HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Standard of nursing provided to resident in intermediate and end-of-life care

1. This Office received a complaint from Mrs B about the standard of care provided to her late father, Mr A, by Ruapehu Masonic Association Trust (trading as Masonic Court) between 1 July and […] August 2021. The complaint concerns the adequacy of nursing care, communication with family, escalation of care, and end-of-life care planning.

Information gathered

2. Mr A, aged 97 years at the time, was admitted to Masonic Court on 1 July 2021 following a four-day hospitalisation for pneumonia.[1] Mr A initially received intermediate care[2] while waiting for a needs assessment, and on 22 July 2021 he transitioned into long-term care.

3. Mrs B stated that she requested a general practitioner (GP) review due to Mr A's worsening respiratory symptoms and was advised by Masonic Court that this was unlikely to occur. Progress notes record that a GP review was requested on 14 July 2021. Masonic Court said that residents in intermediate care retain the services of their own GP. Mrs B said that Mr A's GP was based in […], and she expected that there would be a plan in place for GP care of residents who lived outside [the local area]. A Masonic Court registered nurse (RN) measured Mr A's vital signs and neurological observations and concluded that they were within normal range. A caregiver recorded in the progress notes that Mr A was 'confused' and 'not feeling well'. However, there was no nursing assessment of Mr A's respiratory symptoms, cognitive and behavioural status, and pain levels.

4. Further to the above, the RN advised Mrs B that it could be difficult for Mr A's GP to attend. Masonic Court said that this was because the concern had been voiced in the evening when the GP clinic was closed. However, progress notes record that the nurse contacted the Emergency Department (ED) at [the local] hospital for clinical advice, conveying the assessment findings. Neither a STOP and WATCH tool[3] nor the ISBAR[4] communication tool was used during this process. The ED advised the nurse that an admission was not required given that Mr A's vital signs were normal and that the primary concern related to his cough. The nurse also contacted Mr A's GP on 21 July 2021 regarding his ongoing cough, and an expectorant and antibiotics were prescribed. This was communicated to Mrs B as well as Mr A's enduring power of attorney (EPOA).

[1] A type of respiratory infection.
[2] An arrangement with the public hospital where the older person is admitted to a care home for a short period of time.
[3] A tool used for identifying acute deterioration. Acute deterioration | Te tipuheke tārū (Frailty care guides 2023) | Te Tāhū Hauora Health Quality & Safety Commission
[4] A communication framework used to enhance transfer of critical information. Communication tools | Te Tāhū Hauora Health Quality & Safety Commission

Names have been removed (except Masonic Court and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. Mrs B stated that staff did not take sufficient notice of Mr A's comorbidities. Clinical notes show that during intermediate care, the RN had developed an initial care plan based on the clinical notes provided by the hospital, which noted Mr A's clinical and functional needs. In addition, a pressure area risk assessment, falls risk assessment, oral assessment, and incontinence assessment and management plan were completed. Masonic Court also said that RNs completed handover notes and verbal handovers every shift and that residents are seen by nurses during medication rounds. Following the transition into long-term care on 22 July 2021, there was an admission assessment by an RN and a nurse practitioner (NP) on 22/23 July 2021.

6. There were limited progress note entries completed by RNs. Masonic Court said that these notes are normally written by caregivers with inputs from the RN. Progress notes record that Mr A had reduced food and fluid intake from 22 July 2021. However, a care plan for Mr A's poor nutritional intake (and associating monitoring records) was not completed until 10 August 2021. Further, a care plan for falls prevention was not developed until 13 August 2021, despite Mr A having a fall on 21 July 2021. Mr A's falls risk was not reviewed following a second fall on 12 August 2021. Likewise, a care plan was not developed to prevent/manage pressure injuries, despite a caregiver noting a pressure injury on 18 July 2021, or to manage Mr A's respiratory condition, despite his ongoing cough and chest infection. Further, there were inconsistencies noted across the documentation in relation to falls risk, pain levels, and skin integrity.

