

**A Decision by the
Deputy Health and Disability Commissioner
(Case 21HDC00863)**

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Introduction

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
2. The report discusses the care provided to the late Mr B, aged in his sixties at the time, by Waitematā District Health Board (now Te Whatu Ora Waitematā) (Te Whatu Ora), and in particular the management of his discharge from Hospital 1 on 30 Month⁷ and support received following discharge until he passed away on 4 Month⁸.
3. On 20 April 2021, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her partner, Mr B, by Te Whatu Ora during Month⁷ and Month⁸.
4. Mr B had been diagnosed with idiopathic pulmonary fibrosis² (IPF) in 2020 by a respiratory physician, following a referral from his general practitioner (GP), Dr A. The respiratory physician referred Mr B for specialist respiratory care and, as a result, he became an out-patient at Hospital 2 under the care of Dr C. Mr B's health deteriorated, and he was admitted to Hospital 1 on 20 Month⁷.

¹ Relevant months are referred to as Months 1–8 to protect privacy.

² Idiopathic pulmonary fibrosis is a serious condition that affects the tissues of the lungs. Normally the lung tissue is soft and flexible, making it is easy to breathe, but in someone with IPF the lung tissue stiffens and becomes damaged from scarring. The scarring (fibrosis) of the lung tissue is permanent.

5. My sympathy and heartfelt condolences go to Ms B for the loss of her partner of many years. From the information reviewed to prepare this report, it is clear that Mr B was thought of highly by the medical team who cared for him. I acknowledge that it will have been a difficult process for Ms B to write her detailed notes to support this complaint, and I hope that this report will bring some healing for her.
6. The following issue was identified for investigation:
- *Whether Te Whatu Ora|Health New Zealand provided Mr B (dec) with an appropriate standard of care in 2020.*
7. The parties directly involved in the investigation were:
- | | |
|------------|----------------------------|
| Mr B | Consumer |
| Ms B | Complainant/Mr B's partner |
| Hospital 1 | |
| Hospital 2 | |
8. Further information was received from:
- | | |
|------|---------------------------------------|
| Dr A | GP |
| Dr C | Respiratory physician |
| Dr D | Respiratory physician |
| Dr E | Registrar |
| Dr F | Registrar |
| RN G | Respiratory clinical nurse specialist |
9. Dr H, oxygen physiologist, is also mentioned in the report.

Background

10. In 2020, following Mr B's confirmed diagnosis of IPF, the respiratory physician discussed with Mr B and Ms B the treatment options available, including trialling anti-fibrotic agents (pirfenidone and nintedanib).³ Whilst Mr B was not eligible for funding of these drugs at the time, as he did not meet the relevant criteria in relation to lung function and FVC⁴ reduction, Ms B has advised that subsequently he became eligible in Month1.
11. Mr B first trialled pirfenidone from Month1 until Month4, but on 24 Month4 he was advised to stop because of a rash on exposed areas of his body. In Month6, Mr B trialled the second drug, nintedanib.
12. At an appointment with Dr C at Hospital 2 on 16 Month7, it was noted that Mr B's condition had changed over the previous couple of weeks. In a letter to Dr A dated 16 Month7, Dr C

³ Pirfenidone and nintedanib are anti-fibrotic agents approved for treatment of IPF. Clinical trials have shown that these drugs slow down the rate of fibrosis (scarring) in the lungs.

⁴ Forced Vital Capacity (FVC) refers to the amount air that can be forcibly exhaled from the lungs after taking the deepest breath possible. FVC is measured by spirometry (see below).

stated: ‘Something seems to have happened in the last week or two, where [Mr B] has very suddenly become quite breathless.’ Dr C confirmed that Mr B had stopped taking nintedanib because of this.

13. Just prior to the appointment, a chest X-ray was carried out, but no FVC/spirometry test⁵ was undertaken. Ms B stated that Dr C asked Mr B where the FVC test results were as he could not find them on his system at this appointment. Ms B informed Dr C that Mr B had not been called for an FVC test whilst they had been waiting. Dr C told HDC that it is likely that the FVC was not undertaken ‘because someone thought [Mr B] wasn’t well enough to perform the test or there may still have been Covid related restrictions on testing at that time’. Whilst Ms B has queried why the FVC test was not carried out, I note that in Ms B’s complaint, she recalled that Mr B indicated to Dr C at the appointment that he would have been unlikely to have been well enough for the FVC to go ahead at that time.
14. Te Whatu Ora stated that whilst the oxygen saturations⁶ are not recorded in Mr B’s records, Dr C considered that it was a good nursing decision not to go ahead with the spirometry, as he felt that Mr B would not have coped. Te Whatu Ora acknowledged that ‘this should have been documented and communicated to [Mr B] and [Ms B]’.
15. Following the examination on 16 Month7, Dr C made urgent referrals to Hospital 2 for a CT chest scan and urgent spirometry and DLCO.⁷ Dr C described this to Dr A as a ‘more detailed lung function’ at Hospital 1. Dr C’s intention was to see Mr B again once he had received the results.
16. Ms B advised HDC that over the weekend of 17/18 Month7 and 19 Month7, Mr B’s breathing was still laboured and he was short of breath, and other members of the family raised concerns about this.

Admission to Hospital 2

17. Mr B experienced further episodes of shortness of breath, and in the early hours of 20 Month7, Ms B called a telehealth service. Following a discussion with Mr B, at 4.51am the telehealth service called an ambulance to take him to Hospital 2.
18. On arrival at Hospital 2 Emergency Department, Mr B was seen by Dr C. Mr B was admitted to Hospital 2, and over the next few days he was treated with broad-spectrum antibiotics, high-dose steroids and supplemental oxygen. Te Whatu Ora’s e-clinical notes record that during a ward round Dr C explained to Mr B that ‘this [was] a serious set back and [Mr B] may have lasting [deterioration] in lung function following this’.
19. Te Whatu Ora’s e-clinical notes on this date show that Ms B asked the General Medicine registrar to speak to Mr B’s medical team to ask a number of questions, including ‘whether

⁵ Spirometry measures the air entering and leaving the lungs (and is used to determine lung function in the diagnosis of lung disease).

⁶ The amount of oxygen circulating in the blood.

⁷ Diffusing capacity of the lungs for carbon monoxide — a measurement to assess the ability of the lungs to transfer gas from inspired air to the bloodstream.

[Mr B] need[ed] to be referred to community palliative care', and questions around advanced care planning.

