**Developmental Evaluation Report Summary – McGlynn Homes**

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

|  |  |  |
| --- | --- | --- |
| **Name of provider:** | McGlynn Homes | |
| **No of houses visited and location**  **(number of people)** | 3 | Southern |
| **Date visit/s completed:** | All house visits occurred between the 17 and 24 February 2021 | |
| **Date report finalised:** | Report finalised on 22 March 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 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 as a full team member. 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 two senior SAMS Evaluators reading all of the reports for each region, 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 two overview reports were then read by an independent person for clarity and balance.

**General Overview:**

|  |
| --- |
| **Introduction**  McGlynn Homes is privately owned service that provides residential accommodation to people with physical disabilities (primary diagnosis) in Dunedin, Mosgiel, Oamaru and Invercargill. It has a philosophy to provide ‘excellent individualised levels of care’ to allow people to ‘continue living a high quality life with as much independence as possible’.  During the developmental evaluation phase of this review we visited four homes (one with only four people) and completed separate reports for each property. The Midpoint reviewed three homes for five or more people (these are listed above).  All three homes involved in this Midpoint review were homes previously run by CCS Disability Action. Some of the people living in these homes have therefore done so for a number of years.  The general view of the service provided in all properties we reviewed was very positive. There are a number of staff in each home who have worked in each place for some time (in excess of four years) and provide a stable platform for the staff team. Relations with the managers of the service was also very good from the perspective of staff, the people living in each setting and family/whanau.  The people in each home have a variety of day time activities that include work roles for several people (one person works full time), a variety of day services options (including IDEA, Studio 2 in Dunedin), gym activities (especially Iron Warriors in Dunedin), craft groups, visiting shops, cafes, libraries, parks, swimming pools and beaches.  The families we were able to interview were in general very pleased with the support provided and reported good communication with the staff and managers associated with the home.  There are good quality service delivery plans and an excellent understanding of the support needs of each person. However, reviewing the methods of developing and supporting personal planning goals and aspirations is suggested in each report.  The service is yet to consider the ramifications of Enabling Good Lives and the impact it is having on service delivery within New Zealand. In all of the reports we have recommended the service actively reviews the principles and finds methods of educating all stakeholders about them.  **Number of people formally interviewed during this evaluation**  People living in the three homes xxx, family/whanau/advocates (7), staff (12) managers (3)  **Strengths**   * Each of the homes felt like a home and not a facility. * Bedrooms and living spaces were personalised. * The majority of people living in these homes were able to advocate for themselves and exercised this right wherever possible. * In two of the homes there was relatively good compatibility. * Most people were able to be very active in their daily lives. * Some access to the community and favoured activities were supported by the service. * There were good relationships with families/whānau and in general very positive responses by families about the support provided and the service in general. * Each person has full access to their personal files and any documentation concerning them. * The staff teams appeared to be relatively stable in terms of turnover and were able to meet together once a month for training or formal staff meetings. * There was a good relationship noted between the household staff and managers. * The service provides good quality service delivery plans that are updated at least annually. These plans are readily available to both staff and the person(s) concerned. * There were good efforts to support individual personal planning goals and some very positive and enthusiastic staff. * The service has a very good focus on health and safety standards and protocols. * The service has been supporting all of its staff to complete certificated training through levels 2 to 4.   **Areas of Development / Consideration**   * Further review and development of personal planning processes and how goals are developed is suggested. * The service and the people supported by the service or their families have not yet engaged with Enabling Good Lives Principles. * Some paperwork requirements around home agreements are indicated in this report. * One of the homes indicated some compatibility issues * Some further review of positive behaviour support is suggested in one home.   **Results from the SAMS Developmental Evaluation**  There was one requirement common to all three reports (1) and one requirement for a single house (2):  **Requirement**   1. The service provides annual home agreements that are signed by each individual and/or their legal representative. See section 2.2 for details.   