Developmental Evaluation Report Summary – Supported Lifestyle Hauraki Trust

At midpoint of certification cycle for community residential services – sensory, intellectual and physical disability

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| Name of Provider: | Creative Abilities & Associates |
| No of houses visited # and location | # 4 Auckland |
| Date visit/s completed: | 23 February 2021 --- 25 February 2021 |
| Name of Developmental Evaluation Agency: | SAMS (Standards and Monitoring Services) |

**Methodology**

Individual service (house) reports were completed by a range of SAMS Evaluators using a standardised developmental evaluation process and evaluation framework.

The SAMS Developmental Evaluation Approach primarily uses qualitative methods and a partnership model.

The methodology is consistent with:

* individualised focus
* partnership
* inclusion
* equity.

The approach enables both a process and outcome focus allowing the Evaluation Team to equitably represent the different views of the defined groups and compare the outcomes for the differing groups.

Evaluations are conducted by teams and normally each team includes at least one consumer or family member. Evaluation Team leaders and team members receive comprehensive training.

Information can be gathered through:

* observation
* individual and group face-to-face interviews
* telephone interviews
* review of protocols and procedures.

Before departing a service, initial feedback is presented to those involved in the evaluation process. A draft report is prepared on the basis of evaluation team consensus and circulated. This draft is then negotiated with the provider to determine a final document, including recommendations for development.

Individual service (house) reports were then collated to identify themes. The primary method of analysis involved a senior SAMS Evaluator reading all of the reports, summarising the key areas against the checklist specifications and providing a count of broad categories for each recommendation. The themes, drawn from the finalised individual service (house) reports, are the basis for this report.

Once summarised, the overview report was read by an independent person for clarity and balance.

General Overview:

Four residential services were the subject of this mid-point review of Creative Abilities, Ltd and involved xx people aged between xx and xx years living in the xx area. The Evaluation Reports describe the positive experiences the people and their families are having as a result of the new hub structure and being supported by staff committed, caring staff. The reports also describe the efforts the organisation is taking to bridge the challenges faced by insufficient transport resources.

The people and the 12 families interviewed spoke encouragingly about the support they were getting, and indicated satisfaction with the services being provided. The people have opportunities to become involved in activities through the Community Hub based on their interests and several people described what they liked about the things they were involved in.

Areas for development were varied and in one instance was ‘person’ specific. Improving personal plans so they reflected aspirational goals was identified in all of the reports, as was the need for staff to meet more regularly. Further addressing the communication needs of some of the community members was also identified in all reports.

**Areas of Service Strength**

* Caring, committed staff who know the people well
* Introduction of hub structure resulting in smaller staff teams
* Transition processes are used when people living options.

**Areas of Suggested Development**

* Address communication needs and cultural preferences
* Increase participation and 1:1 opportunities
* Improve goal setting to include aspirational goals.

**1 – My Identity / Tuakiri:**

The community members in this review represent a wide range of cultures and all of the reports gave indication that cultural identity was acknowledged through their support plan. In two of the reports there were indications that further recognition of cultural practices would be beneficial. In two reports it is noted that NZ Sign Language is used by community members and recognising associated practices could further ensure a holistic approach is embraced. The above concerns were reported as recommendations in three reports.

Many of the community members have strong connections with their whānau. The reports talked about some community members deciding the role their whanau has in their lives while noting others require support to maintain communication. There was consistent praise from whanau for the way in which they were kept informed during the recent pandemic lockdown. All families advised that since the new hub structure has been in place communication has improved and they feel more connected and have a greater understanding about what is happening in the service. One report commended the dedication of the staff team to maintain contact with one community member’s close whānau who resides in a rest home.

The reports described the range of communication methods used by the community members. While few community members require assistance, most benefited from augmentative techniques to communicate their needs, including an understanding of their unique body language. A yes/no communication board and sign language are currently in use and in two of the reports it was suggested that the community member take the lead in teaching their peers and staff sign language. In all reports further emphasis on improving communication was reported as a recommendation.

