

# Final Inspection Report

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## **Bosnyak Lifecare Management Limited - Regency Home and Hospital**

Date of inspection: 31 August 2009

RELEASED UNDER THE  
OFFICIAL INFORMATION ACT

HealthCERT  
Quality & Safety  
Sector Accountability and Funding  
Ministry of Health

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**Undertaken** 31 August 2009  
**File Ref:** WBO05  
**Provider:** Bosnyak Lifecare Management Limited -  
Regency Home and Hospital  
**Contact Person:** Mr XXX XXX  
**Premise:** 60 Onewa Road, Northcote, Auckland 0627

## Executive Summary

### History:

Bosnyak Lifecare Management Limited - Regency Home and Hospital is certified to provide Hospital (Geriatric & Medical) care services and Rest Home services for a period of 3 years, expiring on 4 September 2010.

Before this, the provider applied for certification in September 2004 and was certified for three years. In the 2004 certification audit there were six partially attained criteria identified which required corrective action. In the 2007 recertification audit, there was one partially attained criterion which did not require corrective action reporting.

A routine surveillance audit was carried out on 29 January 2009 by Bureau Veritas New Zealand, Designated Auditing Agency, and no corrective actions were required.

### Previous Recent Complaints:

February 2008: Complaint from XXX XXX about a presumed unsuitable resident and abuse of staff and residents by the resident. HealthCERT undertook an unannounced inspection on 14 April 2008. The complaint was not substantiated. CLOSED

April 2009: Complaint from XXX XXX, resident, about theft of money; assault by a staff member; and concerns about his Government Superannuity going to the home. The allegations were found not to be substantiated by the DHB and Police. CLOSED

August 2009: Complaint from XXX XXX, re care provided to her mother. OPEN

### Nature of Current Complaint:

The Ministry of Health received a complaint from XXX XXX about the care provided to her mother, XXX XXX, a resident at Regency Home and Hospital.

In summary, Ms XXX alleges that:

- she was not properly notified after her mother fell, sustained a fracture and was transferred to North Shore Hospital
- appropriate steps were not taken to reduce her mother's known risk of falling
- restraint techniques were not used appropriately
- hip protectors were not provided for her mother on the day of her most recent fall, even though they were specified in her care plan.

In addition to the complaint, the Ministry was notified on 3 August 2009, of an adverse event, under Section 31 (5) (b) of the Act of a Police Investigation after a resident at Regency Home and Hospital ingested a cleaning product and subsequently died.

**Further Information (DHB/ HDC):**

On 18 August 2009, XXX XXX, Portfolio Manager, Waitemata DHB, forwarded a copy of his briefing on the adverse event involving the ingestion of cleaning product at Regency Hospital and Home and subsequent death of the resident, plus his comments on the current complaint. Suggested HealthCERT conduct an investigation.

**Service Description**

Bosnyak Lifecare Management Limited - Regency Home and Hospital provides Aged Residential Care Hospital & Rest Home services. The occupancy and capacity on 31 August 2009 is outlined below:

Area	Occupied	Capacity
Hospital	30	30
Rest Home	38	44
Dementia	18	18
<b>Total</b>	<b>86</b>	<b>92</b>

**Reasons for the inspection**

The purpose of the inspection was to determine whether health care services being provided by Bosnyak Lifecare Management Limited - Regency Home and Hospital are being provided in compliance with Section 9, Health and Disability Services (Safety) Act 2001. To ensure that a person providing health care services of any kind must meet all relevant standards.

Health and Disability service providers are required under section 9 of the Health and Disability Services (Safety) Act 2001 (the Act) to provide services:

- while certified by the Director-General to provide health care services of that kind; and
- while meeting all relevant service standards;
- in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and
- in compliance with this Act.'

## The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor HealthCERT, and XXX XXX, Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

## Methodology

The inspection was conducted to investigate the adverse event and the complaint made to the Ministry of Health that may have resulted in systems failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted utilising the following methods:

- Interview with Manager
- Interview with Registered Nurse (Clinical Leader)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff
- Document and policy review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

## Limitations

This inspection did not constitute a full audit against the Health and Disability Services Standards 2008.

## Entry Meeting

XXX XXX, HealthCERT; XXX XXX HealthCERT; XXX XXX, Manager.