There were home agreements on each person’s file but all of these were signed on admission only. They also did not include a section on “how the residential subsidy portion of the person’s MSD Work and Income benefit will be paid to the Provider orthe amount that is left (which will be retained by the Person)” (section 6.9.1 b, c of the residential contract).   1. Personal planning be reintroduced for people who are less able to make informed decisions about aspirational goals development and/or goal progression. (Section 2.2).   One home did not provide evidence of offering personal planning in a manner that may prompt up-take.  **Recommendations**  There was one developmental recommendation common to all of the homes reviewed:   1. The service completes an organisational self-review and begins a process of educating staff, whānau and the people within the home about EGL Principles. (Section 11.1).   The service had yet to develop an understanding the Enabling Good Lives (EGL) principles either with regard to their service organisation or practice, or with regard to informing and engaging all stakeholders in the principles (including staff, disabled people and whanau).  The remaining recommendations were unique to the various houses but included:   1. The service reviews the methods of developing and understanding personal planning. (Section 2.2). (Common to two homes) 2. The service introduces training in positive behaviour support strategies with the staff team and considers specific situations when reviewing positive behaviour support strategies. (Section 1.3). 3. The service continues to review and consider strategies for addressing compatibility issues, in partnership with each person and their whānau. (Section 2.2).   While personal plans were provided (in three of the four houses we reviewed) they tended to provide goals that were typical of each person’s daily living or they were support needs goals more likely to be included in the service development plans. The Evaluation Team suggested reviewing personal planning goals with regard to aspirations or goals that reflect what people really enjoy.  It was noted that training in behaviour support was provided alongside discussion of service delivery plans (see responses to corrective actions at the end of this report) but these may not be sufficient in more complex cases. In particular, there was some confusion in one home about the meaning of ‘consequences’ when ABCs were discussed in notes (ie antecedent, behaviour, consequence) and it was felt talking in terms of the impact of a behaviour may be more useful. Also, the team suggested staff in this particular home review behaviour in terms of its function, and focus on altering or anticipating triggers (or antecedents). This is a more focused and person specific suggestion of training that may step beyond that provided generally to staff.  The last recommendation concerned with compatibility was deemed a recommendation as this is a situation that needs to be considered and discussed among all stakeholders (not the least of which the people living in the home). In this particular case, there were no clear solutions or alternative support arrangements.  **Correction Actions for Certification with HealthCert**  There were three “Corrective Actions” previously agreed between McGlynn Homes and their Designated Audit Agency (*these are formally summarised at the end of this report*).   1. The first corrective finding made the following statement:   Of the xxx residents interviewed xxx mentioned being “told off” or being “yelled at”. A review of the complaints for 2018 and 2019 documents that issues around staff boundaries and communication style with residents are a recurring theme.  The corrective action states:  Ensure all residents are communicated to and treated with respect (PA Low, due 60 days, Criterion 1.1.3, 1.1.3.7).   1. The second corrective finding states:   Formal training has not been documented as completed in the last two years around; restraint/enablers and challenging behaviour  The corrective action states:  Ensure that all compulsory subjects are documented as provided (PA Low, due 180 days, criterion 1.2.7.5).   1. The second corrective finding states: 2. One resident had a documented toe wound with RN review of the toe, however, following the initial RN review there was no documented follow-up, formal wound assessment or plan (Noting, staff inform that the care has been provided and the toe has improved) 3. One resident with continence needs did not have the management of continence products documented, progress notes referred to ‘double padding’ at night. 4. Neuro observations were not consistently documented following one resident with a blow to the head.   The corrective action states:  (i)-(iii) Ensure that all care interventions are documented as occurring and the neurological observations are documented as per policy (PA Low, due 90 days, criterion 1.2.7.5). |

**Quality of Life Domains**

*The quality of life domain headings have been changed from previous summary reports to fit the new evaluation tool and template requirements*

|  |
| --- |
