

# Benhaven Care Limited - Benhaven Rest Home

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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 BSI Group New Zealand Ltd, 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: 23 September 2021 End date: 24 September 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 20

# 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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 provides residential services for people with physical and intellectual disabilities and residents requiring rest home level care. Twenty-one of a potential twenty-one beds were occupied on the day of the audit. The service is managed by a registered nurse who has aged care experience and has been in the position for eight years.

This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

Residents and family interviewed spoke very highly of the service and the support provided.

There were no shortfalls 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.

The staff at Benhaven ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process.

## 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.

The owners live on-site and there is a manager (a registered nurse) who is supported by long serving staff.

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan has goals documented. There are policies and procedures that provide appropriate support and care to residents with physical and intellectual disability and rest home level needs. There is a documented quality and risk management programme that is implemented.

Staff receive ongoing training and there is a training plan developed and adhered to. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs.

## 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 service has assessment processes and residents' needs are assessed prior to entry. Assessments, resident care plans and evaluations were completed by the registered nurse/manager within the required timeframes and reflect a person-centred approach to care. Risk assessment tools including interRAI assessments and monitoring forms were available and implemented. Care plans were individualised and identified involvement of allied health professionals.

Three of the care staff have a dedicated role in implementing an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

All meals and baking are prepared and cooked on site. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks were available over 24hours.

## 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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The building has a current warrant of fitness. Preventative and reactive maintenance occur. There are essential contractors available 24/7. All communal areas are easily accessible for residents using mobility aids. External areas provide seating and shade.

## 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.

The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There is one resident using an enabler.

## 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.

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer. There are infection prevention and control policies and procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends and discussed at staff meetings. There have been no infections year to date.

## 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	16	0	0	0	0	0
Criteria	0	41	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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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	<p>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at the key points throughout the service. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints. There is a complaint register that includes relevant information regarding the complaint. Documentation includes acknowledgement of the complaint/concern and follow-up letters and resolution to the satisfaction of the complainant within the required timeframes.</p> <p>The service has had three written complaints since previous audit (one via the DHB). Two corrective actions recommended from this have been undertaken. The second complaint related to odour from a grease trap. Immediate action was taken and followed up by a contractor. On the day of audit there were no unpleasant smells. New carpet had been purchased – to be laid when tradesperson was available. There had been an issue of a resident urinating in inappropriate places, management believed through active interventions this had been reduced. The third, received on first day of audit, related to one resident complaining that another resident spoke too loudly – the manager was addressing this at time of audit. The manager/RN, three caregivers (one of whom shares responsibility for running the activities programme) and cook were interviewed and could easily describe their responsibilities around complaints. The community psychiatric nurse was also interviewed and would direct complaints to the manager. All recommendations from complaints have been followed up and relevant training has been provided.</p>

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Relatives interviewed (two plus a welfare guardian) stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Residents (five interviewed) also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur six monthly (or more frequently if appropriate and family are invited) and the manager and owner have an open-door policy. Aged care residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents and their family. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. Information meets the needs of those with intellectual and physical disabilities and on audit it was noted that staff took time to communicate with residents in a manner that was appropriate to the residents' level of understanding.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Benhaven provides residential services for people with physical and intellectual disabilities and residents requiring rest home level care for up to 21 residents. On the day of the audit there were 20 residents onsite plus one resident in hospital having surgery. Eighteen residents are under the aged residential care agreement, one of whom is under 65 years but 'of like', one DSS-unlimited life (in public hospital at time of audit) and two are sectioned under the mental health act.  The manager is a registered nurse with considerable aged care experience who has been in the role for eight years and has maintained eight hours annually of professional development activities related to managing a rest home.  The two owners live on site and are actively involved in the day-to-day operation of the home.  The goals and direction of the service are well documented in the business plan and the progress toward previous goals has been documented.
Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management	FA	The manager facilitates the quality programme and ensures the internal audit schedules are implemented. The internal audit schedule is implemented. Corrective action plans are developed, implemented and signed off when service shortfalls are identified.  Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident/accident and infection control data collection and complaints management. All quality improvement data is discussed at monthly staff meetings. Internal audits were all undertaken as per plan for the year to date. Two of the monthly cleaning audits resulted in corrective action reports being generated. Identified actions had been undertaken and signed off as complete. Further to these actions the directors had purchased new carpet for the facility but with covid and lack of available trades people it was yet to be

