

Coastal View Limited - Coastal View Limited

Introduction

This report records the results of a Certification 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:	Coastal View Limited
Premises audited:	Coastal View Limited
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 November 2021 End date: 26 November 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:	38

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

Coastal View is a purpose-built facility in Nelson. The facility initially opened on 30 April 2021. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 63 residents. On the day of audits there were 38 residents.

Coastal View Limited operates under Qestral Corporation Limited as a subsidiary company. The executive team of Qestral Corporation have operated in Aged Care as owner/operators and been involved in the industry for more than 30 years.

This certification audit was conducted against the relevant Health and Disability services standards and their 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.

An experienced aged care management team oversee the service. The facility nurse manager who is a registered nurse, started in the role during February 2021, and has many years' experience in hospice and in aged care management. A clinical nurse manager supports the facility nurse manager. The management team are supported by the organisation's clinical operations manager. The clinical nurse manager and facility nurse manager provide monthly reports to the Qestral clinical operations manager.

The service has continued to develop processes and systems since opening the new facility on 30 April 2021. Policies, procedures, and processes have been established to meet the Health and Disability Services Standard and contracts. Quality systems are established, and a culture of quality improvement has been embedded into the delivery of services and care.

This audit identified improvements required around the staffing levels, and service delivery 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.
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Coastal View provides an environment that supports resident rights and culturally safe care. Staff demonstrated an understanding of residents' rights and obligations. There is a Maori Health plan and a resident advocate who is also their resident Kaumatua. The service works collaboratively to embrace, support, and encourage a Māori worldview of health. They provide high-quality, equitable, and effective services for Māori, framed by Te Tiriti o Waitangi. Residents receive services in a manner that considers their dignity, privacy, and independence. Coastal View provides services and support to people in a way that is inclusive and respects their identity and their experiences. The service listens and respect the voices of the residents and effectively communicate with them about their choices. Care plans accommodate the choices of residents and/or their family/whānau. There is evidence that residents and family are kept informed regarding adverse events and the care provided. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.
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The Business plan is Coastal View specific and includes their mission statement. Values are embedded into all levels of practice.

The service has an effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of residents and their staff. Quality improvement projects are implemented. Internal audits, meetings, and collation of data were all documented as taking place as scheduled, with corrective actions as needed.

Human resources are managed in accordance with good employment practice. A role specific orientation programme and regular staff education and training are in place. Mandatory annual training programme is implemented. There is a staffing and rostering policy.

The service ensures the collection, storage, and use of personal and health information of residents is accurate, sufficient, secure, accessible, and confidential.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed by the need's assessment service coordination service prior to admission to determine the required level of care. There is an admission package available to residents and families prior to or on entry to the service. The registered nurse assesses, plans, reviews and evaluates residents' needs, outcomes, and goals with the resident and/or family/whānau input, and are responsible for each stage of service provision. The service has information available for Māori, in English and in te reo Māori.

The electronic care plans demonstrate service integration, there is a plan in place for registered nurses to review assessments and care plans at six-monthly intervals . Short term care plans have been reviewed in a timely manner. The organisation has developed their own electronic resident management system. Resident files are electronic and included medical notes by the general practitioner, nurse practitioner and allied health professionals.

The diversional therapist provides and implements a wide variety of activities which include cultural celebrations. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and resident preferences. Residents are supported to maintain links within the community.

Medication policies reflect legislative requirements and guidelines. The registered nurse is responsible for administration of medications and have completed education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner or nurse practitioner. Medications are stored securely.

All food and baking are prepared and cooked onsite in the centrally located kitchen. Residents' food preferences and dietary requirements are identified at admission. There are two spacious dining rooms. The menu has been reviewed by a dietitian and meet the required nutritional values. Alternatives are available for residents. The service registered their food control plan.

Policies and procedures are implemented around the transfer and discharge of residents.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place. The building has a code of compliance, which expires in January 2022. There is a planned and reactive maintenance programme in place. Residents can

freely mobilise within the communal areas with safe access to outdoor areas, seating, and shade. Resident rooms are spacious and personalised, all have full en-suites and sliding doors providing access to a decked area.

Emergency systems are in place in the event of a fire or disaster. There is always a staff member on duty with a current first aid certificate. Management have planned and implemented strategies for emergency management. Fire drills occur six-monthly.

There are dedicated housekeeping staff, who provide all cleaning and laundry duties. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

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 restraint coordinator is the clinical nurse manager. There is currently one resident using a restraint. There are no residents with enablers. Restraint assessment, interventions, monitoring, and evaluation have been completed. Restraint minimisation training is included as part of the annual mandatory training plan, the orientation booklet and annual restraint competencies are completed. The service considers least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.

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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A suite of infection control policies and procedures are documented. The pandemic plan has been developed in partnership with the district health board. The infection control programme is appropriate for the size and complexity of the service.

The infection control coordinator is a registered nurse with support from the clinical nurse manager. The infection control committee includes representation from all areas of the service. The infection control team have access to a range of resources. Education is provided to staff at induction to the service and is included in the annual education planner.

Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Internal benchmarking within the organisation occurs. Staff are informed about infection control practises through meetings, and education sessions.

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	46	0	3	1	0	0
Criteria	0	97	0	3	1	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Coastal View ensures that all residents and families are informed about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The Code of Health and Disability Services Consumers' Rights is also displayed at the entrance to the facility and is also available and displayed in accessible formats such as te reo Māori. Policies around the Code is implemented, and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service and is included in the 2021 in-service education and training planner. Interviews with staff (three healthcare assistants, three registered nurses, and one diversional therapist, one chef), reflected their understanding of the key principles of the Code
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	An informed consent and advance directive policy & related form is in place. Discussions with the healthcare assistants and registered nurses confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents' rooms. Informed consent processes are discussed with residents and families on admission. Written general consents for photographs, release of medical information, and medical cares were signed as part of the admission agreement. Indemnity and outing consent are scanned into the resident electronic file.