**Area of Service Strength / Improvement Noted**

The organisation endorses the rights of all community members to live life their way, in an inclusive community. The reports described interactions between community members and staff members as dignified, respectful, thoughtful, kind and encouraging. One report noted that while valuing language was often used, there were instances where the community member’s mana could be promoted in a more positive light. One report noted that the use of a ‘medical model’ detracted from the mana of the community members. These concerns were reported as recommendations in two reports.

**Area of Service Strength / Improvement Noted**

Each community member has a current service plan from the local Needs Assessment and Service Coordination (NASC) agency and a service agreement.

**2 – My Authority / Te Rangatiratanga**

The community members make many decision which influence their lives, with some requiring input from whānau and staff who know them well. There was evidence in two reports of community members making significant changes to their lifestyles.

A few community members independently access facilities in the wider community, but most activities occur at the Community Hub or in groups with their peers. In all four reports it was noted that community members would benefit from increased opportunities for 1:1 support. Inclusion in activities varied from grocery shopping and meal preparation, to having greater access to the local community and increased opportunities for independence. Most community members have ‘community day’ during the week and it is believed this may provide an opportunity for increased 1:1 opportunities based on individual preference.

**Area of Service Strength / Improvement Noted**

The reports noted that each community member has a personal plan (support plan) which often included long and short-term goals as well as achieved goals. While some goals were aspirational, most reflected ‘everyday/medical’ goals which would be characteristic of a caring service, eg, ‘use my standing frame’, ‘maintain weight’, and to ‘continue the gym programme’ and ‘be happy and healthy’. In three of the reports, the services were encouraged to focus on more aspirational goals that reflect each community member’s individuality and personal interests. Opportunities for ‘ordinary life outcomes and person centred experiences’ are ways the Enabling Good Lives Principles can be demonstrated. These concerns were reported as recommendations in three reports.

**Area of Service Strength / Improvement Noted**

Achieved goals achieved were described as ‘moving to a flat with peers’, becoming a volunteer, attending local tertiary facility and going on a holiday.

All of the community members represented in the reports lived together compatibly, and long-term connections and friendships had been established between the people over the years. One report described the transition process utilised when someone new entered the service and the families reported that they were consulted when a vacant room was being considered for use respite purposes.

The community members participate in the running of their home in different ways with some relying on support staff for all aspects of daily living. Suggestions in the reports encouraged the service to explore how community members could have greater involvement. Most of the people benefit from support to maintain personal care.

Service Agreements have been completed and while comprehensive in a number of areas they are yet to state in the portion of the person’s MSD Work and Income benefit which is retained by them. This was mentioned as a recommendation in two reports.

The people chose who they live with and where they live, a number of people have lived together for some time with newer people transitioning into the service following appropriate introductions. In three reports positive comments were made regarding transitioning from one living environment to another. Comments made by a family member in one report stated “X adjusted very well”. One report highlighted the need to ensure moves between the homes were done with full consultation. Overall compatibility is achieved and some people are supported by staff to manage behaviour that may impinge on the lifestyles of others.

**Area of Service Strength / Improvement Noted**

**3 – My Connections / Te Ao Hurihuri**

All of the community members attend the Community Hub where they meet up with their peers. Additionally, some of the people attend activities in the wider community often with other community members. Many of the community members have one day a week ‘off’ which could be utilise pursuing 1:1 activities.

The role of the client experience coach is described as *enriching the lives of our clients and championing inclusive communities through experiencing Care with Heart.* This role lends itself to getting to know community members as individuals and focusing on their personal aspirations, interests, opportunities for 1:1 support and community-based activities.

In all reports viable transport options were raised as a barrier to accessing individualised activities. The organisation is to be commended for exploring ways in which more sustainable options can resolve the current challenges.

The community members access doctors and specialist as required.

**4 – My Wellbeing / Hauora**

The community members are supported to lead healthy lives and there is a strong focus on their wellbeing and safety. The personal plans includes detailed information about specific care needs which include mobility, skin integrity, equipment instructions, sleep systems and personal care routines. Photos are included in the plans to further demonstrate certain procedures. Medimap is used for dispensing medication and is widely regarded as a very effective system.