<p>system that reflects continuous quality improvement principles.</p>		<p>laid. The facility did appear clean and there were no undesirable odours.</p> <p>There are policies and procedures that are relevant to the various service types offered and are reviewed two yearly.</p> <p>There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. The manager is the designated health and safety officer and has completed training relating to this role. Health and safety issues are discussed at every management and staff meeting with action plans documented to address issues raised.</p> <p>There are resident/relative surveys conducted and analysed with corrective action plans developed when required. The May 2021 survey demonstrated a very high level of satisfaction with 100% satisfaction and comment relating to the high standard of meals.</p> <p>Falls prevention strategies are in place for individual residents.</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>	FA	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twenty-one incidents sampled for the month to date demonstrated appropriate documentation and clinical follow-up. Seventeen of them being falls, ten for one resident. Considerable work was undertaken to determine why, a very rare diagnosis was made resulting in clearer understanding of what was required to reduce falls. These measures had been put in place. Accidents and incidents are analysed monthly with results discussed at the staff meetings.</p> <p>The management team are aware of situations that require statutory reporting. An appropriate notification was made in February 2019 for a resident who wandered off site.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	FA	<p>Six staff files sampled (the manager/RN, one senior caregiver, three other caregivers (also cleaners) and the cook) showed appropriate employment practices and documentation. Current annual practising certificates are kept on file. The orientation package provides information and skills around working with residents with aged care, intellectual and physical disability related needs and was completed in all staff files sampled. All six staff files sampled contained a current annual performance appraisal.</p> <p>There is an annual training plan in place and is implemented. Education around caring for younger people were</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>embedded throughout their education. Staff have completed a number of competencies including medication administration, resident transfer (including hoist use), and fire and emergency. The manager/RN and is interRAI trained. The registered nurse has access to training at hospice and DHB and other training available, which has included Link Nurse Course at the hospice, and more recently the covid testing training.</p> <p>One caregiver has achieved level four of the Health &amp; Wellbeing certificate, two have level three and three caregivers who have level two are working on level three. All senior caregivers have a current first aid certificate.</p> <p>Residents and families stated that staff are knowledgeable and skilled. On interview, staff were knowledgeable of their role and the needs of each resident.</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>	FA	<p>There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty match needs of different shifts and needs of different individual residents. There is an on-call system with a registered nurse (the manager) available at all times.</p> <p>Staff, residents and family interviewed confirmed that staffing levels are adequate.</p> <p>On AM duty there was one carer 7am to 3.30pm, one carer 7am to 12 midday and one carer 7am to 1pm and a cook. On PM duty there is one carer 3.30pm to 11pm and one carer 5pm to 7.30pm. On night shift, there is one carer 11pm to 7am and the owners are onsite and /or a senior staff member who lives across the road. The manager/RN works 40 hours per week and the owners are onsite.</p> <p>A relieving nurse works when the manager is on leave.</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>Medication policies and practice align with accepted guidelines. The manager/registered nurse and caregivers are responsible for the administration of medications. No residents self-medicate. Medications are delivered to the site by the pharmacist. Robotic rolls delivered monthly are checked and signed in by the manager/registered nurse. The medication room was clean and well organised. Ten medicine charts were reviewed. Electronic medicine charts (introduced within the year) listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated, and allergies recorded. All charts had photo identification. Three monthly GP reviews were evident. Eye drops were dated on opening. The medication room temperature is taken and recorded along with the medication fridge temperature; all recording s were within expected ranges.</p> <p>Medication administration was observed at breakfast and lunchtime. The staff member followed recommended guidelines. Annual competencies were undertaken for the administration of medications including the giving of insulin. No residents self-medicate at the time of audit, this is available for residents with process in place if needed.</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. Two cooks cover the service seven days week. Both have completed food safety units. There is a three weekly rotating menu for summer and winter which along with the full food service received a very good review by a dietitian July 2021. The service has an approved food control plan which expires November 2022. The meals are served from the kitchen directly to residents in the dining room. The cook receives notification of any dietary changes and requirements. Two residents on special diets were provided with the same. One resident, on a low potassium diet, had also had their diet reviewed at the dialysis unit. A dietitian is available on referral. Dislikes and food allergies are known and accommodated. Residents and family interviewed spoke positively about the meals and food provided.</p> <p>Fridge and freezer temperatures are recorded daily. All foods were dated and stored correctly. A cleaning schedule is maintained.</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>Staff follow the care plan in the resident file and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RN will initiate a referral. If external medical advice is required, this will be actioned by the GP. Caregivers and RN interviewed stated there is adequate equipment provided, including continence and wound care supplies, air alternating mattresses, a hoist and new chair scales. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. There is evidence of GP, podiatrist, dietitian, community psychiatric nurse and clinical psychologist involvement in care. There were no wounds or pressure injuries.</p> <p>Resident care plans document detailed, individualised interventions to manage clinical risk such as poor mobility, falls, skin integrity, weight loss and when appropriate management of hyperglycaemia and hypoglycaemia – detailed actions are with the blood glucose recording chart.</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	FA	<p>Specific caregivers have dedicated hours each day in which they undertake activities as per the planned monthly activity plan. The programme is flexible with involvement by several team members and caters to the varying needs of the individual residents. The monthly programme is available for all to view and includes van outings (the site has a van), music sessions, quizzes, bingo, exercises, weekly entertainment and numerous outings for individuals. The programme caters to the needs of both aged care and younger residents. Residents interviewed spoke positively about the activities provided.</p> <p>Residents have an activity assessment completed on admission, attendance records are maintained, a monthly report is written for each resident and activities are reviewed along with the care plan six monthly.</p> <p>Residents input on what they would like included in the programme is encouraged. A number of residents have</p>