informed consent.		<p>The service welcomes the involvement of whānau in decision making where the person receiving services wants them to be involved.</p> <p>Training has been provided to staff around code of rights, informed consent and the role of the enduring power of attorney (EPOAs) in 2021. Thirty-six staff have completed the training.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts and activated where required. Advance directives for health care including resuscitation status had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. All seven files included advance directives completed by the resident or medically initiated advance directive by the GP that included discussion with the family/whānau. Resident files show evidence that where appropriate the service actively involve family/whānau in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the HDC office is included in the resident compendium that is provided to residents and their relatives on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. There is a resident advocate (Kaumatua) living in the facility and this is included on the noticeboard for staff. The resident advocate supports all residents through issues raised at the monthly resident meetings.</p> <p>Interviews with the resident advocate/Kaumatua describe how she provides support to residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events. With Covid 19 there have been some restrictions on outings and free visiting, which has impacted on residents and staff as this has meant less of a community feel. However, residents and relatives interviewed confirmed satisfaction with the current restriction times for visitors due to alert level two. Zoom meetings are arranged to support residents to speak to family members during restrictions. Visitors were observed coming and going during the audit. The service provides assistance to ensure that the residents are able to participate in as much as they can safely, and as much as they desire to do. Resident meetings are held monthly. Residents are supported through regular van trips into the community. Regular newsletters are provided to residents and relatives.</p>
Standard 1.1.13: Complaints	FA	The complaints procedure is provided to residents and relatives on entry to the service. The facility nurse

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>There are nine complaints logged in the complaint register since opening in April 2021, including four by one relative. All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Corrective actions are in place around increasing staff in the weekend.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms are available in the compendium in each residents' room, relatives are encouraged to use email. There is a suggestion box and form at the entrance to the facility. Residents have a variety of avenues they can adopt to make a complaint or express a concern. Residents/relatives making a complaint can involve an independent support person in the process if they choose. There is a resident advocate available to support residents if required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the compendium which is provided to new residents and their relatives. The facility nurse manager and/or clinical nurse manager discuss aspects of the Code with residents and their relatives on admission.</p> <p>Discussions relating to the Code are held during the monthly resident/family meetings. All eight residents (three hospital and five rest home) and three relatives (two rest home and one hospital) interviewed, reported that the residents' rights are being upheld by the service. Interactions observed between staff and residents were respectful.</p> <p>Information about the Nationwide Health and Disability Advocacy Service and the resident advocacy is available to residents on the noticeboard and in their compendium. Other formats are available such as information in te reo Maori. There is a resident advocate (Kaumatua) living in the facility.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>It was observed that residents are treated with dignity and respect. Staff were observed to be person-centred and respectful with residents. Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged. The service has a privacy and confidentiality policy in place. The recent resident survey completed October 2021 identified 89% satisfaction around respect.</p> <p>Healthcare assistants (HCAs) and registered nurses interviewed described how they support residents to choose what they want to do. Residents interviewed stated they have choices. Residents are supported to make decisions about whether they would like family/whānau members to be involved in their care or need other forms of support. A social profile is developed on admission with the resident and</p>

		<p>family/whānau members which includes daily routines and what is important to the resident.</p> <p>Electronic residents' files and care plans identified residents preferred names. Information about values and beliefs is gathered on admission and is integrated into the residents' care plans.</p> <p>Spiritual needs are identified, and church services are held. There is a resident advocate (Kaumatua) living in the facility. There are also links to spiritual supports including a chaplain. There is a policy on abuse and neglect and staff have received training on privacy, vulnerability and abuse and neglect.</p> <p>Staff interviewed stated how they respect residents right to have intimate relationships. A married couple share a studio unit and the relative interviewed stated how they appreciate being able to stay together. There is a sexuality and intimacy policy in place.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service.</p> <p>The service currently has one resident who identifies as Maori . The Maori Health plan has been written in consultation with the resident advocate, Kaumatua/Kuia of the Coastal View Care Centre. The resident's Iwi area is identified as Ngati Tama, Te Ati Awa and Te Arawa. The facility nurse manager regularly meets with the resident advocate/kaumatua to ensure services are operating in ways that are culturally safe.</p> <p>The clinical manager identifies as Māori and guides the staff in responding to and supporting the values and beliefs of all residents. The service supports increasing Maori capacity by employing more Maori staff members. There are currently three Maori staff members.</p> <p>Te Tiriti O Waitangi is incorporated into all policies and procedures and delivery of care. Residents are involved in providing input into their care planning, their activities, and their dietary needs. Healthcare assistants and registered nurses interviewed described how care is based on the four cornerstones of Māori health 'Te Whare Tapa Whā'. Care plans include the physical, spiritual, family, and mental health of the residents; however, this was not clearly identified for the Maori resident (see criterion 1.3.5.2).</p> <p>Staff receive education on cultural awareness during their induction to the service and is included in the 2020 education planner. All healthcare assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents. Interviews with the Māori resident (Kaumatua) confirmed that the service is proactive to supporting Māori and confirmed she is being heard and her needs are being met.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Coastal View identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, relatives and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. The residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs (link 1.3.5.2). All care plans reviewed included the resident's social, spiritual, cultural, and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Police checks are completed as part of the employment process. The service implements a process to manage residents' comfort funds, such as sundry expenses. A staff Code of Conduct/house rules is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with registered nurses and healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries and workplace bullying education sessions have been completed during orientation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, twenty-four hours a day. .</p> <p>Physiotherapy services are provided weekly. There is an in-service education and training programme for staff, and all staff have access to an online training programme with sessions staff are to complete during each month. A podiatrist is on site six-weekly. The service has links with the local community and encourages residents to remain independent.</p> <p>Their electronic system is designed and developed by Qestral cooperation and includes all quality reporting including online internal audits. Monthly clinical reports from the clinical nurse manager identifies key clinical indicator outcomes and corrective actions.</p> <p>The service continues to implement quality goals which includes; providing palliative care/end of life care, with support from the Nelson Tasman hospice education team and their ARC support team. The management team continues to look for goals to improve the care that is provided and give the staff the tools to provide that care.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Overall policies have been reviewed and updated to meet the 2021 standards.</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>Policies and procedures relating to accident/incidents, complaints, and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Electronic accident/incident forms have a section to indicate if next of kin have been informed or not. Eleven electronic accident/incident forms reviewed (November 2021), identified relatives are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. The satisfaction survey result showed 85% of residents felt there was good communication. The manager writes a monthly newsletter for residents and relatives updating on the month and upcoming events.</p> <p>Resident rights & Maori health internal audit included communication; this was last completed on 19 November 2021 and identified 97.33% compliance. The resident satisfaction survey dated October 2021 included 89% satisfaction around information received.</p> <p>A compendium of information is provided to residents/relatives on admission. This is kept in each resident room. Monthly resident meetings identify feedback by residents and consequent follow-up by the service. Residents are supported by a resident advocate. An interpreter policy and contact details of interpreters is available.</p> <p>Interpreter services are used where indicated. Staff have access to a translation application/icon on their work cell phones. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items that are not covered by the admission agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Coastal View is a purpose-built facility in Nelson. The facility initially opened on 30 April 2021. The facility is across one level and includes a total of 59 dual-purpose (hospital and rest home) rooms. One wing of 14 larger apartment rooms have been verified previously as suitable as double rooms for couples, however the service only intends to have a total of four couples across these rooms. The total bed numbers at Coast View are 63.</p> <p>On the days of audit there were a total of 38 residents. This included 22 rest home residents including three respite and 16 hospital residents including two respite and two residents on a younger person with a disability (YPD) contract.</p> <p>The Business Plan is Coastal View specific and includes a mission statement. There are six identified values: (i). Respect and Equality, (ii) Show Integrity; (iii). Innovation; (iv). Anti-Institutional; (v). Promote Independence; and (vi). Mana Motuhake: Promoting Māori philosophies, values, and practice. Organisational goals/aim for integrated service delivery are identified. Values are embedded into all</p>

