

# Bosnyak Lifecare Management Limited

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Bosnyak Lifecare Management Limited
<b>Premises audited:</b>	Regency Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 15 February 2016      End date: 15 February 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	76

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Regency Home and Hospital provides rest home and hospital level of care for up to 92 residents. This includes an 18 bed specialist secure dementia unit. There were 76 residents residing at the facility at the time of audit.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included the review of documentation, observations and interviews. The audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There was one area requiring improvement identified at the previous audit, related to the orientation process for temporary staff, this is now addressed. There are no systemic issues that required improvements to be implemented from this surveillance audit.

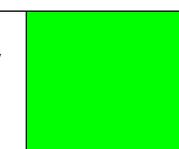
## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families report that they receive open and honest communication and notifications from the staff. All residents can effectively communicate with staff. Translation services are used as appropriate.

There is an easily accessible complaints management system. The complaints register records all complaints and concerns, dates and actions taken. There were no open complaints at the time of audit.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's mission, values and goals are clearly documented in business and quality plans. How the service is performing against key performance expectations is monitored on a regular basis through weekly, monthly and annual evaluation processes.

The service is managed by a suitably qualified and experienced enrolled nurse. The manager is also supported by a clinical leader and registered nursing team.

The service has a documented quality and risk management system, which includes an internal audit programme and hazard identification. The quality data is collated and analysed on a monthly basis. Where there are shortfalls identified, the service carries out corrective actions to ensure improvements are implemented. There are processes for the ongoing review of policies and procedures to guide staff on all aspects of service delivery that reflect current accepted practice and legislative requirements.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established and implemented for the recruitment, orientation and ongoing performance appraisals. The education programme for all staff is available and planned for the year. The required training is

provided for staff who work in the dementia unit. The rosters confirm there are adequate staff numbers to meet contractual requirements and the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents receive timely, competent and appropriate services that meet their assessed needs and desired outcome/goals. The residents are admitted with the use of standardised risk assessment tools and assessed via the interRAI assessment tool, within the required timeframes. Short term care plans are consistently developed and evaluated when acute conditions are identified. Long term care plans are reviewed every six months. Planned activities are appropriate to the needs, age and culture of the residents.

The medicine management system meets the required regulations and guidelines. All staff have current medication competencies. Policies and procedures are in place when residents self-administer medications.

Meal services meet the individual food, fluids and nutritional needs of the residents.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness displayed. There have been no changes to the layout of the service that has required the approved evacuation plan to be changed.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are clear and comprehensive policies and procedures that meet the requirements of the restraint minimisation and safe practice. There is one resident who is using an enabler and nine residents are on restraint. There is a current restraint register. Staff demonstrated good knowledge regarding restraints and enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance of residents' infections is appropriately managed for the size and complexity of the service. There are processes in place for infection surveillance, and for reporting of, analysing trends and responding to surveillance results. The results of the infections surveillance are reported to management and staff.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	39	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints process sighted identifies the required procedures and complies with time frames within Right 10 of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Complaints management information is included in resident information packs and discussed with residents and their families as part of the admission process. Complaints forms are accessible at the entrance to the facility. The residents and families report that if they have any issues or make a complaint, the issues are actioned. The satisfaction survey records that complaints are dealt with in a timely manner. Staff confirmed their understanding of the complaints process.</p> <p>The complaints register contains all complaints and concerns. The register records the date the complaint is lodged and is linked to the complaint form that records the complaint summary, investigation, actions and findings. There were no open complaints at the time of audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>The family/whānau members confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in each resident's file, through the family communication sheet, on the accident/incident forms and in the resident's progress notes.</p> <p>There are some residents who do not speak English as their first language. There are effective interpreting systems implemented by staff and families. Staff demonstrated knowledge of how to contact an interpreting</p>