7. Mrs B said that no discussions were held with Mr A and his family to discuss and plan his palliative care and end-of-life care and what to expect during this time, and a referral to hospice was not discussed. Clinical records show that on 22 July 2021, a conversation occurred between the NP, Mr A, his EPOA, and other family members[5] regarding end-of-life care and that family were 'agreeable for comfort cares when time comes'. Masonic Court said that staff provided regular updates to the family when they visited. However, clinical records do not note what updates were given and whether family were informed of Mr A's deteriorating condition following the conversation on 22 July 2021. There is no evidence of communication relating to end-of-life care or what to expect during this period or of Mr A's and the family's wishes.

8. Clinical notes show that comfort medications[6] were charted and hospice input occurred on 14 August 2021. Mrs B said that she was not aware that Mr A was taking these medications. An advance directive was completed on 23 July 2021, which noted Mr A's wish to be palliated in the event of a serious illness. Further, a resuscitation form was signed noting that Mr A was not for CPR in the event of a cardiac arrest. Clinical records also show that a last-days-of-life care plan was completed.

9. Sadly, Mr A passed away in August 2021. Masonic Court acknowledged that no further contact was made after his passing and that staff could have contacted the family to give them an opportunity to express any concerns. Mrs B said that her family expected a phone

[5] Clinical notes do not record who was in attendance.

[6] This included haloperidol (an antipsychotic), hyoscine butylbromide (to reduce cramps in the gastrointestinal and urinary tract), midazolam (for anxiety), and morphine (for pain).

call from Masonic Court and that a conversation to extend sympathies was all that was needed.

Responses to provisional report

10. Masonic Court and Mrs B were given an opportunity to comment on the provisional report. Masonic Court said that it had no comments to make. Mrs B said that she appreciated the work undertaken to investigate her complaint and the changes made at Masonic Court with ongoing training and implementation of up-to-date processes. Mrs B said that organisations like Masonic Court had an important role to play in caring for older people and that people depend on them. Other relevant comments from Mrs B have been added elsewhere in the report.

Clinical advice

11. In-house clinical advice was provided by aged-care advisor RN Hilda Johnson-Bogaerts (**Appendix A**). She noted the following departures from the accepted standard of care:

- Assessment and management of care on 14 July 2021 = **mild to moderate** departure;
- Nursing input during intermediate care = **mild** departure;
- RN assessment, care planning, and involvement of and communication with the family during long-term care admission and end-of-life care **= moderate to significant** departure.

Decision — breach

12. At the outset, I express my sincere condolences to Mrs B and her family for Mr A's passing.

13. Having reviewed all the information on file, including the clinical advice from RN Johnson-Bogaerts, I find that Masonic Court failed to provide Mr A with a reasonable standard of care in accordance with Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights (the Code). I am critical of the inadequate assessment undertaken on 14 July 2021 and the inadequate nursing care during Mr A's end of life. I concur with RN Johnson-Bogaerts that Mr A showed early signs of deterioration, but the care delivered to him at the time did not reflect the care that was needed. In my opinion, end of life is a critical phase that calls for a close partnership and effective communication with family to promote a meaningful experience for both the resident and their loved ones. However, this did not occur, and I am critical of this.

Changes made

14. Masonic Court has made the following changes since the events:

- It has shifted to using electronic records that provide a real-time view of all clinical notes being undertaken across the facility, as well as prompts and alerts on entry. This system also notifies selected key staff of updates and critical adverse events.
- Caregivers have completed hospice education on palliative care.

[7] The right to have services provided with reasonable care and skill.

- The electronic software provides training videos on palliative care, end-of-life physiotherapy for aged care, falls prevention, and care planning.
- It has a designated palliative care room and a retreat room for family members who wish to spend time overnight with their loved ones.
- Upon notice of a resident passing, management now communicates with family by sending them a card and flowers. In addition, a facility representative attends the funeral service.
- The clinical nurse lead completes progress notes for all hospital-level residents every Monday and Friday. The registered nurse completes progress notes for the remaining days.