		<p>levels of practice.</p> <p>Coastal View Limited operates under Qestral Corporation Limited as a subsidiary company. The executive team of Qestral Corporation have operated in Aged Care as owner/operators and been involved in the industry for more than 30 years.</p> <p>The executive team works with management to meet the requirements of relevant standards and legislation. The executive team is provided with a monthly report from the clinical operations manager with an overview of adverse events, H&S, staffing, infection control and all aspects of the quality risk management plan.</p> <p>An experienced aged care management team oversee the service. The facility nurse manager (registered nurse) commenced her role in February 2021 and has many years of experience in hospice and in aged care management. A clinical nurse manager supports the facility nurse manager. The management team is supported by the organisation's clinical operations manager. The clinical nurse manager and facility nurse manager provide monthly reports to the Qestral clinical operations manager.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures 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.</p>	FA	<p>The clinical nurse manager takes on the managers role in the temporary absence of the facility nurse manager.</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>Coastal View implemented their quality and risk management programme. There is a Quality and Risk management plan that includes 11 quality objectives and 13 quality indicators that are monitored and benchmarked. The quality management systems include (i) performance evaluation through monitoring, measurement, analysis, and evaluation. (ii) a programme of internal audits and (c) a process for identifying and addressing corrective actions.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed and have been updated to meet the 2021 standards.</p> <p>Their electronic system is designed and developed by Qestral cooperation and includes all quality</p>

		<p>reporting including online inter audits. Internal audits, meetings, and collation of data were all documented as taking place as scheduled, with corrective actions as needed. Monthly H&S , combined quality/staff meetings, and clinical meetings ensure that quality data is communicated, discussed and issues acted upon. Infection control meetings are held monthly. Corrective action plans are documented at the end of each set of minutes, detailing actions to be taken and signed off by the facility nurse manager once completed. The corrective action log/register is discussed at each meeting to ensure the outstanding matters are addressed.</p> <p>Monthly clinical reports from the clinical nurse manager identifies key clinical indicator outcomes and corrective actions. The monthly facility manager report includes key operational concerns and data including (but not limited to) complaints, admissions, staffing, audits, H&S, and property issues. Both reports are provided to the organisations clinical operation manager who analyses the data to identify further actions required and reports outcomes to the governing body.</p> <p>The 2021 resident satisfaction survey showed overall satisfaction with the services provided. Shortfalls were identified around the call bells and external environment and corrective actions implemented. The results of the resident survey were sighted as discussed at the quality/staff meetings and clinical meetings.</p> <p>Quality improvement projects are implemented. Current projects include improving communication, the ordering process, and the respite admission process. The service demonstrate that quality improvements are made and embedded into practice as a result of incidents, adverse events, complaints, surveys and investigations.</p> <p>A H&S system is in place with identified H&S goals. Hazard identification forms and an up-to-date hazard register is in place. Health and safety policies are implemented and monitored by the monthly H&S committee. Two H&S representatives have completed H&S training. There are regular manual handling sessions taken by the physiotherapist. The noticeboard keeps staff informed on H&S meetings.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a physiotherapist six hours a week with support by a healthcare assistant who provides exercises and walks. Healthcare assistants interviewed could describe falls prevention strategies as documented in care plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	FA	<p>Individual electronic reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident and accident data is collated monthly and analysed for trending. Results are discussed at the meetings. Eleven resident related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are conducted for suspected head injuries, relatives were notified</p>

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		<p>following incidents. Opportunities to minimise future risks were identified - where possible.</p> <p>Discussions with the managers evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications completed for a pressure injury, a trespass order and a sudden death has been referred to the coroner. There have been no outbreaks at Coastal View</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files reviewed evidenced implementation of the recruitment process, employment contracts, police checks and completed orientation.</p> <p>There are job descriptions in place for all positions. This includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position.</p> <p>A register of practising certificates is maintained. There is an appraisal policy. All staff had a three-month appraisal completed following induction. As the service only opened in April 2021, annual appraisals are not due until 2022.</p> <p>The service has a role specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programmes support RNs and HCAs to provide a culturally safe environment to Māori. Services embed the principles of Enabling Good Lives in their induction processes. Volunteers and the one bureau nurse currently being used have completed an orientation to the service.</p> <p>There is an annual education and training schedule being implemented that includes mandatory training across 2021 and 2022. Toolbox talks are held when required at handovers. The service has been working to embed cultural values in their mandatory training programmes.</p> <p>A competency programme is in place. Core competencies have been completed, and a record of completion and register is maintained. The service also uses an online training programme and staff are monitored to complete certain training sessions each month. The healthcare assistants are encouraged to undertake aged care education (Careerforce). Currently there are five healthcare assistants (HCAs) with level 4 NZQA and four working on completing level 4. There are three HCAs with level 2 NZQA. All HCA's have a minimum of one year's ARC experience, and some have over five years' experience. Cultural training is provided.</p> <p>Training for clinical staff is linked to external education provided by the district health board (DHB). Registered nurse specific training viewed included: syringe driver, wound care, and first aid. There are six RNs employed, five are interRAI trained and one is in the process of completing their training. The</p>