20. Mr B's health continued to deteriorate, and by 23 Month7 his oxygen requirements had increased. Dr C had discussions with colleagues, a respiratory specialist, and a consultant Intensive Care Unit (ICU) physician at Hospital 1, and they considered that Mr B would benefit from a formal review by the ICU team at Hospital 1.

Transfer and admission to Hospital 1

21. On the afternoon of 24 Month7, Mr B was transferred to Hospital 1 under the care of respiratory physician Dr D. The admission form notes Mr B's diagnosis as 'subacute⁸ deterioration of pulmonary fibrosis + emphysema'.
22. Dr D first met with Mr B and Ms B on his ward round on 25 Month7. Regarding his discussions with Mr B that day, Dr D told HDC:

'I made it very clear that things have deteriorated in hospital and that [Mr B] is getting very near the ceiling of care that we would provide on the ward as his oxygen requirement was FiO₂ of 56%, where on the ward 60% would be the maximum.'

23. Dr D said that he felt that he had made it very clear to Mr B that he might not improve, and that going home with oxygen would very much depend on how the oxygen therapy worked on the ward. Dr D stated that he decided not to admit Mr B to the ICU/High Dependency Unit (HDU) 'given [Mr B's] underlying lung disease and poor outcomes even with non-invasive ventilation'.
24. Dr D told HDC that he did not document the discussions he had with the ICU consultant on call that day (25 Month7) about this decision, and his registrar who was present at the time, Dr E, did this the following day. Dr E documented:

'Deterioration is worrying and concerning, and there may be little else we can do to improve condition. If recovery does occur (and it might not), there is a possibility that discharge might be on oxygen.'

25. The following day (26 Month7), Dr E reviewed Mr B in the presence of Ms B and advised them that there was 'some degree of improvement in [Mr B's] clinical condition from the day before'. Dr E explained to HDC that she came to this conclusion because Mr B's oxygen saturation levels had improved from 89–90% the previous day to 95% on 26 Month7.
26. Ms B told HDC that this review by Dr E left her feeling completely confused, and gave them 'false hope', although Ms B described Dr E as having a 'wonderful bedside manner'.

⁸ Rather recent onset or somewhat rapid change.

27. Dr E told HDC:

'I wished to convey that we had some early sign of improvement from his acute exacerbation of interstitial lung disease, and that there was a possibility that he could get better than he had been on admission, but that his condition was still concerning. Whilst I believe I communicated that there was now a chance that he might not be passing away as imminently as we had initially feared, it had not been my intention to give false hope that his condition was no longer palliative. It was not my intention to convey the message that he would recover from his underlying condition, in particular his severe interstitial lung disease.

If my communication was in any way unclear regarding this, or further contributed to confusion regarding [Mr B's] condition, then I am sincerely sorry for this. I had hoped to ease [Mr B's] family's distress where possible, by sharing the information noted above.'

28. From 27 Month7 until his discharge, Mr B conveyed to Ms B and the medical team his wish to be at home. Ms B told HDC that the medical team indicated to them that the plan was to work towards discharging Mr B home on 30 Month7, if the amount of oxygen he required could be reduced and oxygen could be delivered. Ms B advised HDC that she received no specific confirmation of this plan. During this period, Mr B was seen daily on a consultant ward round by Dr D or a relieving registrar on the General Medicine team, Dr F. Dr F advised HDC that daily multi-disciplinary team (MDT) meetings were also held on the ward to 'identify areas or barriers to safe discharge' for Mr B.
29. On the afternoon of 28 Month7, during a discussion with Dr F, Ms B raised concerns about Mr B being transferred back to Hospital 2 that day. Ms B stated that Dr F told her and Mr B that Mr B's hospital bed was needed, and that Hospital 2 could provide the same care as Mr B had been receiving at Hospital 1. Ms B feels that it was only because she asked questions around this that Dr F became aware that Dr C was still on leave from Hospital 2. Ms B said that this incident was the start of where she felt things went wrong.
30. Both Dr F and Dr D told HDC that the decision to transfer was brought up at the request of the 'management team'. Dr F confirmed to HDC that once he had clarification that Dr C was in fact away, the transfer was cancelled, and this was confirmed to Mr B and Ms B.
31. A registered nurse made the following entry in the e-clinical notes at 9.27pm on this date:
- 'Duty Nurse [Manager] phoned to inform us that a bed is available for [Mr B] at [Hospital 2], DNM ... told me to ask the team to phone [Hospital 2] Admitting Registrar in [Assessment and Diagnostic Unit] and identify the accepting doctor. I have informed the team Registrar and he told me that he will ring [Dr D] about this as he is not aware [patient] is for transfer to [Hospital 2]. Team Registrar [Dr F] did not get back to me, I saw him speaking with the patient but nothing written in notes. I tried phone but nil response.'
32. On 28 Month7, a Domiciliary Oxygen Request was made to the Oxygen Service at Hospital 1 on behalf of Dr D for the oxygen Mr B would need at home once discharged.

33. On 29 Month7, a letter was sent from the Oxygen Service Clinic to Mr B's GP advising that the oxygen therapy start date would be '30 [Month7]'. At 10.32am that day, Dr F recorded in the e-clinical notes the following plan in preparation for sending Mr B home:

'1. wean to nasal prong O₂ today if tolerated — accept SpO₂ >88 — trial on NP 6L and measure SpO₂ for 30 mins today and document for preparation for home with [long-term oxygen therapy].'

