is likely his exercise tolerance would improve. I note that the night prior to discharge [Mr A] expressed concern about his planned discharge. The next day it is documented</td></tr>
</table>

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	that he mobilised with minimal assistance in nursing notes. I would say that there is a mild departure from the standard of care as per above and that my peers would likely consider this the case. However, I would comment that medical clearance for discharge is an inaccurate term. It is only one component of safe discharge. [Mr A] was improving medically and planning discharge was appropriate, but safe discharge depends on all member of the MDT being in agreement he was ready for discharge. This did not occur. Mild departure. In my opinion (as referred to above) appropriate tests and investigations and referrals were carried out, with the exception of occupational therapy and physiotherapy referrals. No departure. There is no documentation provided re safety netting. In the absence of documentation, it is not possible to comment of the adequacy of this. It is likely the respiratory nurse service has provided advice about when to seek attention. The follow up plan with referral for further respiratory nurse input and for general surgical/gastroenterological follow up were appropriate. No departure.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future. Please outline any factors that may limit your assessment of the events.	Documentation of conversations regarding his functional state are not transcribed in the medical notes, and it is not possible to make comment on undocumented possible conversations.

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Recommendations for improvement that may help to prevent a similar occurrence in future.	A review of the process of the Ward Huddle would be appropriate and agreement to ascertain that appropriate referrals are initiated independent of any individual staff member being present. ie shared responsibility model, so that members of the Interdisciplinary team can ask “are there any issues preventing discharge” which could be a standard question and referrals could be initiated by any member of Interdisciplinary team. Further with regard to the discharge planning document, the standard described in this document is “that an interdisciplinary discharge plan is completed”. I suggest that a more patient centred standard might be that “we, the patient and whānau know that they are safe to discharge and their concerns have been addressed and their questions answered”.
Name: Denise Aitken	
Date of Advice: 7 December 2023’	

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