		clinical nurse manager provides oversight of the registered nurses and HCAs.
<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>	PA Low	<p>There is a rostering and staff allocation policy that describes rostering. However, the policy does not include detail around staffing and acuity levels of residents. A draft roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>The registered nurses all have current first aid certificates. Interviews with three HCAs stated that over the last month they frequently work short-staffed especially across the weekend. Interviews with management confirmed they are aware of the problem and they have been actively recruiting more staff.</p> <p>Interviews with residents and relatives and review of the resident meetings confirmed comments about being short-staffed over the weekends and call-bells at times not being answered in a timely manner. Workforce engagement surveys have been implemented to receive feedback on staffing levels and skill mix. Corrective actions were identified around staffing and the need for sensor mats.</p> <p>There are currently 22 rest home residents and 16 hospital level residents.</p> <p>The facility nurse manager and the clinical nurse manager are available Monday to Friday each week and share on call duties. They are supported by two registered nurses on the morning shift, one on the afternoon shift and one registered nurse on night shift. A second RN has been added to the afternoon shift 1-3 extra days a week.</p> <p>The morning shift includes five healthcare assistants (HCAs); 3 full shifts in the mornings 7am to 3pm and 2 on short shifts; 7am to 12.30pm and 8.30am to 1.30pm.</p> <p>The afternoon shift includes HCAs; 2 full shifts in the afternoons 3pm to 11pm, and 2 short shifts; 3pm to 9.30pm and 12.30pm to 8.30pm.</p> <p>The night shift is covered by two HCAs who are rostered from 11pm to 7am.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The electronic resident files are appropriate to the service type. Residents entering the service all have relevant initial information recorded in their personal files, within 24 hours of admission. An initial care plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrated service integration. Entries were legible, timed, dated and include identification of the author (relevant healthcare assistant or nurse), including their designation. Electronic systems are password protected. Electronic records are integrated.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The admission policy/ decline to entry policy and procedure, guide staff around the admission and declining processes, this includes required documentation. The facility nurse manager completes a weekly report identifying how many prospective residents and families have viewed the facility, admissions and declined referrals, which are reported to the Board and sales team.</p> <p>The service receives referrals from the needs assessment service coordination services (NASC), the DHB, Hospice and directly from residents or whānau.</p> <p>The service has an information pack (compendium) relating to the services provided at Coastal View which is available for families/ whānau and residents prior to admission or on entry to the service, and kept in the residents' room. Admission agreements reviewed were signed and aligned with contractual requirements. Exclusions from the service are included in the admission agreement. Coastal View have a person-centred and whānau-centred approach to services provided. Interviews with residents and family all confirmed they received information at entry to the service and communication was positive. The service includes information about other support services, such as community support groups, when communicating with the person and their whānau.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The transfer and discharge of resident management policy ensures a smooth, safe, and well organised transfer or discharge of residents. The registered nurses interviewed describe exits, discharges or transfers are coordinated in collaboration with the resident and whanau to ensure continuity of care. There was evidence that residents and their families were involved at all exits or discharges to and from the service and have the opportunity to ask questions. The service utilises the 'yellow envelope' system. A copy of the advance directives, advance care plan (where available), a completed transfer report, and medication chart are included in the yellow envelope. A verbal handover is provided.</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>Policies and procedures are in place for safe medicine management. Medications are stored safely in the medication room. The internal audit schedule includes medication management. The medication management internal audit proved 96.67% compliance in November 2021.</p> <p>Registered nurses administer medications, and all have completed medication competencies. Senior healthcare assistants complete 'second checker' competencies. The pharmacist has visited the facility to provide education sessions around medications. Registered nurses have completed syringe driver training. All medication blister packs are checked on delivery against the electronic medication charts. Policies and procedures for residents self-administering medicines, are in place and this includes ensuring residents are competent and safe storage of the medications. There were two hospital and one</p>

		<p>rest home resident who self-administer inhalers on the day of the audit. All had competencies in place which had been signed and reviewed three-monthly by the GP. There are no standing orders or 'nurse initiated' medications used. All over the counter vitamins or alternative therapies residents choose to use, are required to be reviewed and prescribed by the GP. There are no agency staff administering medications. All medication errors are reported and collated with quality data.</p> <p>The medication fridge and room temperatures are recorded and maintained within the acceptable temperature range. All eye drops sighted in the medication trolleys were dated on opening. All medications no longer required are returned to pharmacy, there were no expired drugs on site on the day of the audit.</p> <p>Fourteen electronic medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and their allergy status is recorded.. The GP had reviewed the medication charts three monthly. 'As required' medications had indications for use identified and were administered appropriately with outcomes documented in progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food services are overseen by a chef. All meals and baking are prepared and cooked on-site by a qualified chef/cook. All food services staff have completed food safety training. The Food Control Plan was registered with the Ministry of Primary Industries (MPI) on 2 March 2021. The four weekly menu has been approved and reviewed by a registered dietitian. The chef (interviewed) receives resident dietary profiles and is notified of any dietary changes for residents. The residents have a nutritional profile developed on admission, which identifies dietary requirements with likes and dislikes.</p> <p>The kitchen is centrally located off the main atrium, in the middle of two dining rooms. There are two doors from the kitchen that open up to the two dining rooms. Residents' meals are served from the bain-marie at the door of the kitchen. There is a tray service available for residents who choose to dine in their rooms. The dining rooms are situated beside the kitchen. The dining areas are spacious and have doors to the courtyards. The menu is displayed at the dining room doors and on a blackboard so residents can easily see what is on the menu for the day.</p> <p>All perishable foods and dry goods were dated and labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Freezer, fridge and end-cooked, reheating (as required), cooling and serving temperatures are taken and recorded daily. Food temperatures are taken, then the food is transferred to the hot box until serving, when it is transferred to the bain-marie. The internal audit schedule includes food service audits. The last internal audit evidenced 98.67% compliance in November 2021.</p> <p>Special equipment such as 'lipped plates' and special spoons are available as required. The resident satisfaction survey completed in October 2021 evidenced 94% satisfaction with food services. Residents</p>