Day of discharge from Hospital 1

34. Ms B told HDC that while at work on the day of the proposed discharge (30 Month7), she had a call at around 9.30am from the oxygen delivery company.⁹ She said that she was advised that an employee from the company was at Mr B and Ms B's home to deliver the oxygen. Ms B stated that as she had not had prior confirmation about the oxygen delivery or discharge from the medical team at the hospital, she told the company employee to take away the oxygen until she had called the hospital. Te Whatu Ora acknowledged to HDC that it was 'an oversight on [Te Whatu Ora's] part' that Ms B was not made aware of the plan.
35. Following Ms B's call to the hospital, a family meeting was held at Hospital 1 at 1.30pm on 30 Month7. It was confirmed that the plan was for Mr B to go home, subject to the oxygen being delivered. Ms B stated that during discussions with Dr F at this meeting, she specifically asked again about 'support at home, signs to watch out for in the care of [Mr B], what [she] should do etc'. Ms B said that she asked Dr F about nursing support and was advised that the only support offered was hospice care. Ms B stated that she was made to feel 'stupid' for asking about nursing support. She said that in discussions about the hospice support that was to be put in place, 'no time frames were given as to when the support would start'.
36. Dr F told HDC that at this family meeting he informed Ms B that 'typically [they do not] have the ability to provide nursing staff to perform the same cares that [Mr B] [received] in hospital at home', and that the option was provided for Mr B to return to hospital if his condition deteriorated, and that this should happen in the case of 'uncontrolled distress of symptoms'. Dr F also stated that he did not intend to make Ms B feel stupid, and apologised if it was perceived in that way. Te Whatu Ora also told HDC that '[Dr F] has reflected and appreciates his communication should have been better' and 'that he failed to recognise the very real request [Ms B was] making for help and support'.
37. Dr F also told HDC that options for support at home were provided to Mr B prior to his day of discharge. Dr F said that various options were discussed, starting with a Needs Assessment Co-ordinator (NASC) service and what that support meant. Dr F advised that Mr B 'did not feel this was necessary'. Dr F's e-clinical notes at 1.27pm on 28 Month7 refer to his discussions, and state, 'Slept well overnight', 'Lives at home with wife', 'Does not feel needs equipment at home', and, 'Toilet about 6m from bedroom'. Dr D confirmed with HDC

⁹ Te Whatu Ora owns oxygen equipment that is maintained and delivered to patients in the community by an independent company.

the discussion by Dr F. Dr D also said: 'I understand not all the details are documented in the clinical notes in this respect.'

38. Dr D told HDC that nursing staff had documented that no issues were raised at the daily MDT meetings about Mr B managing at home, and it was felt that with the oxygen he would manage 'independent[ly] with [his] activities of daily living'. However, Dr D also stated: 'On hindsight this could have been documented clearer for what the MDT thinks of the overall picture.'
39. After the meeting at 1.30pm, Ms B re-arranged delivery of the oxygen for between 2–3pm that day (30 Month7). Ms B described her difficulties and frustration in notifying Dr F of this to allow for Mr B's discharge home and for an ambulance to be booked. Ms B stated that Dr F had told her in their earlier meeting to let him know once the oxygen had been sorted, and that he 'would then proceed based on this information to book in the ambulance to take [Mr B] home'.
40. Dr F told HDC:
- 'I made it clear that we had to have confirmation that oxygen would be at [Mr B's] place prior to his arrival before we could endorse arranging the ambulance and discharge home and I received correspondence from one of the [Community Nurse Specialists] — [RN G] prior to doing so.'
41. Ms B stated that when she informed a nurse on the ward of this information so that Dr F could proceed as planned, she was told that Mr B 'doesn't go home in an ambulance, that if he does it will cost [Ms B] around \$200'. Ms B said that to enable the discharge, she confirmed that she would pay the cost of the ambulance.
42. Dr F told HDC that on the day of Mr B's discharge, 'things felt a bit rushed'. Dr F stated:
- 'There were logistical concerns about oxygen delivery and education and on more than one occasion on the day of discharge I offered to keep [Mr B] in hospital to ensure that everything was in place. [Mr B] was adamant he did not want to stay a day longer if he could help it and therefore we worked to facilitate this. At time of signing off on his discharge and ordering the ambulance I was informed that we had a firm plan for oxygen delivery and education which involved one of our CNS going above and beyond to facilitate this.'
43. The referral for hospice support and the discharge summary from Dr F were received electronically by the hospice at 4.17pm on Friday, 30 Month7. In relation to the time scale, Dr F stated on the referral form: 'No current uncontrolled symptoms but early review and support in the week after discharge would be much appreciated, expecting a rapid decline.'
44. Dr F told HDC that he trusted Dr D's opinion as the respiratory specialist, and Dr D had estimated that Mr B would have 'weeks to short months' to live, and that a review within a week was appropriate based on this. The referral form also confirmed that no other support services were involved.

45. The discharge summary noted the following oxygen requirements for Mr B:

‘Palliative oxygen arranged with stable sats on 3–4L.

Noted by Dr D that if need be may benefit from two [oxygen] concentrators.’

46. Ms B explained that when the oxygen compressor was delivered, instructions were given to her, and she was able to set up the machine. The employee who delivered the compressor advised that another oxygen bottle would be arranged that day (30 Month7) or the following day. However, Ms B stated that she had not been told what the setting should be for the oxygen saturation, and the prescription for Mr B had not been provided.
47. Ms B called the ward that afternoon, and her query regarding the oxygen was passed on to RN G, a respiratory clinical nurse specialist based at Hospital 2. RN G called Dr H, an oxygen physiologist, who rang Ms B to provide reassurance of the prescription and advised that the oxygen saturation should be set between 3–4.
48. Te Whatu Ora and RN G advised HDC that normally she did not do home visits, but she offered to visit Mr B and Ms B on Monday, 3 Month8 to ensure that they were comfortable with how to use the oxygen. Te Whatu Ora said that this was above and beyond RN G’s role.

Subsequent events following discharge

49. Ms B advised that Mr B arrived home by ambulance at around 7pm on 30 Month7. By this time, Ms B had still not received the extra oxygen bottle, and so queried this with the transit nurse. The transit nurse made some enquiries but was unable to help. However, the ambulance driver left an oxygen bottle from the ambulance as a ‘back-up’. Te Whatu Ora told HDC:

‘It is unacceptable that [Ms B] had to ask the ambulance driver to leave a portable cylinder in case of a power cut. It is clear from [Ms B’s] letter that [Mr B] and [Ms B] would have benefited from more robust education on how to use the oxygen at home and ideally this education would be provided on the ward prior to discharge a number of times to ensure that it is understood. We let [Ms B] and [Mr B] down in this respect.’

50. RN G visited Mr B on 2 Month8. She told HDC that she checked the concentrator, provided education on breathing techniques and cycles of breathing with phlegm clearance, and offered an advanced care plan but was advised that there was one in place. Ms B told HDC that RN G asked whether they had physiotherapy for Mr B’s breathing, and she confirmed to her that they did not. RN G told HDC that she had noted a hospice referral in the discharge plan and did not think she needed to revisit. She said that she was sorry to hear of Mr B’s passing and added that Mr B and Ms B ‘were both loving and caring to one another’.
51. On 3 Month8, Ms B rang the hospice and left a message on its answerphone explaining that they were ‘struggling and need[ed] help’. The hospice’s progress notes for this date describe Ms B as quite tearful when the nurse spoke to her. The hospice’s notes record that Ms B raised concerns about not having a hospital bed, commode, or shower stool, and that Mr B had not been reviewed by a physiotherapist for breathing techniques. Ms B advised the

nurse that she felt that '[Mr B] ha[d] fallen through the net'. The hospice's progress notes confirm that Ms B was advised that Mr B had been booked in for first contact on 9 Month8.