Recommendations and follow-up actions

15. I recommend that Masonic Court:

- Provide a formal written apology for its breach of the Code. The apology is to be sent to the Health and Disability Commissioner (HDC), for forwarding to Mrs B and her family, within three weeks of the date of this report.
- Undertake training on the STOP and WATCH tool and the ISBAR tool, within three months of the date of this report. Evidence of training being completed is to be provided to the HDC within three months of the date of this report.
- Undertake file reviews of the last 10 residents who received end-of-life care over the last six months to check whether the care provided to residents was in accordance with its end-of-life care and documentation policies. As part of this review, Masonic Court should outline its findings and any corrective actions, within three months of the date of this report.

16. A copy of this report with details identifying the parties removed, except the clinical advisor and Masonic Court, will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from aged-care advisor RN Hilda Johnson-Bogaerts:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Masonic Court Home for the Elderly. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have been asked to review the provided clinical documentation and advise on the care provided between 1 July 2021 and […] August 2021 specifically to comment on the adequacy of:

   a. recognition of changes and decline in health
   b. nursing assessments, care planning, and care delivery during the last days of life phase
   c. communication with the family.

3. **Documents reviewed**

   - Provider's letter of response dated 20 April 2022
   - HC interRAI assessment dated 9 July 2021
   - Progress notes
   - Contact with family form
   - Admission documentation
   - NP notes

4. **Review of clinical records and clinical advice**

Mr [A] was a 97-year-old man and resident of Masonic Court (MC) where he was receiving rest home-level care. On 1 July 2021, he was admitted at MC to receive "Intermediate Care" after a hospitalisation for pneumonia. Intermediate care is an arrangement with the DHB [district health board] where older people stay for a period at a care home convalescing before being discharged home, or – if no improvement – move into long-term care. Care concerns handed over from the public hospital included "*Extreme fatigue, falls risk, at risk for pressure injuries, low BMI and poor appetite."* At the time, he needed support with his ADL [activities of daily living] from one carer with the goal to gain independence as his health improved. Living with multiple comorbidities, his health continued to decline, with poor appetite, continued respiratory symptoms, and general functional decline. Mr [A] became a long-term care resident for rest home-level care on 22 July 2021. As part of this admission, a "*comfort cares for when the time comes*" was discussed with the family by the NP, and anticipatory prescribing was completed. This was documented in the medical notes. Later, Mr [A] seemed to have entered the last days of life stage on […] August, when he stopped eating and drinking and was sleeping a lot. He passed away peacefully with family by his side on […] August 2021.

Because his initial admission was part of Intermediate Care, the DHB provided the care home with the InterRAI HC assessment and a Care plan. During this time, medical oversight was passed back to his usual GP, who was based in […] (20 min away from [where Mr [A] was]).

On 14 July 2021, Mr [A]'s daughter requested for her father to be seen by a doctor because of the continued respiratory symptoms while his antibiotics course was completed. The nurses who had been taking his vital signs concluded that these were within normal range. The vital signs reported on in the forwarded clinical notes included temperature and oxygen saturation only. It is not clear if any other observations and vital signs were taken informing the need for a medical consultation. The RN tried to set up an appointment with his normal GP, who was unable to attend due to the distance, then contacted the DHB, who responded he would not be seen. It is unsure what information was forwarded to the service for triaging. It is good practice to use the SBAR tool, which prompts to provide a comprehensive picture. The progress notes include "*a bit confused, assisted with toileting, said he's not feeling well".* The progress notes include that the RN started him on two-hourly observations until he would be settled at night. The notes included only the first set of observations, which included temperature (36.7°C) and PO_2 [oxygen in the blood] (97%); no other vital signs or observations were included in the documentation. Reading the progress notes of the following days, they have no further entries from an RN until 22 July 2021, when he was seen by the NP as part of his long-term admission intake and prescribed Augmentin.