The meeting commenced at 0900 hours and ended at 0930 hours.

The introduction meeting covered the following points:

- A copy of the letter of introduction addressed to Mr XXX XXX was provided to Ms XXX XXX (Manager).
- A proposed agenda for the day was discussed and included a request to interview any relatives or health professionals visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

## Inspection findings

Non-compliance with the Health and Disability Services Standards, specific to the complaint and/or adverse event, are reported in the following summary.

The scope of the inspection was widened to include findings from the tour of the facility and interviews with staff.

## Consumer Rights during Service Delivery - Standard 1.1

### Recommendation:

#### 1.1.10.7 - Partial attainment

The provider's Life Support Decisions Form for individual residents had been completed by an EPOA. (Advisors reviewed 10 client files; 5 had been completed by an EPOA). The Form can be misinterpreted as it contains both the advanced directive (which a cognitive resident may sign) and other statements/ consents which are signed by an advocate or EPOA.

Although this is clearly explained within the "Welcome to Regency" information booklet given out on admission, an Advocate/EPOA reading this form might well misinterpret that they are giving an informed consent.

The recommendation is for the form to be reviewed.

## Organisational Management - Standard 1.2

#### 1.2.3.9- Partial attainment

The provider did not reduce the risk of potential harm occurring for 1. the complainant's mother, Mrs X or 2. The adverse event involving Mr X.

1. Although Mrs X. was discussed as a high falls risk in progress notes her care plan (fall risk) did not reinforce this. Specific requirements and evaluation by the RN stated only "no changes required". Re-evaluation of the risk level changing had not been carried out in her care plan following the decision for restraint, for staff to follow. The lack of available restraint equipment (lap belt or vest) and the inability of staff to locate hip protector pants for the resident may have contributed to Mrs X's falling/ injury.
2. Mr X had displayed challenging behaviour, which staff were mostly able to address, however he had also been noted to have had suicidal thoughts and had expressed these. These were evidenced in progress notes; staff interview and in a letter from the DHB, Consultant Physician for the Elderly held within the resident's notes. A referral to the adult mental health services had been made by staff following his expression of suicidal thoughts and challenging behaviour, and an appointment was made.

There was no documentation of a clinical specialist visiting Mr X. evidenced within his notes. Evidence of the clinical specialist visit (Community Mental Health Nurse) was subsequently obtained by the facility on the day following this inspection. The letter had been held by the GP and was therefore not available for staff caring for Mr X. Within the letter is the comment from that MR x, "denied thoughts of harm to self or suicide," and that "insight and judgement were impaired". The letter also recommended recontacting the service if Mr X, did not settle into the rest home, and his behaviour remained challenging. Had a reassessment occurred, due to continuing challenging behaviour, more appropriate placement/ treatment may have occurred.

### Corrective Actions:

Ensure that there is sufficient restraint equipment for staff to carry out safe practice, when the need for restraint has been assessed and is required.

Ensure that there is a process in place to address referral follow up and outcomes.

#### 1.2.7.3 – Partial attainment

The facility has a 1: 9 ratio of care staff within the Dementia unit, It was noted that staff are also required to meet the activity needs for residents during the afternoon.

The registered nurse from the rest home, employed for 40 hours per week, is responsible for the care in the Dementia unit, giving her a total of 62 residents, and also responsible for maintaining DHB contractual requirements and Health and Disability Services Standards compliance for these residents.

The activities staff for the facility are part time employees and the actual time spent with residents is limited due to the three levels of care within the facility and the preparation time needed for planning and documentation for these activities. The total activities hours worked per week are 53 hours for 93 residents, i.e. 1.7 hours per resident per week, excluding any preparation, assessment, documentation or planning time.

**Recommendation:**

Review staff ratios within the Dementia unit; review registered nursing hours for the Dementia unit and Rest Home and review activity staff hours, to ensure that consumers receive timely, appropriate and safe service from suitably qualified/skilled and/or other experienced service providers. Reference: SNZ HB 8163:2005 NZ Handbook "Indicators for Safe Aged-care and Dementia-care for consumers"

**Continuum of Service Delivery - Standard 1.3**

**1.3.3.4 – Partial attainment**

In the case of Mrs X it was evidenced that there was not adequate handover between shifts concerning changes in her care and/or the need for closer monitoring/ assistance. There had also been a loss in provider continuity of service, with a caregiver from another area of the facility caring for her, (as evidenced through interviews and rosters). This should have led to a more detailed handover.

