Developmental Evaluation Report Summary

## For residential services – sensory, learning and physical disability

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| **Name of provider:** | Te Runanga o Toa Rangatira |
| **Number of locations visited by region** | One (Northern Region) |
| **Date visit/s completed:** | 12/03/18 |
| **Name of Developmental Evaluation Agency:** | Enhancing Quality Services |

## General Overview

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| The service supports xxxx people living in two homes. The service is run under the umbrella of Te Runanga O Toa Rangatira Incorporated an iwi based (Ngāti Toa iwi) organisation offering a range of services in and around the Wellington region including, a medical centre and a community health programme, Kura kaupapa and disability support. The homes were originally developed in response to the disestablishment of Porirua and Kimberley hospitals 20 years ago. At this time Te Runanga was approached by the funders to develop a community residential service for a small number of individuals moving into the Porirua community. The service has been operating ever since.  All people in the service require high levels of support and supervision. All have varying levels of mobility and communication, one person utilises a walking frame and two people are a falls risk. Another woman is significantly vision impaired. One man has Autism and has been known to display challenging behaviours in the past and a behaviour support plan is on his file as well as a safety plan. The oldest member of the group is unsteady on his feet and attends an individualised day service from his home.  xxxxx women live in a house and xxx men in a nearby cottage. The homes are set in their own grounds and near to a medical centre and a Marae part of the iwi support services. People use their services which are within walking distance. The people in services frequently attend iwi cultural events at the Marae where they are treated like extended whanau. There are plenty of opportunities for people to experience their culture and this is prioritised in the service  The homes are in close proximity to shops and the service has access to a vehicle to aid community involvement.  xxxxx service users attend external day services and people seemed to enjoy their day programmes. xxx people access an internal day programme from home. Everyone seems to be busy doing interesting activities including gardening, karaoke, arts and crafts, Special Olympics swimming, candle making, cultural activities at the Marae and local weekend community events. People are also encouraged to help out around their home including assisting with meal preparation etc. People have choices and their wishes are respected.    There are sufficient staff on duty, one in each home during the day and an ‘awake’ staff at night. Staff are supported to undertake training and have good supervision. The manager is knowledgeable but aware that a lot of the knowledge is held by her.  Over the years there have been opportunities for Te Runanga to expand services however in most cases this has been difficult to achieve due to the complex nature of new referrals. Currently there are no bed vacancies in the service. However people living in the service are ageing and eventually this may lead to vacancies which may impact on the viability of the service long term.  Two family members interviewed talked about their family members being treated with respect and both knew how to complain if they had any concerns. Families felt the home was nice and that staff were doing a good job. In both cases families felt consulted and had some contact with the service in terms of updates. One service user was interviewed on the day and indicated she was happy with her service. She also indicated that she felt listened to by staff.  Opportunities for improvement were identified how personal plans developed, in themselves interesting, however they lacked timeframes, review dates, resources/support allocated. Progress at meeting the goals could not be ascertained from the documentation. Other area included reconciliation of medication when it came into the home. Reconciling receipts with running balances in personal ledgers. |

## Quality of Life Domains – evaluative comment on how well the service is contributing to people achieving the quality of life they seek