		and relatives interviewed were complimentary of the food services. The chef is involved in the activities themed months, particularly during cultural themed months and celebrations, and the menu is substituted to accommodate cultural meals in line with the theme. Residents are supported to have culturally appropriate food, which can be requested. The activities programme includes baking, and growing vegetables in the courtyard.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>In cases where entry is declined, there is close liaison between the service and the referral team. The service refers the resident back to the referrer and maintain data around the reason for declining. The management team describe reasons for declining entry would only occur if the service could not provide the required service the resident required, after considering staffing, equipment requirements, and the needs of the resident. The other reason would be if there were no beds available. As the facility opened in April 2021, there is currently beds available and no waiting list.</p> <p>Referrals are received for the NASC team, the NMDHB, the local Hospice and at times from residents, their representatives of family/whanau.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Registered nurse completes an initial assessment and care plan on admission to the service, which includes relevant risk assessment tools including (but not limited to); falls risk, detailed pain, pressure injury, skin, continence, and nutritional assessments. Risk assessments are completed six-monthly or earlier due to acute health changes. InterRAI assessments and long-term care plans were completed within the required timeframes, however, outcomes of assessments were not always reflected in the needs and supports, documented in the care plans on the electronic system. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident/relative or significant others are included in the long-term care plans. Pressure risk assessments were not always reflective of current pressure injuries. Wound assessments were not completed to assist with wound management.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The care plans on the electronic resident management system were resident focused and individualised. However not all long-term care plans identified all support needs, goals, and interventions to manage medical needs/risks. Care plans include allied health and external service provider involvement. The short-term care plans integrate current infections, wounds, or recent falls to reflect resident care needs. Short-term needs are added to the long-term care plan when appropriate and removed when resolved. Allied health care professionals involved in the care of the resident included, (but were not limited to) physiotherapist, district nurse, speech language therapist, dietitian.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Care plans are documented for all residents. All care plans have identified goals and family support (where applicable). Residents and relatives/whānau are involved in care planning and review process and when there is an acute change in health status.</p> <p>The registered nurses interviewed describe working in partnership with the resident and family/whānau to develop initial and long-term care plans.</p> <p>Care plans include allied health and external service provider involvement. The short-term care plans integrate current infections, wounds, or recent falls to reflect resident care needs. Short-term needs are added to the long-term care plan when appropriate and removed when resolved.</p> <p>Residents interviewed reported their needs were being met. Family members interviewed stated their relative's needs were being appropriately met and stated they are notified of all changes to health, as evidenced in the electronic progress notes. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or referral to nurse specialist consultants occurs. A personal care internal audit completed in September evidenced 92.2% compliance.</p> <p>There were four residents with a total of thirteen wounds including skin tears and chronic venous ulcers. Two hospital level residents have stage 3 pressure injuries. Incident reports and section 31 notifications have been made to the Ministry of Health. The electronic wound care plan documents the wound management plan and evaluations are documented with supporting photographs, however, there were no documented wound assessments (see criterion 1.3.4.1). The district nurse and GP have input into chronic wound management. Registered nurses are booked onto the next available wound care training session held at the district health board.</p> <p>Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. A continence specialist can be accessed as required.</p> <p>Monitoring charts included (but not limited to) weights, observations included vital signs, weight, turning schedules and fluid balance recordings, however, not all monitoring charts were implemented according to the care plan interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist (DT) who provides activities from Monday to Friday. The diversional therapist collates a social profile of the resident in the electronic system and then arranges what is important to that resident. The DT then develops a social/cultural program based on the information she has gathered. The RNs record some information and include this into a long-term care plan. The care plan includes spirituality and religious preferences. The diversional therapist</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>maintains attendance records and uses these to document progress notes. An internal audit completed in September 2021 evidenced 93.83% compliance.</p> <p>Residents receive a copy of the monthly programme which has the daily activities displayed and includes individual and group activities. The diversional therapist endeavours to include previous hobbies and interests to the planner. There are monthly themes for example, Matariki, spring, gardening, Diwali, and Christmas. The planner includes a list of suggestions for one on activities such as story gathering, wheelchair walks, massage, shopping, manicures, reading, and sensory activities. Residents were involved in crafts and making decorations including making eels from Nelson clay. Recently the service celebrated Diwali and the residents once again were involved in decorating the atrium area with brightly coloured flowers, and a Philippines celebration with food and dancing.</p> <p>There are a wide range of activities on offer, some such as jigsaw building remains set up in the atrium area. On the days of the audit, residents were enjoying making Christmas decorations, listening to entertainers, participating in exercises and relaxation techniques. Activities are held in line with the theme of the month The needs of younger residents are identified and accommodated. The diversional therapist ensures she takes the time so all residents can live their best lives.</p> <p>The service has strong links within the community, the library provides books of interest for residents, in a range of fonts and audible books. The diversional therapist arranged for a clothing store to visit the facility so the residents could purchase clothes. Van rides occur weekly, which used to include lunches and picnics, with the covid restrictions, van rides are now drives to places of interest selected by the residents.</p> <p>Residents provide feedback in a range of forums including a residents meeting held by the advocate, a formal residents meeting. Residents provide feedback informally daily to the diversional therapist.</p> <p>There are three non-English speaking residents in the facility. The diversional therapist has engaged with an online interpreter service, which the service has access to through 'google', on the work phones. The diversional therapist created communication boards in extra-large font, where the residents could read and identify a single word in Romanian and Dutch. These were further enhanced by asking their families to assist in the creating of the boards.(now in Māori, German, Hindi, French, Spanish). The diversional therapist is also working on picture boards for sign language for the staff can immediately interpret signing to English (helping staff learn the language too). This project was a team effort from family, reception, other staff, and the residents.</p> <p>Residents have a laminated copy in their rooms for easy access to staff. Charts can be available in 'Moon' (a type of braille). Residents appear more comfortable and settled in the facility and are gaining confidence to join some activities.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans for long term residents reviewed were evaluated by the registered nurses within three weeks of admission. The GP has reviewed residents three monthly. Short term care plans are regularly reviewed and if the issue is not resolved within three weeks, the short-term care plan is completed, and interventions were added to the long-term care plan. There were no residents who had been in the facility for more than six months, therefore six-monthly reviews are yet to occur. Progress notes reviewed identified regular reviews of residents. A planner was sighted in the nurses' station, documenting when residents' interRAI reassessments and care plan reviews were due.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Policies and procedures are in place for exit, transfer, or transition of residents. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service accesses support either through the GP, specialists, and allied health services as required. There is evidence of referrals for re-assessment from rest home to hospital level of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies around guiding waste management. Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. There is a waste disposal policy and a disinfection and sterilisation policy.</p> <p>Material safety datasheets are to be available in the combined sluice/laundry. Personal protective equipment including gloves, aprons and goggles are available for staff throughout facility. The sluice is located in the laundry in the hospital wing. The sluice/laundry is secure with a keypad. There is a locked cleaner's cupboard for the storage of chemicals and cleaning products.</p> <p>Infection control policies state specific tasks and duties for which protective equipment is to be worn.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that</p>	FA	<p>The maintenance management policy ensures the interior and exterior of the facility are maintained to a high standard, and all equipment is maintained, serviced and safe. The building has a certificate for public use which expires on 18 January 2022. The service has a full-time maintenance man, who is available Monday to Friday. There are essential contractors who can be contacted 24 hours a day. Maintenance requests are logged in the electronic system and checked off once completed by the maintenance man. There is a preventative maintenance schedule maintained. The planned maintenance</p>