**Corrective Actions:**

Ensure that all new or staff from other areas, of the facility, have a process in place to enable them to be fully briefed in the care they are expected to provide, and that they know where and from whom to seek assistance.

Review integrated notes procedures and handover procedures to ensure they comply with policy.

**1.3.4.1 – Partial attainment**

1. In the case of Mrs X, the registered nurse was responsible for the falls risk and restraint assessments. However it was the care staff who were responsible for service delivery, and linkages between the two processes did not exist.

2. In the case of Mr X although comprehensive evidenced based tools for assessment of pain management and behaviour were available, these were not sighted within his clinical notes.

**Corrective Actions:**

Ensure clinical and care staff seek appropriate information and access a range of resources to enable effective assessment and care.

**1.3.5.1 – Partial attainment**

Care plans/ goals were not evidenced as being accurate and up to date for Mrs X. or Mr X.

1. There was no short term plan for Mrs X following the decision to restrain, (or specific requirements re falls prevention in the interim until restraint equipment was available), and the key worker or equivalent was not involved in planning. Specific requirements and evaluation by the RN was merely "no changes required".
2. There was no specific plan/ goals for Mr X. regarding his suicidal thoughts, or for managing his pain, challenging behaviour/mood, and a key worker or equivalent was not involved in planning. Specific requirements and evaluation by the RN was stated only "no changes required".

**Corrective Actions:**

Ensure service delivery plans are individualised, accurate and up to date, and that service delivery staff are informed of the changes.

1.3.5.2- Partial attainment

Both Mrs X's and Mr X's care plans had not been updated to describe the required support and/or interventions to achieve the desired outcomes to address potential harm. Specific requirements and evaluation by the RN was stated only "no changes required".

**Corrective Actions:**

Ensure that individual needs; outcomes and /or goals are documented to serve as the basis for service delivery.

1.3.8.3 – Partial attainment

In the case of both Mrs X and Mr X care plans were generic and not reviewed to include responses ( specific requirements) to expected outcomes.

**Corrective Actions:**

Ensure that where progress is different from expected, changes within the care plan are initiated, implemented and evaluated.

1.3.12.1 – Partial attainment

Medication. Outdated stock, stock from deceased residents; Imprest/bulk stock (antibiotics); currently using remainder from past residents' prescriptions; panadol tablets in nurse labelled bottle observed in hospital.

**Corrective Actions:**

Ensure safe and appropriate disposal of medicines in order to comply with legislation , protocols and guidelines.

## Safe Restraint Practice - Standard 2.2

2.1.2 – Partial attainment

In the case of Mrs X. the approved restraint as per policy had not been documented. There were no interventions or restraint alternatives recorded and communicated to staff, and an unapproved type of restraint had been offered. The restraint had been ordered, but no interventions were recorded for staff on de-escalation and interventions until the restraint became available.

### **Corrective Actions:**

Ensure that all staff are aware of the type of restraint allowed under the provider's policy, and that all staff are aware of the clear lines of responsibility for restraint practice.

Ensure that clear documentation for new restraints is maintained and that all staff are aware of the need for restraint and monitoring of such restraint.

Ensure that restraints provided within the facility comply with accepted best practice and appropriate for individual client needs.

### **Summation meeting**

A summation meeting was attended by XXX XXX HealthCERT; XXX XXX HealthCERT; Mr XXX XXX ; XXX XXX.

XXX thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as more information was required and photocopied information requested and provided needed further analysis. XXX noted that the relative interviewed had been complementary to the service, and that staff were welcoming and approachable, and that many had long term employment with the service. She confirmed that there would be findings against the Health and Disability Services Standards in relation to the complaint and the adverse event.

### **Key issues raised at summation were:**

Relevant to complaint/ adverse event;

- Assessment – pain/falls/restraint
- Planning - handover/ integration/review and evaluation
- Staff levels/ skill mix - Dementia unit/Rest Home/Staff development
- Consumer Rights –advanced directives.