<p>provide an environment conducive to effective communication.</p>		<p>service if required. There are communication strategies for the residents with cognitive impairment.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides rest home, hospital and secure specialist dementia care. There are three rest home wings, two hospital wings and one secure dementia unit. At the time of audit there were 35 rest home, 26 hospital and 15 dementia level of care residents, (this included one resident under the age of 65). The services provides long term care as well as short term respite care. The services are planned to meet the individual needs of each of the residents.</p> <p>The mission, values and directions of the service are documented in the business and quality plan. The business plan includes the ongoing upgrading and refurbishment of the service. The business plan is reviewed on an annual basis, with the manager providing the director with how the service is performing formally through a manager's report on a weekly basis. There is also a monthly governance meeting which includes performance against key performance expectations. The manager and director also have more informal discussions on a daily basis.</p> <p>The service is managed by a suitably qualified manager. The manager has been at the service for over 21 years with 15 years in the management role. The manager's job description documents their role, objectives, responsibilities and key performance expectations. The manager reports to the director. The manager is an enrolled nurse and has attended over eight hours of education in the past year related to management of aged care services. The service is a member of an aged care association and receives regular updates related to aged care management and legislative changes. The manager is support by a clinical leader and the RNs.</p> <p>The residents and families report satisfaction with the care and services provided. This is also confirmed in the resident satisfaction survey.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>The quality plan for 2016 was sighted. The plan includes the organisational goals for the upcoming year. The quality plan details the risks, current controls and ongoing actions required to provide safe and appropriate care. The quality and risk systems are monitored through internal audits, surveys and the quality improvement team meetings. Each of the quality goals identified covers all aspects of care and service delivery. There is an annual evaluation of the service's performance with the 2015 evaluation documenting how the service is achieving against their goals.</p> <p>Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. The outcomes of the internal auditing and quality management systems are discussed at monthly quality and staff meetings and outcomes displayed in the staff room. Staff confirmed they understood and implement the quality and risk management systems. All potential and actual risks are reported to the</p>

<p>principles.</p>		<p>director and reviewed regularly.</p> <p>The organisational policies have been developed by a quality consultant. Most policies are reviewed on a two yearly basis, or sooner if there are legislative or practice changes. There is a folder for the staff to review any new, changed or updated policies. The staff only have access to the most recent version of the policy. All policies sighted have version control information in the footer of the document. The service also uses best practice guidelines from the DHB, which include pressure injury prevention, grading and interventions.</p> <p>Quality data collection and analysis is maintained by the service and evaluation of results shared with staff and management. Corrective actions are put in place when indicated. The internal audit form records the outcomes, actions needed, who is to implement the actions and the review of when the actions have been implemented. Data is collected and reviewed and evaluated for all key components of the service at the quality and risk meeting.</p> <p>The risk, hazard and emergency response plan identifies potential and actual hazards. The plan includes what the hazard is, potential harm, preventative actions and ways to eliminate, isolate or minimise the risk. A hazard identification form and the maintenance job request logs are used to record any new hazards. When new issues are identified, these are reviewed at the quality meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The manager demonstrated understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. This include the requirements of essential notification for stage three and above pressure injuries. Essential notifications forms sighted for 2015 are appropriately actioned.</p> <p>The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. Adverse events are reviewed and analysed on a monthly basis at the quality meeting. The adverse event forms and monthly analysis are used for making improvements where required. The service includes the reporting of pressure injuries in their quality/incident data analysis systems.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>There was a previous area for improvement at criterion 1.2.7.4 to ensure the agency/bureau staff receive an orientation/induction programme that covers the essential components of the service provided. This is now addressed through the development of a bureau nursing staff orientation checklist. There has been minimal usage of agency staff with two staff requiring the orientation in 2015.</p> <p>Professional qualifications and practicing certificates are validated on employment, with a register maintained of when annual practicing certificates are due. All professional staff and contractors have a current practicing</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>certificate.</p> <p>The staff files evidenced that good employment processes are implemented, such as recruitment, interview and reference checking. All staff files and staff interviewed confirmed orientation is conducted and covers the essential components of care, service delivery, emergency management and health and safety. Performance reviews are conducted after three months then at least annually.</p> <p>The in-service education programme covers the essential components of service delivery for rest home, hospital and dementia level of care. The service also accesses ongoing education support from the palliative/hospice care services and other specialist nurses such as wound and gerontology. The 2016 in-service education programme includes skin care and pressure injury prevention and management. The care staffing in the dementia unit meet contractual requirements for the required education related to the national unit standards for dementia care. The diversional therapist and activities coordinator have completed specific training in dementia care. Attendance records are kept for the education that staff have attended, as sighted in each of the staff member's personnel files. The RNs who conduct the interRAI assessments have completed their training and ongoing competency for this.</p> <p>The residents, family and satisfaction survey results confirm satisfaction with the quality and skills of the staff at Regency. One survey records that the staff at Regency 'are the best I have ever met' and 'I have never had it so good all my life'.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The workforce planning policy and rosters clearly document the staffing requirements for the rest home, hospital and dementia services. The policy records that rostered hours are based on the needs of the residents. The sighted rosters meet the contractual requirements for the different levels of care. There is at least one RN on duty at all times, with all but one shift a week on morning and afternoon shift having at least two RNs on duty. There are at least two care staff (RN and caregivers) on duty at all times for the hospital and rest home at night. There is at least one care staff on duty at all times in the specialists dementia unit, with the RN providing additional coverage and support to the dementia unit. In addition to the roster staff, there is a manager (EN) and a clinical leader (RN) on duty full time Monday to Fridays.</p> <p>There is at least one staff member on duty each shift who has current first aid qualifications. There are appropriate staffing level for activities, cooking and laundry.</p> <p>The residents and families report satisfaction with the number and skill of the staff at Regency.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>FA</p>	<p>A medicine management system is consistently implemented to ensure that the residents receive medicines in a safe and timely manner. The medication charts are generated by the pharmacy and photos are present in all reviewed medication charts. There is evidence that medication charts are reviewed regularly. All discontinued</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medications are signed and dated by the GP and allergies are documented. Medicine reconciliation is conducted by the RNs when a resident is discharged back to the service from the public hospital.</p> <p>The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medication rounds in the rest home, hospital and dementia units. Current medication competencies are evidenced in the staff files.</p> <p>The system in place for the management of medicine meets the required regulations and guidelines. The controlled drugs register was correct and current. Weekly stocktake of controlled drugs is conducted by the RNs regularly while the pharmacist conducted six monthly stocktakes with the RNs. Fridge temperatures are recorded regularly. All medications are stored appropriately in the units.</p> <p>There is a resident who self-administers medications and policies and procedures are followed by the staff in relation to self-administration of medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked onsite by the cook. The cooks have current food handling certificates.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete the dietary requirement forms on admission and provide a copy to the kitchen. The kitchen folder which contains dietary requirements of the residents is updated regularly. Additional or modified foods are also provided by the service.</p> <p>Fridge and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the main dining area and the food for the hospital and dementia units are transported in a portable bain marie. The meals are well-presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements and are assisted by the staff during meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>The documented interventions are sufficiently detailed and well-documented to address the assessed needs and desired goals/outcomes. Interventions in the long term care plans address the outcome scale trends in the interRAI assessments. Interventions in managing acute infections were documented in the short term care plans and these are updated when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory.</p>

desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The diversional therapist develops the weekly activity plans with the manager, members of the health team and with the residents who are able to participate. The weekly activities are posted in the main bulletin board and in both hospital and rest home unit lounges. The activity plans are well-documented and reflect the resident's preferred activities and interests. The resident's activities participation log was sighted. Interviewed residents and families verbalised the activities provided by the service are adequate and enjoyable. A 24-hour activity plan is in place for all residents in the dementia unit and involves more visual stimulating activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Short term care plans are evaluated by the registered nurses and the resolutions of the identified acute conditions are documented in the reviewed residents' files. Long term care plans are reviewed and evaluated every six months or earlier as required. Interventions in both long term and short term care plans are modified when the outcomes are different from expected. Interviewed residents and family members reported they are involved in all aspects of care and reviews/evaluations.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness expires in March 2016. There has been no changes to the layout of the service that has required changes to the approved evacuation scheme.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	<p>The facility has a system for infection surveillance which is appropriate to the size and complexity of the service. The infection control coordinator, a registered nurse, collates the monthly surveillance data related to infections. Surveillance results are reported to staff and management at the monthly quality and staff meetings, with the results displayed in the staff room. The surveillance data recorded an increase in respiratory infections in December 2015, with the analysis for January 2016 recording that the actions implemented to reduce this type of infection were successful, with a reduction of chest infections recorded. The staff demonstrated knowledge of actions required to reduce infections. One family member commented that their relative has had an ongoing urinary tract infection and described the measures the service has implemented to reduce the infections</p>

specified in the infection control programme.		reoccurrence.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrates that the use of restraint is actively minimised. There were nine residents using restraints and one resident using an enabler. The restraint register is current and updated. The policies and procedures have definitions of restraints and enablers that are compliant to the standard. Assessments and consents were sighted in the reviewed residents' records that are using restraints or enabler. Interviewed staff demonstrated good knowledge about restraints and enablers.</p>

## Specific results for criterion where corrective actions are required

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Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.