Final Inspection Report

G J & J M Bellaney Limited
Wimbledon Villa

Date of Inspection: 7 March 2013

HealthCERT
Provider Regulation
Clinical leadership, Protection and Regulation
Ministry of Health

Contents

Provider details

Provider:	G J & J M Bellaney Limited
Premise:	Wimbledon Villa
Contact Person:	Dr Grant Bellaney
Internal File Ref:	WGJ01
Inspection Date:	7 March 2013

Executive summary

The Ministry of Health (the Ministry) received information which indicated that G J & J M Bellaney Limited could be in breach of its obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 (the Act) to provide services at Wimbledon Villa.

The Ministry was advised by MidCentral District Health Board (DHB) that a Police investigation was under way after a resident died following an incident at Wimbledon Villa. In addition, the Ministry received information that Wimbledon Villa was not compliant with the New Zealand Fire Service standards for fire evacuation procedures. Both incidents raised concern that residents' safety could be at risk.

As a result of this information an unannounced inspection was undertaken by the Ministry on 7 March 2013 in accordance with sections 40, 41 and 43 of the Act. The provider was found to be in breach of its obligation to promptly notify the Director-General of Health of incidents that occurred relating to the safety of residents.

Summary of findings in respect of obligations as a certified provider under the Act

Failure to notify the Director-General of a serious incident affecting a subsidised resident

HealthCERT was advised by MidCentral DHB on XXXX of a serious incident that had occurred at Wimbledon Villa on XXXX. A resident XXX XXX XXX XXX XXXXXX XXX XXX. The resident died 72 hours later.

HealthCERT received a forwarded email on 8 March 2013 from the owner re the notification of police investigation due to death of resident XXX XXX XXXX XXX XXX.

Under section 31(5) of the Act, a person certified to provide health care services of any kind must promptly give the Director-General written notice of:

(a) any incident or situation (for example, a fire, flood, or failure of equipment or facilities) that has put at risk, may have put at risk, puts at risk, or may be

putting at risk the health or safety of people for whom the person was or is providing the services; and

(b) any investigation commenced by a constable into any aspect of the services, their provision, or any premises in which they were provided; and

(c) any death of a person to whom the person was providing the services, or occurring in any premises in which they were provided, that is required to be reported to a coroner under the Coroners Act 2006.

Outcome – non-compliance with section 31(5) of the Act.

Failure to notify the Director-General of non-compliance with fire safety regulations.

The New Zealand Fire Service visited Wimbledon Villa on 26 February 2013 to look at approving a fire evacuation scheme. The scheme for the building was declined due to non-compliance of the fire alarm system.

The provider failed to inform the Director-General of this situation and was in breach of its obligations under section 31(5) of the Act to provide services at Wimbledon Villa.

Outcome – non-compliance with New Zealand Fire Service standards and section 31(5) of the Act.

Background

The provider is currently certified for three years with an expiry date of 12 December 2014.

February 2012 HealthCERT received a complaint about the care of a particular resident at Wimbledon Villa. MidCentral DHB and a HealthCERT Senior Advisor conducted an on-site visit at Wimbledon Villa to review the standard of care being provided to residents.

The visit identified serious concerns about the actions of a registered nurse and the overall quality of care provided to residents. The nurse in question no longer works at the facility. She was referred by the DHB to the Nursing Council of New Zealand. The service provider was instructed to take immediate steps to begin corrective actions, within specific timeframes. The DHB began monitoring the provider intensely with on-site visits by the DHB continuing until the beginning of December 2012.

In May 2012 the provider advised the DHB that he had engaged an experienced consultant manager to work alongside his facility manager. The provider also employed a new Clinical Nurse Leader.

Current concerns

On 7 March 2013, HealthCERT conducted an unannounced inspection of the health care services provided by G J & J M Bellaney at Wimbledon Villa, Fielding. The inspection was conducted under provisions of the Health and Disability Services (Safety) Act 2001 after the Ministry was advised of an incident which resulted in the

death of a resident, and that the fire evacuation plan did not meet Fire Service requirements. Dr Bellaney was in breach of his conditions as a certified provider because the Ministry was not notified of these events in a timely manner and there was concern for the safety of residents.

Inspection team

The inspection was undertaken by XXX XXX and XXX XXX, Senior Advisors, HealthCERT, Ministry of Health.

Inspection process

The following process was used during the inspection:

- Interview with Facility Manager
- Interview with Clinical Nurse Manager
- Interview with Registered Nurse
- Interview with three care givers
- Physical inspection of premise/equipment
- Review of Clinical Records
- Review of policies and procedures

Inspection limitations

The scope of the inspection was limited to the issues concerning the required notifications under section 31(5) of the Act and standards relevant to those notifications.