| 1. **My Identity**     **1.1 My culture, beliefs and preferences are supported**  The service has very clear policies and procedures concerning the support of people from different cultures and people with varying spiritual beliefs. The policies identify the importance of Te Tiriti o Waitangi and Māori culture (tikanga and te ao Māori). There is also a Māori Health Plan detailed within the policies and procedures.  xxx of the people in all three homes identified as Māori.  Some people were supported to attend church or church groups and the service is sensitive to cultural distinctions within family/whānau groups (traditions etc).  **1.2 My family and whānau are valued**  Most of the families who participated in this review were very satisfied with the service provided and the level of communication and respect shared with them by the managers and staff.  **1.3 I am understood**  At least four of the people in all three homes have communication support needs. The service has had contact with *Talk Links* for some people’s needs and more effective communication devices have been considered. Some people used electronic communication devices and others had limited sign and/or body language that was understood by people who knew them well (including key staff members).  The service records the communication support needs for each person in their service delivery plans.  **1.4 My mana is acknowledged, upheld and enhanced by my contact with support**  The people living in these homes were enabled to speak up for themselves through in-house meetings, the complaints process, through conversations with people they trust, through family and by having access to information that is stored or written about them. One person was involved in advocating for disabled people. Some individuals were also assisted to vote as citizens of this country and have opinions about current affairs that are taken seriously by others.  As well as this, the service treated people with dignity and respect during their daily support and in social/verbal interactions. When/if people were not treated in this manner management was informed and action was taken.    The service has clear written policies regarding restraints and enablers. The service states it does not use restraint of any kind in its service. Each person who needs enablers for wheelchairs, bedrails etc has procedures written into their support plan and as a separate document detailing how and when to use enablers. These are reviewed at regular intervals with the person. Training in restraints and enablers is included in education concerning service delivery plans and is individualised.  Positive behaviour support appears to be understood by the staff, and formal training is again scheduled for October 2021. The service utilises person-specific training for individuals who require ongoing behaviour support in some of the homes.  One home appeared to have some difficulties understanding what ‘consequences’ mean in ABC notes. This would be best reviewed in terms of the impact a behaviour may have if there continue to be conceptual problems within the team. Also, it is suggested the team consider the function of key behaviours and address these as a means to reducing or eliminating disruptive events. Further training in person specific positive behaviour support was suggested for this home.  **1.5 Entry is Easy**  The service has clear entry processes and admission forms.  The homes are accessible for people with mobility requirements in terms of entry/egress, bathrooms and most corridors/doors.  In one home the accessway to the kitchen and living spaces from the back of the home is narrow and difficult to navigate for people who use wheelchairs. As a result, the walls and corners are somewhat battered.  Kitchen workbenches are at standard heights, although there is space to watch preparations and people can help bake or prepare foods at tables located in or near the kitchen.   1. **My Autonomy**     **2.1 I make choices about my life**  There were informed choice documents in the personal files that were signed by each person and/or their guardians.  On a personal level the people in each home were making daily choices about their lives. Wherever possible the service respects these choices. This level of choice can at time create tension, but the service is using good techniques to help the people balance personal choices with the needs or rights of other people in the same home. These techniques extend to staff modifying their practice at times to accommodate some choices (eg, juggling desired bedtimes with tasks of helping others to bed as well).  **2.2 I choose and realise personal goals**  Personal plans were created and revised at least annually or as plans changed. The plans had a number of goals that each person would do as a natural part of their daily living or they were support needs goals more likely to be included in the service development plans. It was suggested by the Evaluation Team the approach taken to develop personal planning with a person occur over a number of days or even weeks. We also suggested, considering with the person what they enjoy, now or in the past, and discussing possibilities with people the person trusts during that time may help generate new goal ideas.  It was noted that the service does break goals down into achievable steps and does provide progress notes on each of those steps. Providing more detail in these notes such as ‘what happened’, ‘what worked well’, ‘what did not work well’ and ‘where to next’, can help prompt the person, the key worker for a goal, and the person’s support network to work together.  