Not relevant to complaint /adverse event;

- General – Food storage; Oxygen cylinders; cleaning/maintenance; security; laundry; infection prevention and control; continence assessment; informed consent and privacy.

Not raised at this meeting but subsequently notified to the provider;

- medication management
- summary for publication on the MOH provider website.

### **Conclusion**

Bosnyak Lifecare Management Limited - Regency Home and Hospital will be required to take the above corrective actions to ensure compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

## Additional Conditions

Additional conditions to be placed on the Certification Schedule

Pursuant to section 28 of the Health and Disability Services (Safety) Act, the Director-General of Health may attach any condition the Director-General thinks necessary or desirable to help achieve the purpose of this Act.

The following conditions are to be included on the certification schedule of Bosnyak Lifecare Management Limited - Regency Home and Hospital:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.3.3.4; 1.3.8.3; 1.3.12.1 as identified in the Inspection Report dated 31 August 2009, must be submitted to the Director-General by 30 October 2009.
2. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.1.10.7; 1.2.3.9; 1.3.4.1; 1.3.5.1; 1.3.5.2 as identified in the Inspection Report dated 31 August 2009, must be submitted to the Director-General by 30 January 2010.
3. HealthCERT may elect to carry out a verification audit in relation to these corrective actions.
4. The Director-General may impose any further condition, or vary any condition, where the Director-General thinks it is necessary or desirable to do so in order to help achieve the purposes of the Act.

## Summary for Publication

The Ministry of Health carried out an unannounced inspection at Bosnyak Lifecare Management Limited - Regency Home and Hospital, on 31 August 2009 in response to a complaint concerning the care provided to a resident, and notification of an adverse event occurring in August 2009.

The purpose of the unannounced inspection undertaken on 31 August 2009, was to determine whether health care services being provided by, Bosnyak Lifecare Management Limited - Regency Home and Hospital are being provided in compliance with section 9, of the Health and Disability Services (Safety) Act 2001. That is a person providing health care services of any kind must do so whilst meeting all relevant standards.

Bosnyak Lifecare Management Limited - Regency Home and Hospital, is required to undertake the following corrective actions to comply with the Health and Disability Sector Standards. Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board including, but not limited to, the submission of reports to the Ministry by 30 October 2009 and 30 January 2010 and the requirement to have the actions verified at the time of the next audit.

### *Organisational Management:*

Ensure that there is sufficient restraint equipment for staff to carry out safe practice, when the need for restraint has been assessed and is required.

Ensure that there is a process in place to address referral follow up and outcomes.

*Continuum of Service Delivery:*

Ensure that all new or staff from other areas of the facility have a process in place to enable them to be fully briefed in the care they are expected to provide, and that they know where and from whom to seek assistance. Review integrated notes procedures and handover procedures to ensure they comply with policy. Ensure clinical and care staff seek appropriate information and access a range of resources to enable effective assessment and care. Ensure service delivery plans are individualized, accurate and up to date, and that service delivery staff are informed of the changes. Ensure that individual needs, outcomes and/or goals are documented to serve as the basis for service delivery. Ensure that where progress is different from expected, changes within the care plan are initiated, implemented and evaluated.

*Safe Restraint Practice:*

Ensure that all staff are aware of the type of restraint allowed under the provider's policy, and that all staff are aware of the clear lines of responsibility for restraint practice. Ensure that clear documentation for new restraints is maintained and that all staff are aware of the need for restraint and monitoring of such restraint. Ensure that restraints provided within the facility comply with accepted best practice and are appropriate for individual client needs.

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## Appendix

### Documents requested

- Staffing and skill mix policy
- Rosters (last month and this month)
- Abuse and Neglect Policy
- Management of Challenging Behaviour Policy
- Complaints management policy
- Complaints records for the last two months
- Clinical Assessment Tools in current use
- Staff orientation policy and process
- Staff training records and in-service training programme
- List of staff with current first aid certification
- List of staff with current medication competency
- Quality and risk management plan
- Emergency Response Policy
- Incident and accidents records for the last two months
- Minutes of staff meetings
- Minutes of quality meetings
- Resident files
- Completed resident satisfaction survey

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