<p>are fit for their purpose.</p>		<p>schedule includes electrical testing and tagging, resident equipment checks, calibrations of scales and clinical equipment. Monthly hot water tests are completed for resident areas and are maintained below 45 degrees Celsius. There are environmental audits and building compliance audits, completed as part of the internal audit schedule. The maintenance audit conducted in August, evidenced 100% compliance. The satisfaction survey for 2021 evidenced an 89% satisfaction rate for environmental safety.</p> <p>The facility is shaped as the letter H with two wings down each side and a centralised foyer/ reception area and atrium with connecting offices, lounge, dining rooms and kitchen. There is a courtyard area off the lounge that is landscaped with paving, a pavilion, and a lawn area. All outdoor areas have been planted and landscaped. An outdoor deck off the lounge provides shade. All resident rooms have sliding doors that open to a deck. There is a secure nurse's office next to the lounge that also includes the clinical nurse manager's office. There is a large, shared lounge with two separate entrances on one side of the atrium, with the two dining rooms on the other side. There are tables set up in the atrium area for residents to participate in crafts and jigsaws, as observed during the audit.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. Outdoor areas had seating and shaded areas available. There is safe access to all communal areas. Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for residents.</p> <p>Each resident room has a spacious en-suite, a shower and toilet with appropriately situated call bells and handrails. Hospital level residents have high/low hospital beds. Residents' rooms are spacious and designed for hospital level care. Each room allows for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites and communal toilets and bathrooms. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, bed, lazy boy or wheelchair. Residents' names are not displayed in corridors, instead, residents' rooms have numbers similar to a residential front door.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal</p>	<p>FA</p>	<p>There is a mobility toilet near the large communal lounge and two other toilets off the atrium. Each resident room has a spacious en-suite with shower. All en-suites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment.</p>

hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' rooms are spacious and designed for hospital level care. Each room allows for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites and communal toilets and bathrooms in all areas. The communal lounge is spacious. When residents require transportation between rooms or services, staff are able to easily move them from where they are, using transportation devices such as trolleys, beds or wheelchairs.</p> <p>Fourteen resident rooms are one-bedroom apartments with kitchenettes. These rooms have been verified as also suitable for couples. There are 26 studio apartments and 19 large hospital rooms. All rooms are suitable to be used as dual-purpose rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large centralised communal lounge and two dining rooms. There are meeting rooms available for whānau/family meetings, with a number of sitting areas around the facility and a large atrium area that is also used as a communal area. Activities were observed to be taking place in the atrium and the communal lounge.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are laundry and cleaning policies and procedures in place. Laundry is completed on site. There is a defined dirty and clean delineation in the laundry. The laundry is equipped with two commercial washing machines in the dirty area. They two dryers are situated in the clean area/ folding room. The laundry room is combined as a sluice/laundry in the identified dirty area. The room is key padded. Processes are in place to ensure that clean laundry (after drying) is placed in a covered clean trolley to transfer to residents' rooms and linen cupboards situated around the facility. The laundry assistant interviewed was knowledgeable around infection control practise and management of infectious laundry.</p> <p>The cleaner's trolley is locked away in the cleaner's cupboard when not in use. All chemicals on the cleaner's trolley were labelled and in original containers., Chemicals are stored in the lockable area in the cleaning trolley when in use. The cleaner interviewed could easily describe processes in line with current best practice, including the use of colour coded cloths and mops. There is an internal audit relating to laundry services and environmental cleaning completed as part of the internal audit schedule. Staff have completed chemical safety training.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The disaster management policy (includes the pandemic plan) outlines the specific emergency response and evacuation requirements for each site as well as the duties/responsibilities of staff in the event of an emergency. The emergency management procedure guides staff to complete a safe and timely evacuation of the facility in the case of an emergency., The emergency management of information technology policy, ensures operational continuity in the case of an IT failure.</p> <p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. A fire evacuation drill was held on 28 September 2021. There are emergency management plans in place to ensure health, civil defence and other emergencies. There are emergency folders with specific information held in the nurse's station and civil defence supplies stored in a centrally located cupboard. All supplies, including food stores are checked monthly. In the event of a power outage there is a back-up generator and gas cooking facilities. There are adequate supplies in the event of a civil defence emergency including a 10,000 litre water tanks. Emergency management training is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is available at all times.</p> <p>There are call bells in the residents' rooms and en-suites, communal toilets and lounge/dining room areas. Residents can choose to have a call bell pendant if they wish, which is connected to healthcare assistant work cell phones. Indicator lights are displayed above resident doors to alert staff of who requires assistance. Residents were observed to have their call bells in close proximity. The 2021 satisfaction survey evidenced a 78% satisfaction rate on answering call bells in timely manner.</p> <p>The building is secure after hours, staff complete security checks at night. Currently under level 2 COVID19 restrictions, visiting is restricted, so the front doors remain locked during the day from the outside. Visitors are instructed to press the doorbell for assistance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The new building is appropriately heated and ventilated. There are underfloor heating and heat pumps, throughout the facility. The temperature in each room can be individually controlled. There is plenty of natural light in the rooms and all have sliding doors leading out to courtyard areas. The service has made some changes to the air conditioning temperatures as requested by the residents.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. All policies, procedures, and the pandemic plan have been updated to include Covid 19 guidelines and precautions, in line with current Ministry of Health recommendations.</p>