The progress notes written by caregivers include that he was given an air mattress and had intact skin at the time. On 18 July 2021, the notes written by the caregiver include that a pressure area was found between his shoulders. Food intake continued to be small. Care staff started to turn him in bed. On 21 July 2021, he experienced a fall when at 1340 hrs he fell on his sensor mat, which alerted the nurses; he said that he wanted to get up and go to the toilet.

The clinical file forwarded to me did not include nursing assessments or nursing care plans as part of his long-term care intake. I did not find references in the progress notes to a care plan relating to essential parts of his care, such as falls risk management, pressure injury risk, poor appetite, and needing thickened fluids, etc.

In addition, I did find very minimal RN input in the progress notes.

Based on the forwarded documentation, I am concerned about the lack of evidence of RN input when Mr [A] was receiving "intermediate care" and at the time of his "long-term care" admission. While the […] DHB care plan was appropriate to be used at the time of his admission on 1 July 2021 for intermediate care, because of his health further deteriorating it is normal practice to complete further nursing assessments as required and update existing nursing care plans accordingly (as for example for the implementation of pressure care and falls prevention). Further, at the time of his long-term admission, it is accepted practice to complete a comprehensive set of nursing assessments and create new nursing care plans based on conversations with the resident's and next of kin's goals for care. Such nursing care plans ensure the

implementation of appropriate nursing intervention, when discussed with the resident and next of kin they serve as informed consent, and when shared with the care team to ensure person-centred care and continuity of care. **In the situation that this was not completed by the nurses, this would be seen by my peers as a moderate to significant deviation from accepted practice**

I am concerned about the lack of clinical assessment, advocacy, and clinical communication on 14 July 2021 when Mr [A]'s daughter requested a medical review. It would seem that the observations taken by the RN were limited to taking his blood oxygen levels and temperature as a basis that he did not need a medical review, while caregivers described him as slightly confused, not feeling well, and coughing, and his daughter was concerned about the lack of progress made and completion of antibiotics course. In the situation, it would be advisable for the RN to start with the STOP and WATCH tool and complete the ISBAR tool for communication with medical care providers. **I found that the management of the situation by the RN was moderately deviating from accepted practice.**

The notes include that on 5 August 2021 Mr [A] was seen by the NP as requested by the family because of his apparent low mood. The notes of 8 August 2021 include that the nurses tried to give him soup due to the continued not eating but that he was not interested; he was, however, having "lots of ice blocks and ice cubes in his water". Generally, it is reported that he was sleeping a lot and would sit in his chair for a short period of time only. He needed now full assistance with mobilising. His temperature and oxygen concentration were checked a few times that day and were within normal range, except the oxygen concentration at 1350, which was only 79% and later back to 95%.

On 12 August 2021, the notes include that he had a fall and that this was communicated to the family. The incident form was completed; however, I did not find a review by the RN of his falls risk or a care plan for the implementation of falls prevention strategies.

[…] August 2021. Mr [A]'s son and daughter stayed for the night. Caregivers described his breathing in the progress notes as "rattly". The notes describe symptoms of having entered the last days of life; however, there was no acknowledgement of this in the notes or the documentation of a conversation with the family. There are no notes from an RN until […] August 2021 in the afternoon when a subcutaneous line was inserted, and he was given medication to ease symptoms. The notes include that Mr [A] passed away that day at around 1810 hrs with family by his side.

From the progress notes, it would seem that Mr [A]'s health continued to deteriorate quickly. In such a situation, it is good practice to commence proactive care planning for the last days of life, such as the Te Ara Whakapiri format, which guides staff to have a more family-inclusive approach as well as implements increased checks for symptoms of discomfort of the dying person.

Reading the clinical file, I did not find any evidence of a conversation with the resident or the family about Mr [A]'s continued deterioration or about last days of life care, what to expect when he would enter the last days of life period and what their wishes are.

