HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health NZ breaches Code in care of older man who died soon after discharge

21HDC00883

The Aged Care Commissioner has found Taranaki District Health Board (now Health New Zealand | Te Whatu Ora Taranaki) breached the Code of Health and Disability Services Consumers' Rights (the Code) during its care of an elderly man who died 40 minutes after being discharged from hospital.

Carolyn Cooper said Health NZ Taranaki did not provide services of an appropriate standard, breaching Right 4(1) of the Code - Tautikanga.

The breach concerns the care provided to the man who was admitted to hospital for treatment of worsening chronic obstructive pulmonary disease (COPD) and abdominal pain. He was in hospital for five days and treated with antibiotics and steroids before being discharged into the care of his elderly wife. He was supplied with prednisone and 'back pocket' prescriptions for antibiotics and more prednisone should he experience further flare ups of symptoms. He was also advised to see his GP or visit the emergency department (ED) if he had worsening shortness of breath.

The man was still experiencing shortness of breath, needing help with moving and the activities of daily living on the day of his discharge. According to his daughter, the man and his wife required assistance from the public to get him from his wheelchair to their car. She told HDC the pair struggled up three flights of stairs into their home where, sadly, he died five minutes after arriving.

Of the man's care Ms Cooper said, "The nursing assessment and care planner was only partially completed. …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 … whether they are concerned about returning home, the level of support services they currently receive, and their arrangements for transport on discharge. None of this information was included."

She further noted that there was no evidence of physiotherapy or occupational therapy during his stay and no referral was made for either of these supports in his discharge plans.

Ms Cooper said the man was discharged in an unsafe manner. "…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."

Since the event, Health NZ Taranaki has trained a senior ward registered nurse to undertake the role of complex discharge co-ordinator to ensure this service is always available on the acute medical ward during work hours.

Ms Cooper made several recommendations including that Health NZ formally apologise to the man's family, audit the completion of admission documentation for the past six months, survey nursing staff on understanding of falls risk, update training on discharge planning and review and update its discharge planning procedure. Evidence of all recommendations must be supplied to HDC within stated times.

1 July 2024

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

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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