Inspection findings

Findings have been reported against the following standards:

- HDSS 1.2 Organisational management
- HDSS 1.3 Continuum of Service Delivery
- HDSS 1.4 Safe and Appropriate Environment

No	Relevant Standard/Criterion	Findings	Required Corrective Action/s
1	**1.2.1 Governance** HDSS 1.2.1, / 1.2.1.3 The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	1.2.1.3 The facility manager had limited knowledge and understanding of aged care services. Interaction with the clinical staff was compromised as a result of limited knowledge of the sector. Although on leave at the time of the serious incident, since her return the manager had failed to update herself and manage the situation and the outstanding issues. This resulted in the clinical staff not being kept informed.	Continued up skilling is required to ensure the facility manager can manage all aspects of service provision.
2	**1.2.2 Service Management** HDSS 1.2.2 /1.2.2.1 The organisation ensure the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	1.2.2.1 During the absence of the manager the facility did not have clear processes for all staff.	The facility manager delegates a suitably qualified person in charge and this is communicated to all staff.
3.	**1.2.3. Quality and Risk Management Systems.** HDSS 1.2.3/ 1.2.3.3, 1.2.3.9 The organisation has a quality an established, documented and maintained quality and risk management system that reflects continuous quality improvement principals.	1.2.3.3 Policies and procedures purchased in 2012 had not been implemented or understood by staff. The Adverse event policy states that there is a requirement to notify both the DHB and Ministry in respect of a serious vent. There was some discussion as to whether this was a serious event which also demonstrated the owners, managers and staff responsible were not familiar with the policy or the definition of a serious event. The Ministry advisors clarified that XXX XXX is a serious event.	An implementation plan for all new policies needs to occur so all service providers are aware of their responsibilities.

No	Relevant Standard/Criterion	Findings	Required Corrective Action/s
		1.2.3.9 There was no evidence that, during the recent building of the additional three rooms, a risk management plan was in place to advise staff, consumers and family of the recent changes.	A risk management plan is developed and monitored
4	**1.2.4 Adverse Event Reporting** All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whanau of choice in an open manner.	1.2.4.2 For the serious event that occurred the notification to the DHB could have been timelier, however there was no notification to the Director-General. This is a Breech of Section 31 of the Act 1.2.4.3 The serious event documentation had not been completed in regard to the review of this event. The manager had not addressed opportunities to improve the service delivery and manage risks six weeks post event. The clinical staff had completed a thorough review from the time of the incident through to the transfer of the second resident to the DHB.	All service providers are familiar with statutory and regulatory obligations. If after hours then notification can occur by email or telephone message. Service providers understand the definition of a serious event and its associated reporting responsibilities. The review of the event is completed in a timely fashion and staff is informed of the outcome.
5	**1.3.6 Service Delivery/Interventions** Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	1.3.6.1 XXX XXX staff had assessed that XXXX's XXXX condition had deteriorated, and the medication for this resident had been reviewed and altered by the GP. There was no monitoring of change of behaviour as a result of change of medication for this resident.	The needs of all consumers are managed when there is an identified deterioration of another resident that could compromise the safety of the individual and all others.

No	Relevant Standard/Criterion	Findings	Required Corrective Action/s
	1.4.7 Essential Emergency and Security Systems	1.4.7.3 Service providers were unaware of the implications of the recent additions in relation to the existing fire evacuation plan. Approved evacuation plan is required prior to any further occupancy.	Staff must be updated as required when reconfiguration changes occur and the potential change of fire evacuation plans. The Final evacuation scheme is completed and approved in accordance with the Fire Service Act 1975 and the Fire Safety and Evacuation of Buildings Regulation 1992. A planned fire drill is required within six weeks.

Meeting at end of inspection

Present: XXX XXX, HealthCERT, XXX XXX, HealthCERT, XXX XXX, MidCentral District Health Board, Joanne Nightingale, Facility Manager, XXX XXX, Registered Nurse, XXX XXX, plus one other registered nurse, Dr Grant Bellaney (by phone). XXX XXX thanked the facility personnel 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 information gathered needed further analysis. The provider was advised that this investigation report would be published on the Ministry of Health website.

Key issues raised were:

The facility manager had limited knowledge and understanding of aged care services. Interaction with the clinical staff was compromised as a result of her limited knowledge of the sector.

During the absence of the manager, the facility needs to have clear processes for all staff. The suitably qualified and/or experienced person performing the manager's role is required to understand the process and management for event reporting.

Policies and procedures developed in 2012 had not been fully Implemented or understood by staff.

For the serious event that occurred, the notification to the DHB could have been timelier. However, there was no notification to the Director-General, this is a Breech of Section 31(5) of the Act.

Documentation for the serious event was not completed in regard to review. The manager had not addressed opportunities to improve the service delivery and manage risks six weeks post event

A written progress report that outlines all actions undertaken by the provider in relation to corrective measures against Health and Disability Services Standards 1.2.1.3, 1.2.2.1, 1.2.3.3, 1.2.3.9, 1.2.4.2, 1.2.4.3, 1.3.6.1, 1.4.7.3 (as approved under section 13 of the Act) must be submitted to your District Health Board by 14 June 2013. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.

Conclusion

Under section 9 of the Act, certified providers must meet all relevant standards and comply with any conditions subject to which the provider was certified by the Director-General of Health. GJ & JM Bellaney Limited is required to undertake the above corrective actions within the specified timeframe. If the corrective actions are not achieved, the Ministry may take action in relation to non-compliance with the requirements of the Act.

The provider was given a copy of the draft report and asked to comment on any factual errors. Dr Bellaney responded in a letter dated 17 April 2013. Dr Bellaney’s comments were considered before this report was finalised. No changes were made to the draft report as a result of factual errors.