The Evaluation Team suggested: “It may be useful for the service to consider personal planning goals in terms of different approaches since how a person considers or interacts with a plan may vary. One approach is the PATH plan (available for review online) but this approach and others can be tailored to suit the individual and/or a service”.  For one home it was suggested to the Evaluation Team that no-one in the home wished to have a personal plan. It was evident that at least two and perhaps three of the women did not require support to either devise or action their own personal goals. However, that was not the case for all of the women in this home. Reviewing how personal planning goals can be developed and the rationale behind personal planning was suggested for the staff team especially as they relate to each person and EGL Principles.    Each person reads and signs a home agreement when they enter the service for the first time. However, the home agreements do not include a section on “how the residential subsidy portion of the Person’s MSD Work and Income benefit will be paid to the Provider,the amount that is left (which will be retained by the Person)” (section 6.9.1 b, c of the residential contract).  **2.3 I** **make decisions about my daily life**  As noted earlier each person makes choices about their daily life. This includes when they go to bed, what activities they participate in during the day, who they communicate with and visit, whether they want a particular prepared meal or an alternative etc.  The service utilises dietitians to help plan menus but each house also allows people to have input into meal planning (especially the smaller homes) or allows people to opt of alternatives if the planned evening meal is not what they would like (this is particularly the case for the larger 12 bed home).  It was great to see pets in some homes and some people were able to assist with gardens (which they greatly enjoy).  The people in two of the homes appear to get on relatively well together or in the case of the larger home have plenty of areas where they can avoid some people. All of the homes have sky television in one lounge area.  One home does indicate some compatibility issues. Due to housing shortages and options in the local area this has not been an easy problem to remedy. However, the problem is a real concern for some of the people in the home. The Evaluation Team suggested all stakeholders consider the issue and together work toward a solution (rather than simply attempting to fix relationships or alter behaviours).  **2.4 Supports are highly tailored to my needs**  Each person has a service delivery plan that is reviewed at least annually or as the need arises. This was readily available to each person and support workers. The plan highlights daily support needs and the goals of support. These may include personal milestones (such as losing weight, physiotherapy, movement or fitness goals) and general support goals. Progress notes are recorded daily   1. **My Connections**     **3.1 I am part of the community**  The people at each home can access activities in the community through wheelchair taxis or sometimes on foot (to local parks, beaches and cafes). Activities tend to occur on an individual basis and people may attend vocational services (IDEA, Studio 2) or craft/church groups. A few people had paid or voluntary work and one person worked full time.  The three community workers employed by McGlynn for all of the Dunedin and Mosgiel homes do assist with some individuals and also arrange for particular outings or events.    Access to the community is often dependent on personal finances (for transport, shops or activities) and on staffing. In some cases, people from a person’s support network (usually family) help the individual access the community or visit friends or other family. In homes on flat sections access to the community was possible for people on foot or using wheelchairs. Many people did not require staff support to access their community.  However, as with most services for people with physical disabilities, there is no provision for transportation in the contract provided for residential services (contrary to what is available for people with learning disabilities). This places a large burden of cost on disabled people who already have very limited funds available to them and who are often unable to access the community independently. For some of these people going out for a coffee with friends becomes a financial burden because of transportation issues.  The service does its best within its own staffing resources to assist the people to access their community and wherever possible this occurs on a one-to-one basis (as indicated above). Individuals get out to the shops, cafes, engage with groups of their choice (craft, church, Studio 2, *People First*), participate in sporting activities (eg, Boccia, Iron Warriors), go to concerts (when they are available), and visit parks and beaches.   * 1. **I have relationships with others that are important to me**   The service has policies and procedures that highlight the right of people to associate with other people freely and the service does encourage the people to seek, maintain and strengthen friendship and family ties.  