service.		planned activities outside the home. One younger resident is transported to activities in Lower Hutt and Upper Hutt five days a week.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial nursing assessment/care plans are evaluated by the registered nurse within three weeks of admission. InterRAI assessments are completed six monthly and used as part of the care plan evaluation process. Care plans reviewed had been updated with changes in health status. Written evaluations against the resident's goals were completed six-monthly or earlier for resident health changes in files reviewed. The general practitioner, registered nurse, caregiver (including those involved with activities), resident and families are involved in the review. Family communication sheets and families interviewed confirmed that family are involved in the evaluation and care plan update process.
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 service has a current building warrant of fitness which expires 28 September 2021. The maintenance person lives on site and is available 24/7. A planned maintenance schedule is in place. Electrical safety testing and calibration of scales is undertaken annually. Corridors are kept clear of clutter. The service continues to refurbish rooms as they become available and new carpet has been purchased for laying when a tradesperson is available. There are a number of external sitting areas with or without shade and access to the garden area. Pathways, seating and grounds are safe and well used by residents. There is a designated smoking area outside. Residents interviewed confirmed the environment is suitable for their needs.
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.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The manager is the designated infection control coordinator and has received training for the role. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly summary and then analysed and reported to staff meetings. There have been no outbreaks since the previous audit.  Infection control is included in orientation and twice a year in the education plan. This had been increased with covid and the public health advisor had been to the site to give an education session on covid. The manager had undertaken covid testing training and the DHB had held zoom meetings at each change of lockdown level. All staff and residents were fully vaccinated and there was evidence of good systems and education around visitors and also around resident outings. Information was posted also in appropriate positions around the home. A recent admission had been screened for covid prior to admission and cared for in isolation for two weeks following admission. There was a good supply of personal protective equipment.

Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint. The restraint policy includes a definition of enablers as voluntarily use of equipment to maintain safety. The day before audit, one resident had commenced using a lap belt as an enabler in his wheelchair. On interview he expressed he was happy with this as it may reduce falls and he demonstrated how he could undo it if he wished.

## **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.

No data to display

End of the report.