The progress notes relating to this period have only two days with an entry of an RN: on 8 August, when oxygen saturation and his temperature were measured, and on […] August when medication was administered.

Good practice requires for the RN to have proactive, initial, and regular care planning conversations with the resident and/or next of kin. During this time, the nurse would listen about any concerns and inform what is possible so that a trusted relationship and care partnership is built. It is important that families understand realistically what can be expected in the care of an older person at the end of life, and it is important for nurses to understand the emotions and concerns the family and the resident may have and to be seen to take these seriously.

In the situation that no care plan was developed for the last days of life, such as Te Ara Whakapiri, and there was no further communication with the resident and the family, informing them what to expect and what their concerns and wishes are, this would be seen by my peers as **a moderate to significant deviation from accepted practice relating to end-of-life care planning and family communication**. I am also concerned about the limited RN documentation in progress notes, indicating that there might have been limited RN input into his cares during this period.

5. Addendum 11 May 2025

Thank you for giving me the opportunity to review a further response from the provider and assess if the information provided changes any aspect of my advice.

6. Additional information reviewed:
   - Provider letter of response 22 October 2024
   - Neurological observations chart completed 14–15 July
   - Admission Format and Initial Care Plan dated 1 July 2021
   - RN Assessment on Admission dated 23 July 2021
   - Resident Handling Profile dated 1 July 2021
   - Risk Assessment for Falls dated 1 July 2021
   - Assessment of Pressure Area Risk dated 1 July 2021
   - Short Term care Plan completed 10 August 2021 relating to poor food and fluid intake
   - Contact with Family form
   - […] DHB Patient Care Plan and
   - Short Term Care Plan relating to falls prevention dated 13 August 2021
   - Provider's Advance Care Planning and Resuscitation Policy, Falls Prevention Programme

7. Concern relating to lack of clinical assessment, advocacy, and clinical communication on 14 July 2021.

Clinical assessments: In addition to the vital signs (temperature and O_2 saturation) documented in the progress notes on 14 July 2021, the provider forwarded the Neurological Observations Document, including two-hourly observations during his waking time (pulse, blood pressure, temperature, O_2 saturation) completed starting 14 July at 1600 hrs until 16 July 1330 hrs. The values were all within normal range. I did,

however, not find documented observations or references relating to his main concern (i.e. ongoing/deteriorating chest infection, i.e. the phlegm, coughing, and his mental state as identified by the caregiver in the progress notes).

Advocacy, clinical communication, and clinical documentation: The provider response includes that the RN called […] DHB and spoke to the RN from the ED and discussed Mr [A]'s situation. Because his vital signs were within normal range, the ED RN advised against sending Mr [A] to hospital, the MC RN then called Dr C on 20 July, who prescribed an expectorant. And on 21 July, the MC RN called [Mr A's GP] because of Mr [A]'s "persistent phlegm", and further antibiotics were prescribed. This was documented in the Contact with Family Form as "*conversation with [Mrs B]*, …". The provider explained that the RN reached [Mr A's GP] both by email and phone call but did not seem to have kept the records. I did not find references of the content of these communications with the [GPs] in the forwarded clinical documentation.

In conclusion: The clinical documentation completed by the RN relating to the situation around 14 July 2021 lacks evidence of clinical critical reasoning or a clear summary of the assessment findings, which are essential for continuity of care. Given that respiratory symptoms and changes in mental state appeared to be concerns, it would have been appropriate and expected for the RN to document targeted assessments of breathing, presence and characteristics of phlegm, how Mr [A] was feeling, pain assessment, and cognitive and behavioural observations in addition to the observations taken. Furthermore, critical communication with the RN of the ED, other medical services, and the family should be recorded or referenced in the progress notes, including any instructions for caregiver staff. With this new information in mind, I conclude that **the management of the situation by the RN was minor to moderately deviating from accepted practice with the level of documentation below the expected professional standard.**

8. Concerns relating to minimal nursing input during intermediate care.

The provider explained that progress notes are normally written by the caregivers with inputs from the RN. Handover notes, however, are written by the RN and used to communicate between the outgoing and incoming RN as well as verbal updates. RNs will make the short-term care plans for the resident where needed.