<p>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>		<p>The annual infection control plan is developed by the operations manager and the organisational quality team, with input from specialists as required. The programme includes infection prevention and antimicrobial management that align with the organisation's strategic document. The board and organisational management team knows and understand its responsibilities for delivering the infection control and antimicrobial programmes and seeks additional support where needed to fulfil these responsibilities.</p> <p>The infection control coordinator is a registered nurse who has been in the role for four months and has a signed, defined job description that outlines the role and responsibilities. The clinical manager supports the infection control coordinator. The infection control team which includes representatives from each area of the service, meet monthly. Meeting minutes are available to all staff and infection control is an agenda topic at staff meetings.</p> <p>The service has worked alongside the DHB to develop their pandemic plan. There have been no outbreaks at Coastal View, however the infection control coordinator and the clinical manager interviewed describe the debrief meeting they would have following an adverse event to evaluate what went well, what could have been done better and discuss any learnings to promote system change and reduce risks. There is a staff health policy.</p> <p>Staff follow the Qestral/DHB/MOH pandemic policy which is available for all staff. All staff have been double vaccinated and most residents are double vaccinated. Visitors are being asked to be double vaccinated or have restrictions to their visits. All new residents are requested to be double vaccinated. Personal protective equipment (PPE) is ordered through the MOH and stock balance is maintained to support any possible outbreak. Adequate PPE stocks were sighted in the centrally located store, which is accessible to all staff.</p> <p>The infection control coordinator and the management team, monitor the change in levels and the number of cases in the community, so they are ready for an outbreak in the local community.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The organisation is a member of Bug control, and the infection control coordinator interviewed, described support from the infection control specialist from the district health board. The organisation has close contact with the New Zealand Age Care Association, who provide guidance for age care facilities on a range of matters including infection control and Covid19. The infection coordinator described utilising the MOH website for information as needed.</p> <p>The infection control coordinator described utilising the online training, system, Ministry of Health (MOH) sites. The infection control coordinator has completed an online polytechnic infection control course which included (but by no means limited to) antimicrobial stewardship, standard precautions, and isolation procedures. The course was module based with a test to complete for each module.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There is a suite of infection control policies and procedures available to staff including (but not limited to), outbreak management, vaccinations, apron usage, communicable diseases, and hand hygiene. Policies and the infection control plan have been approved by the board, who receive monthly reports around infection control matters. All policies can be made available in Te Reo and acknowledge the spirit of Te Tiriti.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator has completed an online polytechnic infection control course which included (but by no means limited to) antimicrobial stewardship, standard precautions, and isolation procedures. The IC coordinator stays up to date with current IPC practice through Bug Control. Education around infection control commences at induction to the facility with a range of competencies and education sessions for new staff to complete. These are then reviewed at least annually as part of the education planner. Staff education includes (but is not limited to); standard precautions, isolation procedures, hand washing competencies, donning, and doffing personal protective equipment (PPE). Registered nurses are required to complete competencies prior to insertion, management, and removal of invasive, indwelling medical devices using aseptic techniques. Competencies are up to date. Resident education occurs as part of care delivery.</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 specific surveillance policy. Infection monitoring is the responsibility of the infection control coordinator. All infections are entered into the electronic database, which generates a monthly analysis of the data. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly comparisons of data. Benchmarking occurs internally with the sister facility. Outcomes are discussed at the infection control team meeting, clinical, quality, staff, and management meetings. A monthly report is prepared and included in the board reports.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The Restraint and Enabler management policy and procedure informs the delivery of services to avoid the use of restraint. The use of alternatives methods, prior to the use of restraint, is a focus of the policy. The policy includes a holistic assessment processes of the person, support plan, and information on avoiding the use of restraint.</p> <p>There is currently one resident with a bedrail and no residents using enablers. While the resident has requested the use of the bedrail for security, the service is managing this as restraint, the rationale being that the resident will not be able to get out of their bed without assistance.</p> <p>Restraint minimisation training is included as part of the annual mandatory training plan, orientation booklet and annual restraint competencies completed. The orientation training week in 2021 included restraint training for staff. All staff have current restraint competencies. A training register supports management to monitor those staff who have not completed training or, who's competencies are out of date.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining 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.</p>	FA	<p>The restraint coordinator is the clinical nurse manager (CNM). There is a signed job description and the CNM has completed specific training to the role through the DHB. The restraint coordinator monitors environmental impacts on the use of restraint and implements changes that contribute to restraint minimisation. An example of this is the use of low-low beds and fall out mats. The restraint committee meets three monthly and monthly when restraint is in use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The Restraint Committee has determined and approved the following restraint equipment types includes bedrails, chair lap belts and fall out chairs. Restraint is only initiated as a last resort after consultation with a doctor, registered nurse, and the restraint coordinator. Restraint decisions involve the resident and or their next of kin or representative. There is an implemented process describing the frequency and extent of monitoring restraint that relates to identified risks.</p> <p>The assessment process includes alternatives and identifies interventions and strategies that have been tried or implemented. There is one resident identified on the restraint register using a bedrail. A restraint</p>