There is no specific policy concerning sexual rights except with reference to privacy and the right to associate. One person was noted to maintain a relationship of long standing with a person from a different residential home run by a different service.   1. **My Wellbeing**     **4.1 I have the best possible health and wellbeing**  The service actively supports the health needs of each person through adherence to the service delivery plans and timely visits to medical practitioners and specialists. Each individual also has regular dental checks and has support from district nurses, podiatrists, opticians and psychological services as required.  **4.2 I am safe**  Personal files include essential contact information on the opening page and a description of the individual’s cultural or spiritual connections. These are followed by risk assessments that are clearly outlined in various sections including behaviour support, allergies and health alerts.  The files include support delivery plans and may also include details on supporting an individual’s particular health needs (eg, epilepsy, diabetes, wound management etc).  Medications are securely stored and require double staff signatures. The medication folders contain information on each drug, the doctors’ prescribing sheets (including as required medications and medication reviews), sample staff signatures, medication checking sheets (when blister packs arrive from the pharmacy) and procedures for issuing PRN medication and other specialists drugs (eg, controlled drugs). Controlled drugs are securely stored inside a strongbox inside the locked medication cupboards and a daily audit is conducted of these drugs.  All staff must complete medication training before they are authorised to issue medications. Medication reviews occur annually.  Some homes had built in sprinklers and these and smoke detectors are checked regularly. Evacuations are practised twice a year. The homes have civil emergency supplies although increasing the amount of water stored would be useful.  The staff described the induction training they had when they first orientated into the service and the house. The service has 147 staff in total with the majority having completed at least level 2 training. Twelve staff are currently completing level 2 training and the service has seven Career Force assessors on its team. The service reports 122 staff have completed first aid training. In-service training includes infection control (2020 and scheduled again for 2021), abuse and neglect, cultural training (completed on-line), manual handing, the code of rights, service delivery plans and nutrition.  Staff meetings include standard agenda items such as infection control, health and safety, fire/emergency and reporting issues (this may include incident reports and hazards). A hazard register was sighted including action plans.     1. **My Contribution**   **5.1 I can contribute to my community and society**  The people we visited during this evaluation were valued members of their family, some people were involved in sporting activities or art workshops. Some people have work roles, one person is a local activist for disabled people, and some have had previous involvement with *People First*. Some individuals are skilled crafts people and at least one has been a finalist in art awards (Also see Mana Enhancing, section 1.4).  **5.2 I am involved in service development**  As a privately owned service there is no governing body that can include representatives of either whānau or the people using the service. Instead McGlynn relies on house meetings, surveys, complaints and compliments, and general conversations with the people using the service. Considering a resident/whānau advisory group may be useful especially as Enabling Good Lives becomes more widespread in the region.   1. **My Support**     **6.1 I am able to choose my support, who supports me and how I am supported**  The staff pool in each in these homes is relatively stable and there is every indication they work well together as a team. In the smaller homes it was easier for the people living in the home to express their preferences about the composition of the team once new people have been trialled.  Each person has their service development plan in their bedroom for ease of access when staff assist them with personal care.  **6.2 I can have my say**  A complaints procedure is readily available to the people living in the home and their whānau. A review of the complaints register indicated there were no serious (notifiable) complaints and a resolution process was noted. It was evident that the people living in these homes and their representatives have been supported to make complaints.    **6.3 I monitor and evaluate the support provided**  Daily diary notes concerning each person are referred to as progress notes and are included in their personal files. Each person has access to these records. Progress notes tend to focus on health and safety needs and do not include much detail on what the people are doing each day.  Also see section 2.2  **6.4** **I have a relationship of shared power in the planning process**  This section of the evaluation tool also states “I am involved in service development” and states in its sections that the service might “utilise hui, and other methods, to involve people in review of strategic plans, policies and procedures, internal review and evaluation.” Some of the methods used to consider the views of the people using the service are talked about in section 5.2.  *This concludes the main summary of the three reports with regard to the indicators in the evaluation tool. However, some sections were added to the reporting template that are not repeated in this summary with the exception of the following:*  **General observations on how the organisation delivers supports according to the vision and principles of Enabling Good Lives**  Enabling Good Lives is a relatively new concept for this service and an area where some exploration is suggested. The reviewers took some time during the feedback for this home to explain how EGL developed and grew within the disability community in New Zealand and how it has been the driving force for change in the sector. The team suggested the service completes an organisational self-review and begins a process of educating staff, whānau and the people within the home about EGL Principles. |
|  |

**Progress on meeting Corrective Actions:**

|  |
| --- |
| **Corrective Action 1:**  Of the six residents interviewed three mentioned being “told off” or being “yelled at”. A review of the complaints for 2018 and 2019 documents that issues around staff boundaries and communication style with residents are a recurring theme.  **Required Action:**  Ensure all residents are communicated to and treated with respect.  Criterion 1.1.3.7 PA Low Due date: 60 Days  **Progress:**  In communication with the DAA assessors the service stated it had “held education sessions throughout all eleven McGlynn homes discussing the Code of Rights and how important it is that residents are spoken to in an appropriate manner as adults. Staff were reminded that this is the resident’s home and they are there to support them and provide supports that allow the resident to have a great quality of life. I [manager] also discussed how important it was to show respect and dignity to residents”.  The went on to state: “The audit findings were discussed and reporting forms that had been written by residents were read out to staff to show staff the perspective of how residents feel at times due to staffs actions or the way they speak. For staff that were unable to attend they have been spoken to individually over the past month by Team Leaders or myself [manager] about what occurred in the education sessions”.  The service then attached evidence to education forms for all houses and certificates that were given to staff that attended (stating the topics that were discussed).  **Evidence:**  The SAMS team sighted training records and had discussion with managers and interviewed 13 people who use the service, 7 family/whanau and 12 staff.  Management indicated that each person has a complaints pack in their room and often ask staff to assist them to use them. Also, they indicated that some people will grab a manager when they are in the home to discuss issues and two monthly residents’ meetings are held with the manager. The manager noted that people in the home prefer the manager to run these meetings rather than an outsider.  House meeting minutes are held by an individual living in each home. There is evidence in these minutes of opportunities for individuals to raise issues about the staff and their support.  The SAMS team also reviewed the complaints that were written during 2020 and 2021. There were a few examples of issues with a particular staff member. In each case management spoke with the persons’ concerned with the complaint and a resolution process was followed.  There were no specific examples provided to the Evaluation Team of staff members not treating people with dignity and respect.  The SAMS team did raise, however, concerns about staff understanding of how to manage specific behaviour issues in one home. A recommendation in that report focused on addressing the function of the behaviour rather than just focusing on how to respond to a behaviour per se. It is possible the function of specific behaviours may be environmental (for example compatibility). While this situation did not raise discussion of dignity and respect in the SAMS report, consideration of responses to behaviour may fit within such discussions. They were not sufficient, however, for us to consider an extension of the corrective action.  **Further Actions:**  Based on the above evidence and observations no further action is indicated for this corrective action.  **Corrective Action 2:**  Formal training has not been documented as completed in the last two years around; restraint/enablers and challenging behaviour.  **Required Action:**  Ensure that all compulsory subjects are documented as provided.  Criterion: 1.2.7.5 PA Low By: 180 Days  **Progress:**  In correspondence to the DAA assessors the service stated: “Formal training had not be provided throughout the whole service for either challenging behaviour or restraints/enablers, however, over the past two years homes that required specific training around either of these areas did get training. To rectify this we have done education throughout the whole service and have discussed service delivery plans and what is in them and how each criteria within these plans works, providing understanding around each section. Two sections discussed in these plans were: My Management and My Behaviour pattern. Discussions included how to manage challenging behaviours, what are challenging behaviours, how are these reported and why is documentation so important when working with challenging behaviours.”  