

# Bosnyak Lifecare Management Limited - Regency Home and Hospital

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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 Q-Audit 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: 4 February 2019	End date: 4 February 2019
<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>	68	

# 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, specialist secure dementia care and hospital level of care for up to 92 residents. Residents and family/whānau reported satisfaction with the overall care and services provided. There have been no changes to the facility or services since the last audit.

This unannounced audit was conducted against a subset of the 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. Interviews were conducted with management, clinical and non-clinical staff, residents, family/whanau and a general practitioner (GP).

There were no previous corrective actions to follow up and the provider continues to achieve full compliance to the standards audited. No systemic issues were identified.

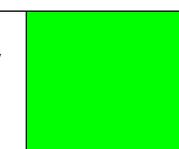
## Consumer rights

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 confirmed that they are treated with respect and that privacy is maintained. Services are provided in a manner that meets residents' rights and acknowledges cultural and individual values and beliefs. Interpreter services are used when required. The sharing of information with residents and family/whanau is documented.

The complaints process meets the requirements of consumer rights legislation. A complaint register is maintained.

## 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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Organisational structures and processes are monitored by management and the owner. Organisational performance is aligned with the organisation's philosophy and goals. The manager is suitably qualified and experienced.

The quality and risk management system continues to support the provision of clinical care and support. Quality related data is gathered and utilised to identify issues/trends. Policies and procedures are current and reflect good practice principles. Adverse events are effectively managed.

Systems for human resources management are maintained. There are adequate staff numbers on each shift to meet the resident's needs. The education programme for all staff is available and planned for the year. Staff education is encouraged. Staff performance is monitored.

## 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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The entry to service process is managed by the nursing team and was completed in a timely manner. The general practitioner (GP) is involved in the admission process and three-monthly reviews of medication as required. The clinical leader (CL) is responsible for developing care plans in consultation with the registered nurses (RNs). Care plans and interRAI assessments are completed within the required time frames.

Planned activities are appropriate for the residents' assessed needs and abilities. Residents and family interviewed expressed satisfaction with the activities provided by the activities coordinator with oversight from the diversional therapist (DT).

There are policies and procedures that clearly document the service providers responsibilities in relation to each stage of medicine management. The service uses a pre-packed medication system that is paper based. All medication administration competencies are current.

Food services meet best practice requirements. The menu has been reviewed by a dietitian as suitable for residents. Special dietary needs are catered for.

## 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 have been no changes to the facility since the last audit. There is a current building warrant of fitness and trial evacuations are conducted as required.

## 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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The use of restraints and enablers are minimised. Policies and procedures regarding restraint and enablers are documented and implemented. Staff receive the required training.

## 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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The infection control surveillance programme is appropriate to the size and scope of the service.

## 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	38	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 meets the requirements of consumer legislation. A complaints register is maintained. There were three documented complaints for 2018, and none this year to date. All three were closed out in a timely manner with appropriate responses and actions. Complaints forms are readily available, with information given regarding advocacy and the complaints process as part of the admission procedure. Staff complete a complaints management self-directed work book within three months of employment. Residents and family/whanau report they are encouraged to provide feedback or make a complaint. Some of the day to day concerns are voiced by residents during resident meetings. There is evidence that issues discussed at resident meetings are addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff education on communication methods is provided. The service has required access to interpreting services for the residents. Policies and procedures are in place if interpreter services are needed to be accessed. Documentation regarding open disclosure following incidents/accidents was evident. Residents and family reported they are informed of any events or concerns.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>The mission, vision, values, philosophy and purpose are clearly documented. The business plan is reviewed annually by the director/owner. The business plan focuses</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>on goals and projects for the year and longer-term future developments. Ongoing monitoring of performance is conducted through a monthly manager reports/meeting with the director. The director has an office on site so there is also ongoing informal monitoring through daily communications.</p> <p>The service is managed by a suitably qualified and experienced manager who is an enrolled nurse with a current practising certificate. The manager has worked at the service for 27 years, with 16 years' in management. The manager has the responsibility for day to day management and reports to the director. The manager continues to work in close liaison with the clinical leader (RN) and administration staff. There is evidence that the manager attends over eight hours' education related to the management of aged care services per year. The manager also receives regular updates from an aged care association regarding management and aged care related topics/issues.</p> <p>Regency Home and Hospital is a continuing care facility, providing rest home, hospital and dementia level of care. This includes 44 rest home level beds, an 18-bed secure dementia unit and 30 hospital beds. At the time of audit there were 11 residents living in the dementia unit, 32 residents accessing rest home level care and 25 residents receiving hospital level of care (including one younger resident under the age of 65). Services are staffed and resourced to meet the needs of the residents at the different levels of care.</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 principles.</p>	<p>FA</p>	<p>There is a planned quality programme that reflects the principles of continuous quality improvement. The quality programme includes a wide range of internal audits which are routinely conducted. All quality related data is discussed at monthly staff and quality meetings. Records of meeting minutes sampled confirmed monthly review and analysis of quality indicators, such as policy updates, feedback from resident meetings and satisfaction surveys, results of internal audit, adverse events and infection surveillance data. Meetings also are the venue for discussing/reviewing any corrective actions. Results of internal audits and analysis of quality data is graphed and displayed in the staff room.</p> <p>Policies cover all necessary aspects of the service and contractual requirements. Policies are based on best practice and the policies sampled were current and up to date. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The policies that are due for review are discussed at the staff and quality meetings. Staff sign to say they have read and understand any updated or new policy</p>