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| **Identity**  The philosophy is based on a Kaupapa Maori service aligned with the local iwi; people are supported to engage with their culture. All service users participate in activities during the day. Records and comments are affirming of the individuals and made in a positive manner. Staff appeared to be very supportive wanting to do the best for the group promoting independence both in and outside the home.  Plans are detailed containing information about supports, communication, mobility challenging cultural connection, behaviour. Usually people have four goals which are interesting and community focused. However it was difficult to ascertain progress as they lack timeframes and regular monitoring. Service user records on file include old and new documentation and improvement was identified in the layout of the files including archiving old material. Home Agreements were not on file in a form required by the Ministry of Health.  There are sufficient staff to provide the service with one staff on duty in each home during the day and an awake staff at night, staff and the Team Leader were enthusiastic about the potential of the group. Overall staff were positive focussed on increasing independence. Staff felt supported by their Manager.    Two family members were interviewed and described being happy with the service. Family knew how to complain if they had an issue. Families spoken to like the home and felt that their family members were well cared for and treated with respect. For one woman the service proactively provides transport to her aging mother so they can maintain their close relations  There is a system to reconcile personal expenditure against receipts, although the system was sound expenditure was not always deducted from the total amount recorded in the person’s running total and mistakes were identified.  The two family members interviewed said that they were satisfied with the service. One of the service users was able to be interviewed and also confirmed she is happy with living there and felt that staff listened to her.  **Autonomy**  Service user records on file include old and new documentation. Documents include specialist letters, NASC assessments, behaviour support plans and medical notes. Where people have experienced challenging behaviour in the past there are behaviour support and safety plans on file. Files are kept securely in a cupboard in the staff office. A staff communication book is utilised to record key messages from each shift. Completed incident reports are entered online and discussed at staff meetings.  People are involved in selecting the menu and have nights where they each help cook the meal. Based on the menu people are encouraged to assist with grocery shopping. They are also encouraged to take an active role in running the home including house work and maintaining their personal garden.  Property inventories are completed where an article is over $80. People’s bedrooms were personalised, comfortable and homely. There is equipment available to promote safe mobility including a walking frame and two people have hospital beds to support good posture at night  **Affiliation**  People are treated with respect and recordings are affirming of the individual. Staff described progress among the service users and staff. There was a clear vision for the service that involves moving the people towards greater independence. There was a great detail of emphasis placed on supporting people to live a healthy life with a high degree of safety.  Information on the HDC Code of Rights and advocacy is kept in the home. Staff when interviewed were aware of what they would do in the event of receiving a complaint. There were also contact details made available for the local health and disability advocate and opportunities for this person to come to the service to share information about the code.  **Safeguards**  Staff are familiar with service users and have a good understanding of areas of risk associated to health, mobility and behaviour. Where people have experienced challenging behaviour in the past there are behaviour support plans developed and safety plans on file. Staff have been trained on strategies to keep themselves safe including the effective implementation of behaviour support and safety plans. Where appropriate Mental Health services and external behaviour services may be engaged. Regular health and medication reviews take place.  There is an incident reporting process in-place that involves an online system. Incident management is discussed at the service during monthly staff meetings, although detailed minutes outlining incident report management was not evident.  There is a folder that contains information on health and safety management and infection control. Fire drills are taking place and there was information on site specific hazards. The physical layout of the homes promote access and people are able to move freely around the homes. The homes are well maintained  Staff have undertaken Career force training and are working towards a Level 4 qualification. There is an annual staff appraisal process in-place. Staff spoken to had appraisals during the year and felt supported by their manager. There appears to be a high level of competence and skill within the team.  **Rights**  Staff are aware what to do if they receive a complaint. As noted the HDC code of rights is in the homes and the HDC advocate also visits the homes. People are treated with respect and recordings are affirming of the individual. Families were kept informed and the service supports families to remain in touch.  **Health and Wellness**  People have their own GP, staff are trained in first aid and copies of first aid certificates are kept on staff files. Staff training records are kept at the main office and were sighted during the desk audit.  Staff are trained on the administration of medication and receive updates. Medication in pill form is ‘blister packed’ and liquid medications and creams are clearly labelled. There was however no master drug chart in any of the folders, there was also no PRN protocols for PRN medications and there was very little information detailing medication side effects.  Policies and processes are in place in relation to identifying suspected abuse and neglect. Staff were knowledge about what to do if they suspected service user abuse.  Administration and governance are provided through the iwi body Te Runanga o Toa Rangatira Incorporated. Annual reports and consolidated financial accounts are published on their web site. Summary of the Strengths of this Service:  * Staff interactions with service users. * Family connections. * Service users’ needs and preferences are central to the service. * Management of the service – supportive and responsive leadership by the Manager. * Presentation and maintenance of the homes. * Experienced and skilled staffing team. * Iwi links and cultural experiences.  Summary of Significant Findings:  * Personal plan’s timeframes and goals not tracked for progress. * Missing medication master drug charts, missing PRN protocols and side effect information.   . |

## Outline of requirements and recommendations (not including those relevant to support for specific individuals)[[1]](#footnote-1)

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| 1. Timeframes review dates included with personal goals 2. Information held in medication folders 3. Reconciliation of personal accounts |

## Recommendations

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| 1. More detailed information on discussions and strategies when responding to incidents 2. Structure of service user files. 3. Develop one consolidated support plan identifying all areas of support. 4. Consolidated health management plan. 5. Adjustments to home agreements |

1. Please see the [evaluation tool](http://www.health.govt.nz/our-work/disability-services/contracting-disability-support-services/developmental-evaluation-disability-support-services) for reference [↑](#footnote-ref-1)