Input from in-house RNs and the Social Worker is available for additional support. One report mentioned that enablers are used by the community members and ensuring these have been approved and regularly reviewed was noted as a recommendation.

Regular fire drills and evacuation procedures are undertaken in the home and follow the protocols of the service. One report mentioned exploring ‘mock’ drills as a way to provide the staff with insight into how to respond to such an emergency as practice drills distressed the community members. Sufficient provisions, eg civil and first aid kits, are kept in the homes so necessary support in an emergency is available. A pandemic plan is in place within the organisation.

The community members are supported by awake care coach overnight and incidents are recorded in the client management system and a *multifunctional meeting* is held to discuss incidents and complaints.

One report noted that the buckled carpet impedes the easy use of a wheelchair and it was recommended that a remedy be explored.

One report raised a ‘person-specific’ concern regarding the need for stronger, more formal advocacy for one community member and this was noted as a requirement.

**5 – My Contribution / Tāpaetanga**

Holding valued roles is one way in which the community member’s contributions are recognised and valued and the roles mentioned in the reports were extensive. The families are involved in their family member’s life and communication was generally considered to be effective. A newsletter provides information, events and activities as well as an avenue for community members to share their stories.

The families indicated they had been involved in surveys and recent feedback from community members and their whānau highlighted areas which required improvement. It was this feedback that led to the initial introduction of the new hub structure which was then reinforced by the processes surrounding the pandemic, resulting in the smaller team approach. The community members, the families and the support staff praised the new structure and note stronger relationships and greater continuity as the most notable improvements.

**Area of Service Strength / Improvement Noted**

he families were confident they can contact staff if needed and there are clear complaint processes in place within the organisation. The directors are supportive of the EGL Principles and are working through how they can be promoted as incongruities between different Ministries have become evident.

**6 – My Support / Taupua**

The interactions observed between the community members and the support staff indicate that they have positive relationships and appreciate the support they receive. In one report it was noted that the families indicated that they can choose who accompanies their family member to appointments and this request is generally fulfilled. Additional comments shared by the community members include ‘X really helps me’ and ‘it’s all good here’. One report noted a family praising the reduced number of staff working in the home as it has ‘minimised the need to start from scratch’.

A new client management system has been implemented which is more aligned to the focus of the organisaiton. To date it has been positively received and the community members and their whānau are looking forward to the access portal which will be implemented in phase 2 of the programme rollout.

**7 – My Resources /Nga Tūhonohona**

Each community member has their support options assessed by the local NASC and the support contract (service agreement) is provided to the service.

As per the current system of service agreements, the amount of funding allocated to the service is unavailable to the families.

**8- Organisational Health**

Measured against the Social Sector Accreditation Standards.

The organisation has completed the Social Sector Accreditation Standards (letter dated 23 May 2019) with the Ministry of Social Development. Accreditation covered the following services:

* Client-centred services (Level 4)
* Staffing (Level 4)
* Health and safety (Level 4)
* Governance and management structure systems (Level 4)
* Financial management and systems (Level 4)
* Resolution of complaints related to service provision (Level 4).

**9 – Value for Money**

Each of the community members is supported within a PD community residential contract and service agreements are held by the provider. The organisation understands how and when to request reviews by the NASC and when to ask for additional services.

**Progress on Meeting Corrective Actions**

The letter dated 9 February 2021 from Q-Audit stated that the Surveillance Audit carried out on 2-3 February 2021 resulted in “all nonconformities from the last audit were closed”.

**Outline of requirements and recommendations:**

**Number of Requirements made 2:**

**Number of Recommendations identified in Evaluation Reports 18:**

Review Home/Service Agreements (x 2), Aspirational goals (x 3), Improve Communication/cultural practices (x 3), increase staff meetings, develop easy-to-read processes, update information, follow-through with enablers, participate in consultation, review staffing hours.