52. Given Ms B's concerns that day, the nurse arranged for a prescription of midazolam nasal spray¹⁰ through Mr B's GP, Dr A. Dr A also visited Mr B that evening. The hospice arranged to contact a district nurse and make a NASC referral (both were done that same day) and planned a referral to a physiotherapist. The intention was to telephone Mr B and Ms B the next morning to arrange for an initial assessment by a clinical nurse specialist.
53. During the early hours of 4 Month8, Ms B called the hospice to advise that Mr B was struggling with his breathing, and she was given advice. Ms B called again and, whilst waiting for a return call around medication management, she called an ambulance because of Mr B's worsening condition. The hospice's progress notes show that at 6.20am a call was received from a paramedic who was with Ms B, to say that, sadly, Mr B had passed away.
54. In her complaint, Ms B highlighted the difficulties and distress she and Mr B encountered after his discharge until when he passed, due to the lack of support and equipment.

Further information from Te Whatu Ora

55. Te Whatu Ora carried out an internal investigation in relation to Ms B's initial complaint, which was made directly to Te Whatu Ora. Te Whatu Ora's findings, dated 24 February 2021, were provided to Ms B and copied to HDC. Te Whatu Ora recognised that it was a very difficult journey for Ms B without proper support for Mr B in place. Te Whatu Ora's letter to Ms B stated:

'You were left nursing [Mr B] with little or no support and this must have been a distressing experience ... It is concerning that the team was so focused on meeting [Mr B's] desire to be home, and given that he appeared to have stabilized in hospital, and he appeared to be managing his breathlessness on the ward, a full multidisciplinary assessment was not carried out. As a consequence we did not ensure that all the possible supports required to support [Mr B] at home were in place.'

56. Te Whatu Ora also stated in its summary of care: 'It is distressing to hear that despite multiple attempts by [Ms B], community support was not provided when she needed it.'
57. Te Whatu Ora said that it did not expect Mr B to progress to end of life so quickly, and the referral for hospice support had been made on the prognosis being weeks to months. Te Whatu Ora advised:

'A prognosis is always difficult to make. While clinicians always attempt to give the best prognosis based on medical knowledge and experience, sadly, this can be wrong and we are sorry we were wrong with respect to [Mr B]. We can only imagine what a shock it was to suddenly lose [Mr B] so soon after going home.'

¹⁰ Midazolam nasal spray can help to reduce feelings of panic and anxiety caused by being short of breath, and it is used for people receiving palliative care.

58. Te Whatu Ora also recognised that better communication throughout the period of care concerned would have made Mr B and Ms B's journey easier. Te Whatu Ora stated: '[E]veryone has reflected on their method of communication and apologised that it impacted a smooth transition home.'
59. In relation to the education around oxygen, Te Whatu Ora stated that Ms B's complaint has highlighted the importance of ensuring that education is provided until staff are 'sure that the patient and caregiver know how to use it'. Te Whatu Ora said: 'We want to ensure that no one has to endure what [Ms B] did, wondering if the oxygen would run out.'
60. Te Whatu Ora told HDC that whilst support at home had been offered to Mr B but declined:
- 'On reflection, a more frank discussion with families about how different and challenging it can be at home in this situation might be beneficial so that support can be fully considered in context.'
61. Te Whatu Ora's letter to Ms B on 24 February 2021 recognised that there were missed opportunities to refer Mr B to the inpatient palliative care team and the District Nursing Service, and that a family meeting with all members of the multi-disciplinary team would have benefited Mr B and Ms B. Te Whatu Ora highlighted that if these referrals had happened, the inpatient palliative care team 'may have either prioritized his outpatient hospice referral or they may have delayed his discharge home', and the District Nursing Service could have provided support over the weekend after Mr B's discharge. Te Whatu Ora also highlighted that some of the multi-disciplinary team would have been more aware than Dr F of the nursing and carer support available.

Further information from Dr D

62. Dr D acknowledged that the documentation on the ward at the time of Mr B's admission did not reflect the time and effort of the medical team. Dr D told HDC: 'I will emphasise [to] my junior team the importance of documentation of family meetings and important discussions.'
63. Dr D also agreed that better support and education is needed for the patient and their family when a patient requires oxygen therapy. Dr D suggested that this could be done by repetition of the education provided on the ward prior to discharge and at home.

Responses to provisional opinion

64. Ms B was given an opportunity to respond to the 'Introduction', 'Background' and 'Changes made' sections of the provisional opinion.
65. Ms B told HDC that whilst Mr B may have declined the care offered at home on 28 Month7 (see paragraph 37 above), she felt let down by the failure to involve her in these discussions, as his caregiver and partner.
66. Ms B also clarified that she had been concerned about the oxygen bottle running out on, or around, 3 Month8. She told HDC that she 'was able to provide higher levels of oxygen to [Mr

B] on the oxygen bottle than what the concentrator provided'. She confirmed that because the oxygen in the bottle was getting low, she transferred Mr B back to the concentrator to reserve the remainder of the oxygen in case of a power cut.

67. Te Whatu Ora was given an opportunity to respond to the provisional opinion. Te Whatu Ora stated:

'We acknowledge the opportunity to improve the care and experience for our patients and whānau. We recognise that we did not meet the standards expected in the discharge planning for [Mr B]. For this we are sorry, and we have reflected on this with the wider team.

Providing comprehensive discharge care has been a core focus of our service especially over the last 15 months since the inception of our Hospital in the Home service (HITH). This service has sought to provide immediate advice and support through daily phone contact, and the ability for patient and whānau-initiated contact, when needed. We will bring the learnings from this report to our service governance group and the Hospital in the Home Steering committee, in addition to implementing the recommendations. Supporting patients requiring oxygen on discharge is already planned for review and discussion through our HITH project team, and this will provide an opportunity for us to consider how we can use our Hospital in the Home service to enhance the care delivery process.'

68. Te Whatu Ora also told HDC that it had spoken directly with Dr F to reflect on the findings of the report and the recommendations. Te Whatu Ora acknowledged the adverse comments, including those concerning communication and documentation. Te Whatu Ora stated:

'Together we have and will continue to use this opportunity to build on [Dr F's] training and care for patients. [Dr F] has reached out to colleagues across the multidisciplinary team to further learn about comprehensive discharge care planning and immediate support on discharge.

