

Benhaven Care Limited - Benhaven Rest Home

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 and Disability Auditing New Zealand 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:

Legal entity: Benhaven Care Limited

Premises audited: Benhaven Rest Home

Services audited: Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical

Dates of audit: Start date: 26 October 2017 End date: 27 October 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 21

Executive summary of the audit

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

Benhaven rest home is certified to provide residential disability – physical and intellectual level care and rest home level of care for up to 21 residents. On the day of the audit there were 21 residents.

The owners live on-site and work in the facility. The manager who is a registered nurse with a current practicing certificate has been in the role since February 2014. The owners and manager run the facility with the support of long serving staff. The residents and a relative interviewed spoke positively about the care and support provided at Benhaven rest home.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, relatives, general practitioner, management and staff.

The service has addressed all four previous shortfalls around meeting minutes, open disclosure, provision of staff education and review of the infection control programme.

This audit identified further improvements required around incident reporting and restraint documentation.

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.

Benhaven provides care in a way that focuses on the individual resident. Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

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.

Some standards applicable to this service partially attained and of low risk.

Benhaven is implementing a quality and risk management system that supports the provision of quality care. An annual resident satisfaction survey is completed and there are regular resident meetings. There is a monthly collation of quality data and this is discussed at quality and staff meetings. Internal audits are completed as per the annual audit schedule. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes skill mixes.

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.

The registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The activities officer provides an interesting and varied activities programme for the residents that includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. The service uses a paper based medication system. Staff who are responsible for the administration of medicines, complete annual education and medication competencies. The general practitioner reviews medications three-monthly.

All meals are prepared on-site. Individual and special dietary needs are catered, and alternative options are available for residents with dislikes. A dietitian has reviewed the menu. Residents interviewed responded favourably to the food provided.

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.

The building has a current warrant of fitness.

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.		Some standards applicable to this service partially attained and of low risk.
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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There was one resident who had restraints in place. There was a shortfall in the process which has resulted in a finding relating to the safe use of restraint. Staff have received training in the management of challenging behaviour.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (manager/RN) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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)
Standards	0	17	0	2	0	0	0
Criteria	0	39	0	2	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)
Standards	0	0	0	0	0
Criteria	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission. The manager leads the investigation and management of complaints (verbal and written). Complaint forms are visible around the facility. Two complaints had been received in the last twenty-two months with evidence of appropriate and timely follow-up actions taken. One was to the Health and Disability Commissioner (no further action required). Documentation including follow-up communication and resolution demonstrates that the complaints were appropriately managed. Interview with residents confirmed they are supported to make a complaint where needed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Thirteen incident/accident forms reviewed identified that family had been notification. The relative interviewed (relative of a YPD resident) confirmed they were notified of any changes in their family member's health status. The manager described how emphasis is placed on clear communication with residents at all levels of service delivery (a number of whom have intellectual impairment). The previous shortfall around open disclosure has been addressed.

<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>	FA	<p>Benhaven provides care for up to 21 residents across two service levels (Rest home and residential disability – intellectual (ID) and physical (PD)). On the day of audit, there were 21 residents. There were 12 residents under the ARRC contract, two private and two residents on LTS-CHCH contracts. There were four residents under MOH disability contracts (two ID and two PD).</p> <p>The owners/directors work in the facility. They are supported by the manager/RN who is fulltime and on call. A relieving RN covers call for one week each month and when the manager is on leave.</p> <p>The Benhaven goals for the 2017 year includes developing strategic alliances, creating a stimulating environment for residents (including providing meaningful activities for the residents), education of staff, re-certification, maintaining occupancy and a viable business and safety for residents, relatives and staff. Each goal has objectives and management controls.</p> <p>The manager has maintained eight hours annually of professional development activities related to managing a rest home.</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>	FA	<p>Benhaven is implementing a quality and risk management system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at least two-yearly. The content of policy and procedures is detailed to allow effective implementation by staff. Caregivers interviewed confirm they are made aware of any reviewed policies and sign to declare they have read and understood the content.</p> <p>Quality matters and monthly data are discussed at the facility staff meetings and monthly quality meetings. Infection control and health and safety are incorporated into the staff meetings. Meeting minutes evidenced trending and analysis of quality data including accidents and incidents (link 1.2.4.3), complaints, infections and the use of enablers/restraint. Meeting minutes reviewed, including resident meetings, demonstrated that issues raised are followed through and closed out. Residents (including YPD residents) have input into changes/improvements and there was evidence of this with the suggested changes being made and well-liked by the residents.</p> <p>An internal audit programme is followed with corrective actions followed up and addressed.</p> <p>A relative satisfaction survey is completed annually (the last survey occurred in October 2017). The relative survey results reported that they are either very satisfied or satisfied, with the exception of the laundry service, which did not achieve 75% satisfaction. Corrective actions had been undertaken to remedy this.</p> <p>Falls prevention is managed on an individual basis with identified risks and interventions documented in the resident care plan. There is a current hazard register.</p>

Standard 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/whānau of choice in an open manner.	PA Low	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise risk. Thirteen incident forms reviewed showed timely RN assessments and follow-up as appropriate. A fourteenth incident had occurred but there was no documented evidence in the accident and incident register that it had occurred, no incident form could be located, or any corrective actions had been taken as per the accident/incident policy.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	<p>There are human resources policies to support recruitment practices. A current practising certificate is available in the RN file. Six staff files were reviewed (manager/registered nurse, three caregivers, cook and activities officer) and all had relevant documentation relating to employment. Performance appraisals were current.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented checklists. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is a two-yearly education plan in place. All mandatory topics had been covered, including (but not limited to), cultural safety (June 2016) and wound management/skin integrity (June 2016). There is evidence that additional topics and opportunities for learning are offered to staff such as education on diabetes. Interviews with caregivers and the manager/registered nurse confirm training opportunities are available. The previous finding relating to education has been addressed.</p>
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>Staffing is as follows: Two caregivers on morning and afternoon shifts (one on each duty works a shorter duty) and caregiver at night, the owners are available on-site as needed. A cook is on daily and a recreation officer part-time Monday to Friday.</p> <p>The manager/RN is full time Monday to Friday and on call. The caregivers, residents and relative interviewed stated there were sufficient staff on duty at all times.</p>

