Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

# Inadequate support in place for woman living with dementia discharged from hospital

## 20HDC02175

Aged Care Commissioner Carolyn Cooper today issued a report finding Waitematā District Health Board (DHB) (now Te Whatu Ora Waitematā) breached the Code of Health and Disability Services Consumers' Rights (the Code) for their care of a woman in her eighties.

The woman was living with dementia and lived alone in the community. She was predominantly supported by her friend (who also had dementia) and her friend's daughter-in-law. The woman's daughter (who held Enduring Power of Attorney) was residing overseas at the time of the events.

The woman was admitted to North Shore Hospital on two occassions over two consecutive months. During both admissions, the woman was observed to be confused and disorientated and her support people raised concerns about how she was coping at home.

After both admissions, the woman was discharged and returned home without sufficient support in place to monitor her food intake and medication management.

On the afternoon of the first discharge, it was reported that the woman returned home by taxi and had no keys to enter her home.

On the evening following the second discharge, her friend reported that the woman was disorientated and agitated when she had arrived home by taxi. She was then re-admitted to hospital as a 'failed discharge' and remained there for two weeks before being discharged to aged residential care.

Ms Cooper found Te Whatu Ora Waitematā failed to comply with the Health and Disability Services Core Standards and that cumulatively, the failings amounted to a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

These failings included: not making a referral to a specialist older person's health service during both admissions. During the second admission, the deterioration in cognitive function was clear and the Occupational Therapist identified that this would likely be the woman's last chance to live independently at home.

Ms Cooper noted that the decision to discharge the woman the second time, given her clear decline in cognitive function from the first admission, was inappropriate, particularly given the decision was made prior to the occupational therapy assessment and the woman's daughter was not made aware of the results of that assessment.

Te Whatu Ora Waitematā also failed to make a referral to Primary Options for Acute Care (POAC) for immediate commencement of cares during the woman's first admission.

Finally, during both admissions, Te Whatu Ora Waitematā failed to contact the woman's GP to gather information about her cognitive function and failed to appropriately act on

information supplied by the woman's support people. This information could have enhanced care and discharge planning.

The woman's friend, who was the complainant in this case, stated that she wanted others living with dementia in New Zealand to be well cared for in hospital. "Families shouldn't have to rant or complain to receive safe and appropriate care for their loved ones," she said.

Ms Cooper also found Te Whatu Ora Waitematā breached Right 4(5) of the Code, which gives consumers the right to co-operation among providers to ensure quality and continuity of services.

"The woman 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," Ms Cooper said.

"Te Whatu Ora Waitematā had a responsibility to ensure that the woman was provided with services that complied with the Code, and for ensuring that it planned and coordinated the woman's discharge from hospital appropriately and safely."

Since the event, Te Whatu Ora Waitematā have introduced Winscribe for gerontology nurse specialists in the Health of Older Adults Service. This means letters can now be dictated soon after the assessment and, once approved, automatically sent to the GP. This will enable delays in the process to be tracked.

- Ms Cooper recommended that Te Whatu Ora Waitematā:
  Provide a written apology to the woman, her whānau, and her friend for the failings identified in this report.

- Consider the recommendations set out in the advice provided by the registered nurse advisor who assisted with this investigation.

- 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.

Health and disability service users can now access an online animation to help them understand their health and disability service rights under the Code.

2 October 2023

***Editor's notes***

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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