		<p>and are also provided with the opportunity to suggest changes.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. There is a risk register which identifies actual and potential risks for all levels of service. Minimisation strategies are documented.</p> <p>Resident and family satisfaction surveys sampled confirmed general satisfaction with the quality of care and services provided.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	FA	<p>The manager confirmed an understanding of responsibilities related to mandatory reporting and essential notifications. The required policies and procedures are in place.</p> <p>Incidents are tracked by category/type and location. Residents at risk are identified. Incident reports sampled confirmed appropriate emergency management/first aid (if required), timely follow up and notification to family members.</p> <p>The numbers and type of incidents are collated monthly. Any trends identified are noted and information fed back to quality and staff meetings. The service identifies strategies in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident's care plan as required. There is also evidence that additional staff training is provided if a certain category of event is tracking upward.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting at the managers discretion, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records sampled show documentation of completed orientation and a performance review after three-months and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Staff working in the dementia care area have completed the required education. The diversional therapists have specific education and experience in</p>

		dementia care. Nursing staff have access to relevant training from the district health board and the gerontology resource nurse provides training on site. The clinical leader is interRAI trained. Records sampled confirmed completion of the required training and completion of annual performance appraisals. The director/owner conducts an annual performance with the manager.
<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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The manager adjusts staffing levels to meet the changing needs of residents. The number of care staff in the rest home, hospital and dementia unit exceeds the minimum contractual requirements.</p> <p>The manager and clinical leader are on duty Monday to Friday, and on call at other times. There is at least one staff member on duty with a current first aid qualification each shift. There are two RNs on duty in the rest home and hospital sections on morning and afternoon shifts and one RN on duty for night shift.</p> <p>In the dementia unit, there is at least two caregivers on duty during the morning and afternoon shifts and one during the night. At night, there are four care staff on duty, which allows for the staff member in the dementia unit to call for assistance if required.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. In addition to the care staff, there are sufficient management, activities and support staff to meet the needs of the residents and facility up keep.</p> <p>Observations and sampling of roster cycles confirmed adequate staff cover is being provided, with staff replaced in any planned and unplanned absence.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. All staff responsible for medication administration have current competencies. Medication management training records were sighted. The service uses a pre-packed medication system. Three monthly medication reviews are completed by the GP. Allergies or sensitivities are indicated, and residents' photos are used as part of the identification method.</p> <p>The RNs were observed administering medication correctly in the hospital, rest home and dementia wings. Medication reconciliation is conducted when the new medication packs are delivered. The controlled drug management system complies with legislation. The medication fridges are checked daily, with recording within recommended ranges. Medication is safely stored in locked cupboards and drug</p>

		<p>trolleys. There was no expired medication onsite. Medication audits are conducted, and corrective actions are acted upon.</p> <p>There were no residents currently self-administering their medication. There are policies and procedure to guide this practice if this is required.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents. Additional snacks are provided to residents as needed. The resident's nutritional information is developed on admission which identifies dietary requirements, likes and dislikes and is reviewed as needed. Supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates were on all containers and records of temperature monitoring of food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. All decanted food had use by dates recorded on the containers and were current. The food service was registered under the new Food Control Plan. The residents and family interviewed indicated satisfaction with the food service.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term and lifestyle care plans are sufficient to address the residents assessed needs and desired goals/outcomes. When there is a significant change in the resident's condition the care plans are updated to address these needs. Short term changes are recorded on the short-term care plan. Monthly observations are completed and are up to date. Progress notes are completed daily by registered nurses and senior care staff. All clinical supplies are adequate as confirmed by staff interviewed. It was observed during the audit that residents are accorded respect, privacy and dignity and this was also confirmed during interviews with the residents and families. The GP confirmed that all prescribed nursing treatments/interventions were implemented as required.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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</p>	FA	<p>Activities are planned by the diversional therapist (DT) with assistance from the activity's coordinator. Activities are resident focussed and appropriate for people living with dementia, under 65, rest home and hospital level of care. A weekly planner is posted on the notice boards that is accessible to residents in all wings of the facility. The activities provided take into consideration residents' interests and</p>

<p>service.</p>		<p>abilities. Residents and their family are consulted in the activity assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking groups; van outings art and craft. There is community involvement with external entertainers invited, church, music groups and various community clubs. Attendance lists are completed daily, and documentation maintained. Evaluation of the individual activity plans are completed every six months, or when there is significant change.</p> <p>Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family and residents. Residents and family members interviewed reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit. In interview conducted the DT reported that the attendance was still the same since the last audit. The activities programme was awarded a continuous improvement rating at the last audit. The same activities programme has remained in place.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' lifestyle care plans and activity plans are evaluated every six months and is updated when there is any significant change. Reviews are documented and include the resident's current status, any changes, and achievements towards goals. The interRAI assessments are conducted six monthly and the outcomes are used as part of the evaluation process. Six monthly multi-disciplinary reviews (which include family input) are conducted to evaluate the effectiveness of the residents' progress. Family and staff input is sought in all aspects of care. Short term care plans are developed and reviewed as needed.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There have been no changes to the facility since the last audit. The current building warrant of fitness was sighted.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has the symptoms of infection and antibiotics are prescribed following confirmation.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint minimisation policy. This includes methods for minimising restraint and approved alternatives. Definitions of restraint and enablers are consistent with this standard. The assessment, approval, monitoring and review process is the same for both restraints and enablers. Current approved restraints/enablers include bed rails and vests. The use of both restraints and enablers is monitored. An updated restraint register was sighted.</p> <p>Records sampled confirmed that staff work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and quality management team meetings.</p> <p>All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.</p>
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## 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.