I wish to convey my opinion that [Dr F] will use this finding to build significantly on his practice, his continued passion for patient and whānau c[e]ntered care, his communication and documentation.'

69. Te Whatu Ora recognised that the recommendations are comprehensive and hopes they will bring some healing for Ms B.
70. Te Whatu Ora again offered its sincere condolences to Ms B.

Opinion

Introduction

71. I acknowledge the difficulties encountered by Mr B and Ms B, particularly following Mr B's discharge from hospital on 30 Month7. It is evident that Mr B was not comfortable at home

at the end stage of his life, and could have benefited from nursing, medical and hospice care, and appropriate equipment to support him and Ms B. I recognise that it would have been distressing for Ms B to see Mr B struggling. I was moved when reading Ms B's notes, and I note that she did everything she could to make Mr B as comfortable as possible in the circumstances. I commend her for bringing this complaint.

72. To determine whether Mr B was provided with the required services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), I have considered the advice of an independent respiratory physician, Dr Nicola Smith (Appendix A).

Te Whatu Ora — breach

73. I have undertaken an assessment of the information gathered as part of this complaint made by Ms B. I find that Te Whatu Ora breached Right 4(1) of the Code.¹¹ The reasons for my decision are set out below.

Clinical care provided by Te Whatu Ora's respiratory team

74. Te Whatu Ora had a responsibility to ensure that there were adequate systems in place for Mr B by way of appropriate medical care and support, both in hospital and when he was discharged home during the period Month7 to Month8.
75. During Mr B's admission to both Hospital 2 and Hospital 1 in Month7, specialist respiratory physicians were mainly responsible for his clinical care and treatment — namely, Dr C and Dr D, with support from the relieving registrar, Dr F. My independent advisor, Dr Smith, considered that the clinical care provided by the respiratory team at Te Whatu Ora during the period concerned was of a high standard. As a peer, Dr Smith felt that the respiratory team involved in Mr B's care provided him with the 'maximal therapy possible for his advanced condition'. I accept Dr Smith's advice.

Hospice referral

76. A referral to hospice was made electronically on Friday, 30 Month7 (the day of discharge). Given Mr B's prognosis by the medical team at Te Whatu Ora of weeks to months, the referral requested that contact be made by the hospice within the week after discharge. Dr Smith confirmed that based on this prognosis, both the communication and electronic referral were adequate in the circumstances. I accept this advice and consider that based on Mr B's condition at the time he was discharged from hospital, the referral timeframe was appropriate.

Communication of oxygen plan and education on oxygen use for discharge

77. There is no question that Mr B's wishes were to go home. This was confirmed by Te Whatu Ora, the medical team, and Ms B. On 29 Month7, Te Whatu Ora advised Mr B's doctor that the oxygen therapy start date would be 30 Month7. However, I note that on 30 Month7, when the medical team decided that discharge home would be clinically safe, Ms B was not clear on the plan for oxygen to be delivered to their home that morning. Ms B was contacted by the delivery company when she was at work, and she was not prepared for the delivery.

¹¹ Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

78. Given that on 29 Month7 Te Whatu Ora was aware of the oxygen start date, I would have expected discussions with Ms B to have taken place several days prior to the day of delivery. Later on 30 Month7 the oxygen plan was discussed with Mr B and Ms B at a meeting held at the hospital. Te Whatu Ora acknowledged in its summary of care that it had been an oversight on its part not to have notified Mr B and Ms B of the oxygen plan beforehand.
79. On the day of discharge, Ms B encountered further difficulties, as she was unsure of the setting for the oxygen saturation and was concerned that there was no spare oxygen cylinder. Te Whatu Ora has acknowledged that better education on the ward on how to use the oxygen at home prior to discharge would have helped Ms B and Mr B. I agree and consider that this should have occurred.

Adequacy of discharge planning and support

80. I note that from 21 Month7, Ms B asked whether Mr B should be referred to the community palliative care team. Clearly, Ms B had concerns around support for Mr B from the early stages of his admission to hospital, and she continued to raise her concerns even after his discharge.
81. Dr Smith advised that Mr B would have benefited from hospital palliative care involvement and stated that this 'may have facilitated a smoother transition to the community hospice services'. Dr Smith said that given Mr B's circumstances, it would have been standard care for Te Whatu Ora to have provided an inpatient palliative care assessment. Dr Smith considered the lack of inpatient palliative care input to be a mild departure from the accepted standard of care. Te Whatu Ora acknowledged that there was a missed opportunity to refer Mr B to the inpatient palliative care team, and I agree that this should have happened.
82. On 28 Month7, discussions were held with Mr B and the medical team around specific NASC home support, and further discussions around support occurred at the meeting on 30 Month7, prior to his discharge. However, Dr Smith considers that these discussions were not sufficient. She advised that whilst it was clinically appropriate for Mr B to be discharged from hospital, a multi-disciplinary assessment 'should have occurred prior to discharge'. Dr Smith stated:

'[Mr B] was not reviewed by an occupational therapist or physiotherapist prior to discharge. The medical team appeared to rely on [Mr B's] statement that he didn't feel he needed any additional equipment at home and nursing notes recording that [he] was independent and mobile on the ward. The letter of complaint records the difficulty [Mr B's] partner had caring for [him] at home without additional equipment. A physiotherapy and occupational therapy assessment, including a home visit prior to discharge, would have allowed for the necessary equipment to be in place to allow [Mr B] to be as comfortable as possible in his last days of life.'

83. Te Whatu Ora acknowledged that by not carrying out a full multi-disciplinary assessment prior to discharge, Mr B and Ms B were not provided with all the available support for Mr B at home.

84. Dr Smith considers that the failure to carry out these assessments was a moderate departure from the accepted standard of care. I accept Dr Smith's advice. Had these assessments occurred, Mr B's discharge would have been more comfortable, and Ms B would have received more support in caring for Mr B when he returned home.

