

# The Consensus Approach to Service Evaluation: Team Composition and The Value of Team work

Christine Wilson<sup>1</sup> and Audrey Buel  
Standards and Monitoring Services, New Zealand

Standards and Monitoring Services (SAMS) has been carrying out qualitative evaluations of services for people within the disability sector for more than 25 years. The vast majority of these evaluations have been in the field of intellectual disability with a particular emphasis on group home settings. SAMS uses a consensus approach to conducting developmental evaluations on a number of key areas. The consensus approach is used to reduce the possibility of bias unduly influencing the results of an evaluation. SAMS has recently conducted a survey of teams using individual rating forms across a number of key indicators and then comparing these with the same rating form subsequently completed using a consensus approach. Preliminary results suggest that individual team members may provide quite different ratings on specific indicators and that the consensus may cause a shift in some of these ratings. These data will be discussed in terms of using ratings systems per se and with reference to the benefits of using teams when conducting service evaluations. The data will also be discussed in terms of team composition. In particular, a SAMS evaluation team will always include either a family member or a person with a disability (or both) who has been trained to conduct service evaluations.

Standards and Monitoring Services (SAMS) has been providing developmental evaluations of services supporting people with disabilities for over 25 years. Developmental evaluations differ from typical compliance style audits in as much as they are aimed at discovering what a service does well and building on this foundation to suggest areas where improvements can be devised. Developmental evaluations guide services to improve rather than impose corrective measures or solutions to particular issues that are discovered during the evaluation process. The evaluation process does not involve rigid checklists but rather relies on open-ended questions and investigative techniques aimed at discovering what is important to the individuals who use a particular service at that point in time. SAMS aims to work in partnership with the service and hopes that services will use the skills and knowledge of the Evaluation Team to their advantage.

Evaluations do not focus solely on quality of life issues, although these are integral to a successful evaluation. However, the subjective domain of formal quality of life tools is of limited value during service evaluations, as providing accurate measures would require the accurate responses of the individual who is using the service. In a large majority cases, the services under review are those catering to people with very high needs who cannot fulfill this requirement (Hatton, 1998). In addition, the alternate use of proxy raters on quality of life indicators is limited for a number of reasons. In particular, while the Teams interview as many family members as possible, many are not well connected with the individual concerned (at least on a day-to-day level), are absent entirely, or are unable to meet for face-to-face interviews because of distance, work obligations or for personal reasons. Front line staff are also

---

<sup>1</sup> Technical assistance for this paper was provided by Andrew Coleman, Senior Economist, Reserve Bank of New Zealand.

frequently transient in New Zealand so that providing a good pool of informants on subjective indicators is haphazard and unreliable. Furthermore, it is unclear from the literature whether secondary informants such as family members or front line staff are reliable (Cummins, 1998, 1996, cf., Schwartz and Rabinovitz, 2003). However, Schwartz and Rabinovitz (2003) have found some concordance in family member views on subjective indicators.

Subjective quality of life is also a measure that is related to the physical conditions of life. For instance, Cummings (2005) argues that the majority of individuals adapt to their personal circumstances and will, after a period of adjustment, fall within a specific range of subjective well being. This suggests that people appear well adjusted on subjective indicators but can live in circumstances that do not help them maintain or improve aspects of their personal or physical lives. Cummings (2005) maintains that it is when a crisis event occurs (e.g. loss of bodily function or loved one) or where extreme duress occurs that people will vary in their subjective ratings toward the negative end of the spectrum. He further argues that people who have disabilities are often less likely to maintain their equilibrium on subjective indicators (homeostasis), perhaps due to a history of frequent change, poor support networks and repeated failures (Cummins, 2005). Developmental evaluations frequently challenge service providers to move beyond merely providing the basic needs of life and moving toward a process that enables people to fulfill their dreams and aspirations, while at the same time reducing the experiences that cause a sense of failure or loss.

Developmental evaluations do focus on the type of indicators noted in the objective domain of quality of life scales, but these are done in relation to *what* a service is doing to improve the conditions of life for *each* of the individuals they support. Quality of life tools therefore have limited value when evaluators are attempting to advise services on how they can develop to better address the needs of the people they support.

The team consensus approach is used for two key reasons. Firstly, it reduces the potential of individual bias, especially when teams vary in terms of the individuals involved. Secondly, Team members will differ in background (for instance, family member, person with a disability, volunteer or professional), gender, age, experience with evaluations and culture. It is hoped that this variety of people with their varying perspectives will be united with the common purpose of improving the quality of services for the benefit of the people who use them (SAMS, 2007, see also Giangreco, Edelman, Luiseli and MacFarland, 1996). A central core of the consensus process therefore is effective facilitation, so that when the Team finally meets at the end of an evaluation to decide on the content of a report, the views of all the Team will be taken into consideration (SAMS, 2007). Consensus hinges on the assumption that no single individual will dominate the evaluation process. Thus, the purpose of this study is to determine whether the Team Leader or the Team Member will dominate the evaluation process and how the consensus moderates the views of either or both parties.