The service also stated the following section in the service delivery plans was discussed with staff: “My Mobility: this includes enablers. Discussion was held around what an enabler is for our residents, how are they managed, who puts these in place, why are they used and how are these checked and signed off daily. Moving forward we will ensure that challenging behaviour and restraint/enablers are educated on every 2 years”.  **Evidence:**  SAMS sighted training records and noted a behaviour support training event was scheduled for October 2021. We also sighted staff meeting minutes and previous discussion of behaviour support, and restraints and enablers. SAMS also reviewed policies and procedures relating to positive behaviour support and restraints/enablers. Documentation relating to behaviour support and use of enablers was noted on individual files in the sections indicated by the managers (above). There are also written records in contact notes (daily records) and behavioural issues are discussed at staff meetings (ie staff meeting minutes).  We also interviewed 13 people who use the service, 7 family members/whanau, and 12 staff members.  SAMS is satisfied the service had undertaken the training indicated in their written statement.  In the Developmental Reports SAMS did indicate an issue with regard staff understanding of positive behaviour support strategies in one home. This was a specific issue and it was probable that having learned some things about positive behaviour support had been useful but may have resulted in some interpretations that were not helpful. These are discussed in this summary report (Section 1.3) and resulted in a recommendation toward further development. The situation was also discussed in relation to the first corrective action (noted above). Ongoing review of this particular situation and more intensive training about positive behaviour support strategies that are person/situation specific were suggested. However, in terms of the corrective action the service did make the appropriate responses and no further action was indicated on that specific corrective action.  **Further Actions:**  Based on the evidence and discussion above no further actions are indicated.  **Correction Action 3:**  (i) One resident had a documented toe wound with RN review of the toe, however, following the initial RN review there was no documented follow-up, formal wound assessment or plan (Noting, staff inform that the care has been provided and the toe has improved.  (ii) One resident with continence needs did not have the management of continence products documented, progress notes referred to ‘double padding’ at night  (iii) Neuro observations were not consistently documented following one resident with a blow to the head.  **Required Action:**  (i)-(iii) Ensure that all care interventions are documented as occurring and the neurological observations are documented as per policy (PA Low, due 90 days, criterion 1.2.7.5).  **Progress:** In correspondence to the DAA assessors the service stated: “We have introduced a wound treatment chart, to be used for all wounds within the service that are not being managed by district nurses. This form ensures that any staff who work with the wound such as changing a dressing or assessing the wound etc must document their actions on this chart so that there is a running record of how the wound is tracking. All staff have been shown how this chart works in each home”. (They indicated evidence was provided with the response).  With regard to point 2 - The service stated: “All service delivery plans have now been changed to include the number of incontinent products the person is entitled to in a day and how often these are to be changed throughout the day. Service delivery plans now also clearly state that no resident is to be double padded. Education was provided in all homes regarding the use of products by the RN.” (They indicated evidence was provided with the response)  With regard to point 3 – The service stated: “All service delivery plans were changed to include what symptoms to look for if a person falls and hits their head along with instructions on who to contact if they do observe symptoms. Our team leaders who do On Call were also given information, ‘Care Plan for Assessment of Head Injury after a Fall or Accident’. ‘On Call checklist’ on what to assess if contacted regarding a resident who has fallen and hit their head. This provides them with information to ask and check when receiving a call to determine if the person requires further medical attention”. (They indicated evidence was provided with the response).  **Evidence:**  Service Delivery Plans: included wound care documentation and information regarding continence products.  Observation of bell usage and evidence from incident/accident reports, complaints forms and conversations with people who use the service and family/whanau. Also, review of staff meeting and training records. Discussion with the RN and manager.  SAMS is satisfied the service has responded appropriately to the corrective action  **Further Actions:**  No further actions were indicated. |
|  |