Overall communication and documentation

85. Ms B was also left feeling confused around the communication about Mr B's improvement on 26 Month7, and she was not provided with a time frame for when the hospice support would start.
86. I note that there are references to discussions not being documented or being made clear in Te Whatu Ora's clinical notes on 16, 25, and 28 Month7, and in the MDT daily meeting notes.
87. I am concerned that Ms B has stated that on 30 Month7, a nurse on the ward told her that Mr B would not be transported home in an ambulance and referred to the cost if that is what Ms B and Mr B wanted. However, I note that Dr F told HDC that he endorsed arranging an ambulance to transport Mr B home on discharge and he did not refer to the cost (see paragraph 40 above). Given Mr B's condition and the requirement for oxygen, I consider that an ambulance would have been the most appropriate form of transport for him on discharge, and I am critical that there was confusion for Ms B around this.
88. Te Whatu Ora and some of the medical team acknowledged that communication with both Mr B and Ms B could have been better whilst Mr B was being treated by the medical team. Dr D acknowledged to HDC that clearer documentation could have been made by the medical team in relation to the overall picture regarding Mr B's manageability. Better communication and clinical documentation would have provided some clarity for both Mr B and Ms B, as well as medical staff, and I am critical of this.

Conclusion

89. Te Whatu Ora did not carry out crucial assessments or make appropriate support referrals prior to Mr B's discharge, which meant that Mr B and his partner, Ms B, did not have the necessary and appropriate support to ensure that Mr B's last few days were as comfortable as possible. I also consider that Te Whatu Ora's documentation and overall communication with Mr B and Ms B were inadequate. Accordingly, I find that Te Whatu Ora breached Right 4(1) of the Code by failing to provide services to Mr B with reasonable care and skill.

Dr F — adverse comment

Communication and documentation

90. On the days leading up to Mr B's discharge and on the day of discharge, Dr F, as relieving registrar for Dr D, was the visiting physician and had most of the discussions with Mr B and Ms B around his prognosis, support, and discharge.
91. On 28 Month7, despite Dr F having had discussions with Mr B and Ms B around the transfer, it was noted by the nursing team that Dr F did not get back to them and had written 'nothing in notes', which did not help the nursing team supporting Mr B.

92. Dr F advised HDC that on 28 Month7, prior to discharge, he had a meeting with Mr B regarding support options and the NASC service. However, the full details of these discussions and options of support were not documented in the clinical notes. Dr D also acknowledged this.
93. In relation to the meeting at 1.30pm on 30 Month7, Ms B highlighted that it was not clear to her what the time frame would be for when the hospice support would start, and she was made to feel stupid when she asked Dr F about nursing support. It is also apparent that when Ms B had subsequent discussions with nursing staff after the meeting, they were not aware of Dr F's discussion with Ms B regarding him requiring information to book an ambulance. This demonstrates poor communication on Dr F's part, both with Ms B and the nursing staff. I am also critical that despite Ms B asking questions around support, she was left not knowing when this would happen, even though Dr F would have been aware of the time scale, as he had stated this on the hospice referral form.
94. I am concerned about Dr F's poor communication with Mr B and Ms B at a difficult time when they were relying on him for clear guidance around support for Mr B's discharge. I am also critical that discussions were not documented appropriately in the clinical notes. The notes do not give a full picture of the discussions that were held with Mr B around the NASC support offered, and do not give nursing staff sufficient information on the proposed transfer.
95. Dr F has emphasised that things were rushed on the day of discharge, and I have taken this into consideration. In addition, Dr F has recognised that his communication could have been better, and he has reflected on his approach around Ms B's request for nursing help and has acknowledged that this could have been better.

Changes made

96. Te Whatu Ora told HDC that since Ms B's complaint, the following actions have been taken:

'Inpatient palliative care team involvement

- The Medical wards have access to the inpatient palliative care service and will refer patients to them as appropriate.

Family meeting with multidisciplinary team (MDT)

- There is a daily MDT meeting on the ward. The wards have been encouraged to include carers in all family meetings and when discharging patients it has been emphasized to teams that they need to be aware of the supports the carer may require.

Notifying GPs of patient discharge

- We recommend that the discharging team directly notify the patient's GP of discharge, particularly if this is a Friday or over the weekend.'

97. Te Whatu Ora also stated that because of the evolving nature of the public health system, and impacts of COVID-19, it has developed and implemented the 'Hospital in the Home' (HitH) service. Te Whatu Ora told HDC:

'HitH provides clinical monitoring via phone or telehealth for Te Whatu Ora — Waitematā domiciled patients who have been discharged from its hospital facilities. The service aims to provide patients with options to facilitate an earlier and more supported discharge from hospital with ongoing monitoring of their clinical condition. Once patients can be safely cared for by primary care, handover to these services takes place.'

Recommendations

98. I acknowledge that Te Whatu Ora has recognised areas for improvement in the discharge process for patients requiring palliative care. I also note that Te Whatu Ora has implemented an HitH service as an option for patients being discharged, to provide more support and ongoing clinical monitoring until handover when their primary carer or other support services are in place. I consider that this new service will help to avoid the concerns raised by this complaint.
99. I recommend that Te Whatu Ora provide a written apology to Ms B. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.
100. I also recommend that Te Whatu Ora undertake the following, and report back to HDC within six months of the date of this report:
- a) Provide HDC with its updated discharge policy, which includes reference to:
 - i. referrals to be made to the inpatient palliative care team before discharging patients at the palliative stage of their illness;
 - ii. arranging a family meeting with all members of the multi-disciplinary team prior to the day of discharge to ensure that all supports are considered and arranged for patients requiring palliative care at home; and
 - iii. if a patient is palliative, then the discharging team should notify the patient's GP of the patient's discharge, particularly if this is on a Friday or over the weekend.
 - b) Provide the materials and attendance list of training that covers the provision of education around the use of oxygen cylinders and saturation levels for the patient and/or their carer — both on the ward prior to discharge and at home.
 - c) Review the current policy/guidance regarding hospice referrals to ensure that this includes reference for a call to be made to the hospice by a member of the medical team on the day of referral when a patient is requiring urgent care or is palliative. Te Whatu Ora is to report back to HDC on any changes made as a result of this review, provide HDC with a copy of the relevant policy/guidance, advise how any changes are being implemented and communicated to relevant staff members, and provide details of how adherence to these will be monitored.

- d) Confirm that regular training is provided to staff around making clear notes and documentation, and around good forms of communication with patients. Again, please provide the training materials.
- e) Review the process when considering transfer of patients between hospitals, to ensure that:
 - the clinical status of the patient and input from clinicians as to the merits of any such transfer will be given appropriate weight in the decision-making; and
 - necessary checks will be carried out to ensure that specialist physicians required for continuation of care for a transferred patient are available at the hospital to which the patient is being transferred.

Te Whatu Ora is to report back to HDC on any changes made as a result of this review, provide HDC with evidence of any changes made, including a copy of any updated policy/procedure documents, advise HDC of how these changes are being implemented and communicated to relevant staff, and provide details of how adherence to these will be monitored.