		assessment had been completed which linked to the care plan (see criterion 1.3.5.2).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint is only used as a last resort and approved by the restraint coordinator (clinical manager). Any restraint use is reported through monthly clinical manager reports to the clinical operations manager, these reports include restraint alternatives. The care plan was reviewed of the one resident using a bedrail. While the care plan includes some interventions around the use of the bedrail, the care plan does not include all interventions to manage identified risks related to the resident's medical condition such as chorea (see criterion 1.3.5.2). Monitoring requirements for restrain use are identified in the care plan. Records reviewed, identified the regular two-hourly monitoring while the bedrail is in place. Progress notes describe restraint events.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Each episode of restraint is evaluated. The restraint use for the resident with a bedrail was evaluated monthly and was last completed on 11/11/21. The evaluation considered the requirements as listed in criterion 2.2.4.1. The resident and family/whanau are involved in the reviews.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Monitoring requirements are identified in the care plan and related to risk as determined through the assessment process. The service is working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities. The service includes review of restraint processes in their annual internal audit programme. Internal audits are completed six-monthly. The outcome of internal audit goes to the restraint committee and the combined quality/staff meeting. The restraint committee meets three monthly and includes a review of restraint use, restraint incidents, and education needs. Restraint data including any incidents are reported as part of the clinical nurse manager report to the facility nurse manager and the organisations clinical operations manager. Restraint data is benchmarked, and the restraint coordinator described how corrective actions would be implemented where required.</p>

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)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>The registered nurses all have current first aid certificates. Interviews with HCAs stated that over the last month they frequently work short-staffed especially across the weekends. Interviews with management confirmed they are aware of the problem and they have been actively recruiting more staff. Two new HCAs have been employed to commence 13 December and commencement of a further HCA is currently held up due to visa issues. With the increase in resident numbers the service is also recruiting a further two registered nurses.</p> <p>The service employed two new HCA who will be starting work on 13 December with a third HCA also currently being employed however, there is a hold-up due to issues with their visa. Due to increased numbers of residents the service is currently in the process of employing an additional two registered nurses, this process is underway.</p> <p>Interviews with residents, relatives and review of the resident meetings confirmed verbal feedback about being short-staffed over the weekends and call-bells at times not being answered</p>	<p>(i). There is a rostering and staff allocation policy that describes rostering. However, the policy does not include detail around staffing and acuity levels of residents, first aid cover, on-call cover, mix of senior and junior staff. (ii) There have been a number of shifts where they are short-staffed especially over the weekends.</p>	<p>(i). Update the rostering and staff allocation policy to evidence an acuity methodology rationale that ensures safe services. (ii) Continue to employ sufficient staff including casual staff to ensure the roster is fully covered.</p> <p>60 days</p>

		in a timely manner. There is a rostering and staff allocation policy that describes rostering. However, the policy does not include detail around staffing and acuity levels of residents, first aid cover, on-call cover, skill-mix of senior and junior staff.		
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	Initial assessments were completed on admission to the service, and all residents had an interRAI assessment completed within expected timeframes, however not all assessments linked to the care plan. Wound documentation included a wound plan and evaluations including photographs, however wound assessments were not documented.	<p>(i). InterRAI assessments were not linked to the care plans for three hospital level residents.</p> <p>(ii). Pressure risk assessments identified a low risk of pressure injury for two hospital level residents with stage 3 pressure injuries.</p> <p>(iii). Wound charts did not document assessments of the wound, including measurements, wound bed, and surrounding skin.</p>	<p>(i). Ensure interRAI and risk assessment outcomes are linked to the long-term care plan interventions.</p> <p>(ii). Ensure risk assessment are completed or risks are reassessed to reflect changes in resident condition.</p> <p>(iii). Ensure wound assessments are completed to determine wound management.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the</p>	PA Moderate	All residents had an electronic care plan documented which was completed within expected timeframes. All care plans are completed by registered nurses, and considers residents lived experiences, social and spiritual preferences. Registered nurses work in partnership with the resident and whanau to develop care plans as confirmed during interviews however, not all current interventions were documented in care plans. Progress notes were completed electronically, entries were according to policy, , and contained detail around the residents' current condition, changes to condition and care interventions	<p>(i). Interventions were not documented for a hospital level resident at the end of life, this was addressed on the day of the audit.</p> <p>(ii). There were no documented interventions or signs and symptoms of cyanosis for HCAs to be aware of for two hospital residents using oxygen</p>	<p>(i)-(x). Ensure all interventions are documented to support all assessed needs</p> <p>90 days</p>

ongoing assessment process.		provided.	<p>therapy, including ongoing maintenance of oxygen concentrators.</p> <p>(iii). There were no documented interventions for a hospital level resident with a current urinary tract infection.</p> <p>(iv). There were no side effects of an anticoagulant drug a hospital level resident was prescribed.</p> <p>(v). There were no individualised triggers or de-escalation strategies documented for three hospital residents identified as having challenging behaviours.</p> <p>(vi). There were no non pharmaceutical interventions documented for two hospital residents with chronic pain.</p> <p>(vii). There were no interventions documented around oral cares for four hospital and one rest home resident.</p> <p>(viii). There were no documented interventions around pressure injury equipment used for a hospital level resident with a stage 3 pressure injury. All pressure relieving equipment was in place on viewing the residents' room.</p>	
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			<p>(ix). One rest home resident who identifies as Maori, did not have cultural preferences, their Iwi or affiliations documented.</p> <p>(x). Interventions were not documented around the risks of Chorea (involuntary movements) related to their medical condition, for a resident using bedrails as a restraint.</p>	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Care plans are documented for all residents. All care plans have identified goals and family support (where applicable). Residents and relatives/whānau are involved in the care planning and review process and when there an acute change in health status. Monitoring charts were sighted for vital signs, neurological observations, weight, blood sugar monitoring, wounds, turning charts, and behaviour, however not all monitoring charts were in place.</p>	<p>(i). A behaviour monitoring chart was not implemented for a hospital level resident with challenging behaviours as per care plan intervention.</p> <p>(ii). A turning chart was not evidenced as completed for a hospital level resident as per care plan intervention</p>	<p>(i)-(ii). Ensure monitoring charts are implemented and maintained as instructed in the long-term care plans</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, these 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.