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>Medication policies align with legislative requirements and safe practice guidelines. The service uses a paper-based medication system. The RN and caregivers responsible for the administration of medications have completed annual competencies and medication education. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. The RN and care staff interviewed, were able to describe their role in medicine administration. Medications were stored safely. The medication fridge temperature was monitored weekly. Eye drops are dated on opening and there were no expired medications. There were no residents self-medicating and there were no controlled medications on-site. If residents are competent or wish to self-medicate the facility puts systems in place. No residents were self-medicating on day of audit.</p> <p>Standing orders were in use and reviewed by the GP (16 October 2017).</p> <p>Ten medication charts and administration signing were viewed on the medication system. Prescribing and three-monthly medication chart reviews met legislative requirements. Medication administration observed on audit met safe practice.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	<p>All food is prepared and cooked on-site at Benhaven rest home. Two cooks cover the seven-day week. There was a summer/winter three-weekly rotating menu in place, which a dietitian had reviewed May 2017.</p> <p>The food is prepared and served directly to residents in the two dining rooms. The cook receives resident dietary profiles and is notified of any dietary changes and requirements. Dislikes are accommodated. Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained. Residents interviewed spoke positively about the food and meals provided.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relative interviewed confirmed care delivery and support by staff is consistent with their expectations. The family interviewed confirmed they were informed of any changes to resident's health status. Resident files reviewed included communication with family.</p> <p>Staff report there are adequate continence and dressing supplies. On the day of the audit, supplies of these products were sighted. There were no wounds on the day of audit. There were no pressure injuries. The manager/RN could describe the referral process to a wound specialist or continence nurse.</p>

Standard 1.3.7: Planned Activities 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.	FA	<p>The service employs an activities officer for 12 hours per week Monday to Friday, who is responsible for the planning and delivery of the activities programme. The activities officer has a current first aid certificate and undertakes some hours as a carer. Carers also assist in running activities.</p> <p>The flexible programme is responsive to what the residents wish to do and is arranged to accommodate the needs of the range of residents including YPD. Residents have the opportunity to provide suggestions for activities and outings and are encouraged to establish/continue with activities/interests in the community. The facility has a van and regularly takes residents out for drives and activities in the community and friends/family are encouraged to continue relationships with the residents. The facility provides transport to enable residents (in particular YPD residents) to continue networking with friends and interests in the community as they choose. Entertainers regularly visit the facility.</p> <p>Residents attend church services on-site and are supported to attend church in the community (a YPD resident attends church in the community).</p> <p>Residents have an activity assessment completed on admission. Activity plans were sighted in the resident files reviewed. Activity plans had been reviewed at the same time as care plans.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>The RN has evaluated initial nursing assessment/care plans (sighted) within three weeks of admission. InterRAI assessments are completed six-monthly or earlier due to changes in health status. Long-term care plans reviewed have been evaluated at least six-monthly by the multidisciplinary (MDT) team. As able residents are actively involved and families are invited to attend the MDT meetings.</p> <p>Short-term care plans have been reviewed regularly by the RN and either resolved or added to the long-term care plan if the problem is ongoing.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness expiring 28 September 2018.

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme had been reviewed (December 2016). The previous finding relating to infection control programme review has been addressed</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 specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (manager/RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections and systems in place are appropriate to the size and complexity of service provided. Infection control data is collated monthly and discussed at both the quality and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. There have been three infections year-to-date. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Benhaven rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The manager/RN is the restraint coordinator with a job description defining responsibilities of the role. The restraint coordinator confirms that the service promotes minimisation of restraint. Challenging behaviour and restraint minimisation and safe practice education has been provided. Restraint/enabler use is discussed at monthly staff meetings. The caregivers interviewed were knowledgeable in the use of enablers/restraint (link 2.2.3).</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining</p>	FA	<p>Click here to enter text</p>

approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	There was one resident assessed as requiring one type of restraint, which the policy/process had been adhered to. However, the same resident was also having another type of restraint applied with no documentation/instructions pertaining to the second restraint.

Specific results for criterion where corrective actions are required

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	There was evidence of the reporting of accidents and incidents and follow-up actions, however this was not consistent.	A resident had collapsed following drinking a chemical (or alcohol) on-site and was transferred to hospital. There was no documented evidence that an accident and incident form had been completed or follow-up action pertaining to the adverse event and how to avoid a possible repeat of the adverse event. The resident involved received appropriate emergency care	Record all accidents and incidents as defined in the policy and follow through the adverse event to mitigate further risk

				90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. 	PA Low	<p>One resident had been assessed for the use of a lapbelt as a restraint when up in a chair. The consent process has been followed and the restraint introduced and reviewed. The same resident had a bedrail installed but not was assessed as part of the restraint approval process.</p>	<p>There was no restraint process documentation (assessment, approval and monitoring) completed for one resident with a bedrail</p> <p>Ensure that the restraint process is followed for all restraints used.</p> <p>90 days</p>	

Specific results for criterion where a continuous improvement has been recorded

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.

No data to display

End of the report.