- f) Review the effectiveness of the new HitH programme and the changes to the discharge process, and report back to HDC on the outcome of the review.
- g) Consider using the HitH programme in other Te Whatu Ora districts, if found to be successful.
- h) Use an anonymised version of this report as a case study, to encourage reflection and discussion during education sessions for clinical staff of Hospital 1 on the importance of communication, keeping detailed documentation, and understanding a patient's support needs.

101. I recommend that Dr F confirm to HDC that he has met with the multi-disciplinary team to obtain a better understanding of all the support options available for future discussions with palliative care patients and their families on discharge. This confirmation should be provided to HDC within three months of the date of this report.

102. I recommend that Dr F provide a written apology to Ms B. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

Follow-up actions

103. A copy of this report with details identifying the parties removed, except Te Whatu Ora | Health New Zealand Waitematā and the advisor on this case, will be sent to Te Tāhū Hauora | Health Quality & Safety Commission and the Royal Australasian College of Physicians and 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 Dr Nicola Smith, a respiratory physician:

'Expert advice to the Health and Disability Commissioner regarding C21HDC00863.

Dr Nicola Smith

I have been asked to provide an opinion to the Commissioner on case number C21HDC00863 and have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Dr Nicola Smith. I am a Respiratory Physician and have been employed for 12 years in that role at Wellington Hospital. My undergraduate training was at the University of Auckland, and my advanced training in Respiratory Medicine was completed at Wellington Regional Hospital and Sir Charles Gairdner Hospital, Perth, Australia. I have the following qualifications and professional memberships — MBChB, BHB, Dip Ch. Health, FRACP.

The advice requested was to provide comment on:

1. The appropriateness of the clinical care provided by the respiratory team at Waitematā DHB to [Mr B] between [Month7] and [Month8].
2. The appropriateness of communication between Waitematā DHB clinicians and [Mr B] and his partner relating to [Mr B's] prognosis.
3. The adequacy of Waitematā DHB's communication with the Hospice service prior to and after discharge.
4. The appropriateness of the clinical decision to discharge [Mr B] from hospital care.
5. The adequacy of the discharge planning.
6. The lack of pre discharge assessments undertaken prior to [Mr B's] discharge home on 30 [Month7], including no multidisciplinary team meeting or review by an occupational therapist or physiotherapist.
7. The decision to discharge [Mr B] on a Friday.
8. The lack of oxygen prescription provided to [Mr B] or his partner.
9. The lack of in hospital palliative care input prior to discharge on 30 [Month7].
10. The lack of contact with [Mr B's] General practitioner prior to discharge on 30 [Month7].
11. The adequacy of safety netting provided to [Mr B] and his partner.
12. The overall adequacy of the support and instruction provided by Waitematā DHB to [Mr B's] partner as his sole carer.

Sources of information reviewed:

1. Letter of complaint dated 20/04/21 including additional letter from complainant.
2. Waitematā DHB response dated 22/07/21 including cover letter.
3. Meeting notes 25/03/21.
4. Statements from [Dr D], [Dr E], [Dr C], [Dr F], RN ..., [RN G], RN ...
5. Summary of care
6. Clinical records covering the period to [Month8].
7. Response from Waitematā DHB dated 2nd of November 2022

Brief factual summary of events

[Mr B] was admitted to [Hospital 2] on 20 [Month7] and diagnosed with respiratory failure on a background of progressive Interstitial Lung Disease (ILD). He was investigated with a CT scan which showed inflammatory change. Possible causes were considered including infection, drug reaction, acute exacerbation/progression of ILD. Treatment was started with IV hydrocortisone, Prednisone, Amoxicillin, Doxycycline, Cotrimoxazole and prophylactic Clexane. On 23 [Month7] [Mr B] was reviewed by his usual respiratory specialist [Dr C] who was in agreement with the management plan. [Dr C] spoke with [Mr B] and his partner and explained the most likely cause for the deterioration was progression of the ILD, however a reversible cause such as infection was possible. [Dr C] discussed that if [Mr B] deteriorated further he could be transferred to [Hospital 1], and that he had discussed with ICU and [Mr B] would not be a candidate for intubation and mechanical ventilation and non-invasive ventilation would be provided if required. On 24 [Month7] an additional [respiratory specialist] was consulted who agreed with the diagnosis and management plan. A decision was made to transfer [Mr B] to [Hospital 1]. On 25 [Month7] [Mr B] was reviewed by [Dr D]. His impression was concordant with the previous specialists. [Dr D] discussed the care plan with [Mr B] and his partner. [Dr D] informed them that the deterioration in [Mr B's] health was concerning and that there may be little that could be done to improve his condition. [Dr E] reviewed [Mr B] on the 26 [Month7] and noted that there had been some reduction in his oxygen requirement. [Mr B] was still dependent on oxygen. It is recorded that [Mr B] expressed that he wanted to go home and that both he and his family were aware that he was on maximal medical therapy and if he were to deteriorate further there would be no additional medical therapy available. [Dr D] reviewed [Mr B] on the 27 [Month7] and did not note any significant improvement. A further review by [Dr D] on the 28 [Month7] again noted that this was a serious illness and that [Mr B] was struggling to maintain adequate oxygen levels. On this ward round it is recorded that [Mr B] did not feel he needed any additional equipment at home and that his toilet was about 6 metres from his bedroom. A plan was made to attempt to reduce the oxygen to a level at which he could be discharged on domiciliary oxygen and aim to discharge him in two days' time on Friday the 30th of [Month7]. A domiciliary oxygen request form was completed with an expected discharge date of 30th of [Month7]. On 29 [Month7] an oxygen prescription is completed by [Dr H] respiratory

physiologist confirming oxygen therapy for two to four litres per minute via nasal prongs, one high flow concentrator, one high flow regulator, 1DCS cylinder every three weeks and the appropriate tubing.

On 30 [Month7] [Mr B] was reviewed by registrar [Dr F]. It is recorded that [Mr B] states that he really wants to go home and [Mr B's] partner discussed a number of reservations that she had. It was recorded in the notes that the conclusion of the conversation was that if the oxygen could be put in place that day then [Mr B] would be discharged. If this could not be confirmed then the plan was for [Mr B] to be discharged on the Saturday. A Hospice referral was also discussed and [Mr B] agreed to an outpatient Hospice referral. CNS progress notes dated 30 [Month7] 3:30 PM document a phone call from a nurse clarifying if oxygen had been delivered for [Mr B]. A phone call to [Mr B's] partner confirmed that the concentrator had been delivered. A further note by [Dr F] at 4:30 PM that day records that he had been contacted by an oxygen nurse stating that the oxygen prescription and instructions had been completed. A discharge summary was subsequently prepared and sent and [Mr B] was discharged.