The provider forwarded assessments completed by the RN on 1 July 2021 when Mr [A] was admitted for interim care. The provider explained that the care plan developed by […] DHB was used to drive cares during this period and also forwarded the Initial Nurse Care Plan to evidence RN input during this period. Reviewing the documentation, I have found that expected RN input was provided with the completion of assessments and the development of the initial Nursing Care Plan document besides the […] DHB care plan. I am concerned that the finding of the named pressure injury did not trigger additional pressure risk assessments and the creation of a pressure injury prevention plan and that his identified falls risk did not result in the development of a management plan to prevent incidents of falls. In this situation, the absence of this information in the care plans appears to be a documentation oversight rather than a lack of clinical action.

Therefore, I consider the nursing input during this time to have been a mild deviation from accepted practice.

9. Comprehensive nursing assessments and care planning relating to Mr [A]'s long-term admission (22 July 2021) and end-of-life care

Comprehensive assessment on admission

Following Mr [A]'s transition to long-term care on 22 July 2021, an RN completed nursing assessments on 23 July 2021. While the completion of these assessments was timely, inconsistencies were evident across documentation. For instance, Mr [A]'s mobility was described as "fully mobile" in one assessment and as "requiring full assistance" in another. Similarly, the RN assessment noted "no pain", while a previous assessment completed on the 1 July 2021 indicated that Mr [A] experienced pain associated with rheumatoid arthritis.

Skin integrity was assessed as "dry skin" on one assessment tool, while progress notes include the presence of a pressure injury between Mr [A]'s shoulders. No formal pressure injury risk assessment or related care plan was completed despite the use of a pressure-relieving mattress.

The variability across assessments suggests that the information gathered was not sufficiently reconciled or synthesised into a coherent clinical picture by the RN. Comprehensive and accurate assessment is essential for effective care planning.

Management of chest infection and nutritional decline

Mr [A]'s major health concern was his ongoing chest infection, characterised by coughing and sputum production for which antibiotics were prescribed. Despite this, there was no care plan in place to guide the management of this respiratory condition. Accepted practice requires targeted care plans to be developed by the RN that specify treatment and symptoms management, monitoring for deterioration, escalation protocols, and communication with the consumer and family.

Additionally, Mr [A]'s reduced food and fluid intake as recorded by caregivers in the progress notes was not addressed in a care plan until 10 August 2021, while it was already evident on 22 July.

End-of-life care planning

Records indicate that anticipatory medications were prescribed and a conversation between the NP and Mr [A]'s family occurred regarding his end-of-life care. Hospice services were also engaged and visited on 14 August 2021. These actions are in keeping with accepted practice; however, I did not find evidence of communication with the family relating to Mr [A] approaching the end of life. I am concerned there does not appear to have been a formal "last days of life" care plan developed or initiated. Such a care plan, in line with the Te Ara Whakapiri framework, is a documented plan that addresses the holistic needs of dying and the family during this critical period.

Conclusion

While several appropriate actions were taken during Mr [A]'s care, such as the completion of admission assessments, prescribing anticipated medication and initiating palliative interventions, important gaps were noted in RN oversight relating to the integration and documentation of care planning. In particular, the inconsistencies in the admission assessments, the absence of condition-specific care planning for his chest infection and nutritional risk, and the lack of a formal end-of-life care plan did not align with accepted practice.

Therefore, my conclusion remains that RN assessment, care planning, and involvement of and communication with the family deviated moderately to significantly from accepted practice.

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Nurse Advisor (Aged Care)
Health and Disability Commissioner'