1. The appropriateness of the clinical care provided by the respiratory team at Waitematā DHB to [Mr B] between [Month7] and [Month8].

The clinical care provided by the respiratory team at Waitematā DHB to [Mr B] between [Month7] and [Month8] was of a high standard, and there has been no departure from accepted practice. [Mr B] was thoroughly assessed and investigated by several respiratory specialists, who formulated an appropriate differential diagnosis, and provided [Mr B] with the maximal therapy possible for his advanced condition.

2. The appropriateness of communication between Waitematā DHB clinicians and [Mr B] and his partner relating to [Mr B's] prognosis.

Communication between Waitematā DHB clinicians and [Mr B] and his partner relating to [Mr B's] prognosis was appropriate. [Dr C] communicated in the outpatient clinics that there was no cure for [Mr B's] interstitial lung disease. On admission to [Hospital 1] [Dr D] discussed the care plan with [Mr B] and his partner. [Dr D] informed them that the deterioration in [Mr B's] health was concerning and that there may be little that could be done to improve his condition. This communication around prognosis is confirmed in the letters of complaint from [Mr B's] partner which record that her understanding following [Dr D's] ward round was that [Mr B] was on maximal medical therapy and if he were to deteriorate further there would be no additional medical therapy available.

3. The adequacy of Waitematā DHB's communication with the Hospice service prior to and after discharge.

Waitematā DHB's communication with the Hospice service prior to and after discharge was adequate given the expected prognosis by the medical team. Telephone communication to the Hospice service is standard practice if a patient being discharged is expected to have a prognosis of days, and usually discharge in these circumstances would not occur until hospice care is in place. The response from Waitematā DHB states

that the doctors involved in [Mr B's] care had assessed his prognosis as weeks to months, and therefore an electronic referral was adequate. I do not consider that there has been a significant departure from accepted practice in this regard.

4. The appropriateness of the clinical decision to discharge [Mr B] from hospital care and the decision to discharge [Mr B] on a Friday.

It was clinically appropriate to discharge [Mr B] from hospital. [Mr B's] therapy by 30 [Month7] was oxygen and oral medications which could be delivered at home. [Mr B] had a limited prognosis and expressed a strong desire to be at home, and therefore the medical and nursing team facilitated this request. Whilst I do not consider that there has been a significant departure from accepted practice in this regard the lack of multi-disciplinary assessment prior to discharge resulted in increased difficulty for [Mr B] and his partner at home — see comment below. I do not consider the day of the week to be relevant, the appropriateness of the decision to discharge is based on medical stability, and the appropriate supports being in place. In this case the domiciliary oxygen was in place, and the hospice referral had occurred, however allied health reviews had not occurred — see comment below.

5. The adequacy of the discharge planning and the lack of pre discharge assessments.

[Mr B] was not reviewed by an occupational therapist or physiotherapist prior to discharge. The medical team appeared to rely on [Mr B's] statement that he didn't feel he needed any additional equipment at home and nursing notes recording that [Mr B] was independent and mobile on the ward. The letter of complaint records the difficulty [Mr B's] partner had caring for [Mr B] at home without additional equipment. A physiotherapy and occupational therapy assessment, including a home visit prior to discharge, would have allowed for the necessary equipment to be in place to allow [Mr B] to be as comfortable as possible in his last days of life. I consider this a moderate departure from accepted practice, however I note that [Mr B] was expressing a strong desire to return home on the day of discharge and this influenced the decision made by the medical team. The letter from Waitematā DHB to [Mr B's] partner dated 24/02/21 acknowledges that [Mr B] would have benefited from an occupational therapy assessment and that a family meeting with the multi-disciplinary team should have occurred prior to discharge. Waitematā has apologised to [Mr B's] partner that this did not occur.

6. The lack of oxygen prescription provided to [Mr B] or his partner.

It is not standard practice to provide an oxygen prescription to a patient. The prescription is delivered to the Nurse or other health care provider overseeing the oxygen delivery and education.

Domiciliary oxygen was requested by the medical team on 28 [Month7] with an expected discharge date of 30 [Month7]. On 29 [Month7] Dr H, respiratory physiologist, completed an oxygen prescription for domiciliary oxygen two to four litres per minute via nasal prongs, one high flow concentrator, one high flow regulator 1DCS cylinder every three weeks and the appropriate tubing. At a family meeting on the day of

discharge the oxygen prescription was explained. Later that day [the oxygen delivery company] set up the oxygen equipment. [Mr B's] partner was subsequently unsure how much oxygen to give. This was rapidly remedied by [RN G] and respiratory physiologist [Dr H] through a telephone call to [Mr B's] partner. This occurred prior to [Mr B] arriving home. I do not consider that there has been a significant departure from accepted practice in this regard.

7. The lack of in hospital palliative care input prior to discharge.

In hospital palliative care input would have been beneficial for [Mr B] to assess symptoms such as breathlessness, discuss end of life care, and provide psycho-social support. Inpatient palliative care involvement may have facilitated a smoother transition to the community hospice services. An inpatient palliative care assessment would be standard care in these circumstances, and I find the absence of this is a mild departure from the accepted standard of care. The letter from Waitematā DHB to [Mr B's] partner dated 24/02/21 acknowledges that [Mr B] should have been referred to the inpatient palliative care team. Waitematā DHB has apologised to [Mr B's] partner that this did not occur.

8. The lack of contact with [Mr B's] General Practitioner prior to discharge.

A discharge letter transferring care of [Mr B] to his GP was written at 3.30pm on 30 [Month7], prior to discharge. This is normal practice and I do not consider that there has been a significant departure from accepted practice in this regard.

9. The adequacy of safety netting provided to [Mr B] and his partner and the overall adequacy of the support and instruction provided by Waitematā DHB to [Mr B's] partner as his sole carer.

As discussed above the support and instruction provided to [Mr B's] partner was adequate, but could have been improved by inpatient palliative care input and occupational therapy assessment and a family meeting with the multi-disciplinary team. Discharge planning, including safety netting, and support and instruction provided to [Mr B's] partner was influenced by [Mr B's] strong desire to return home on the Friday of discharge. Acknowledging the areas for improvement, overall I do not consider that there has been a significant departure from accepted practice in this regard.

Dr Nicola Smith
Respiratory Physician

16/02/22'