## Method

The evaluations undertaken in this research were for group homes for people with an intellectual disability. A small checklist was used that provided 29 indicators across a number of areas commonly focused on during developmental evaluations (see appendix two). These indicators were rated on a five point scale with an allowance to rate between points on the scale if desired (therefore a rating of 2.5 could be used for instance). The exceptions were the two indicators concerning advocacy in Table 1 were rated on a yes/no (1 or 2) basis. Many of the indicators were broad based, potentially containing a number of variables. During consensus meetings the full breadth of a particular indicator is discussed and the main issues, positive or in need of development, noted. A smaller checklist was preferred over a tool that attempts to provide for every facet of a service simply due to time constraints within the evaluation process. Furthermore, an “all encompassing” tool (if this were possible) would draw away from the developmental process and create an atmosphere where compliance was the focus. Thus while it is acknowledged that the smaller tool is hampered by the limitations of multivariate indicators, the style of tool used more closely resembles the developmental process.

Typically at the end of the data gathering process the Evaluation Team retires to begin discussions aimed at reaching a *general consensus* of what is important in the service under review. This discussion is guided by a checklist developed by the Ministry of Health<sup>2</sup>. In addition to this normal evaluation process, the Team members also separately completed the rating form devised for the study and left a space of time between these individual ratings and the consensus ratings (for instance, overnight, after lunch or after the general consensus process) and did not refer to their individual forms while completing the consensus ratings.

The homes reviewed during the research ranged from small dwellings for one or two people (or flats, n=11) to larger group homes three to five people (n=16). A small sub-sample were respite settings for children and young persons (n=6). The average larger home was for four to five individuals. The individuals who reside in these settings range in ability from semi-independent to individuals who rely on residential staff for most of their individual cares. In most cases the individuals living in these homes also attend activities during the week ranging from paid employment to day programmes ideally provided by a different agency. Evaluation Teams interview managers, as many staff and family members (or advocates) as possible, and visit the individuals themselves at their place of residence and, if possible, at their place of employment or their day programme. As well as the personal interviews the Team reviews such things as documentation, health and safety issues, management practices, advocacy issues and looks at the physical setting.

This study is based on 33 homes visited so far. There are four different Team Leaders (two family members and two professionals) and a variety of different Team Members, all of whom were family members.

An Evaluation Team typically spends around one day in the field per home (of four-five people) with time set aside for Team meetings (i.e. consensus) and a verbal feedback to the service. Both the Team meeting and the verbal feedback would often

---

<sup>2</sup> Typically SAMS checklist are developed in partnership with people who have disabilities, their families, service providers, umbrella groups and funders.

fall on the morning of a second day for a single house evaluation. It is more likely that a Team will visit two houses during a single evaluation. Therefore, for the purposes of this study a rating form is completed for each house visited (individually and during a consensus)

## Relative importance of the Teal Members and Team Leaders

It is of interest to know if Team Members and Team Leaders are equally important in the consensus process. This can be tested formally using regression analysis to ascertain the relationship between the consensus ratings and the two individual ratings. Let

$Y_i$  = consensus rating on a question at the  $i$ th house;  
 $X_i^L$  = Team Leader rating; and  
 $X_i^M$  = Team Member rating.

If the consensus rating was the simple average of the two ratings, then

$$Y_i = 1/2 X_i^L + 1/2 X_i^M$$

In general, the rating can be expressed as a weighted average of the two ratings, with weights  $\alpha^L$  and  $\alpha^M$ , plus a “bias factor”  $\alpha^0$  and an idiosyncratic “error” term  $e_i$ :

$$Y_i = \alpha^0 + \alpha^L X_i^L + \alpha^M X_i^M + e_i$$

The bias factor is the extent to which the consensus process leads to a lower or higher rating than the simple average. This might occur, for instance, if the Team Leader and the Team Member saw different aspects within a specific indicator and when each recognized a new issue in the consensus process they reduced the consensus rating below either individual rating. The “error term” reflects any other factor that leads the consensus rating to differ from a simple weighted average of the individual scores. This would occur if in the consensus process the Leader and Team Member discuss matters in a way that goes beyond the individual summary scores.

A regression can be used to estimate the weights  $\alpha^L$  and  $\alpha^M$ , the bias  $\alpha^0$  and the fraction of the variance in  $Y_i$  that reflects the idiosyncratic terms. In Table 1 below the weights are reported, along with their standard errors and the  $R^2$  of the regression (the fraction of the variance of the consensus rating that can be explained by the weighted average). In addition we report the tests of the following two hypotheses.

Hypothesis 1:  $\alpha^L = \alpha^M$  ;

Alternative hypothesis:  $\alpha^L \neq \alpha^M$

This hypothesis is that the weights on the Team Leader and the Team Member used to construct the consensus rating are the same. If  $\alpha^L - \alpha^M > 0$  it means the Team Leader’s view is more important. The hypothesis is examined using a t-test to ascertain whether  $\alpha^L - \alpha^M$  is statistically different from zero or not.

Hypothesis 2:  $\alpha^L = \alpha^M = 1/2$ ;

Alternative hypothesis:  $\alpha^L \neq \alpha^M$

This hypothesis is that the consensus rating is best described as a simple average of the Team Leader's and Team Member's scores, with a possible allowance for a bias factor. The alternative is that there is a better weighting scheme. The hypothesis is examined using an F-test to ascertain whether the regression explains a significantly greater fraction of the variance of the consensus score than the simple average.

## Results

The above regression was estimated for 29 separate questions. Results for twelve of these questions where there is some variation in the weightings of the Team Leader and the Team Member are shown in Table 1, along with the result for one question where the consensus is a simple average, *physical setting*. In this case the Team Member and the Team Leader both have a weighting coefficient very close to 0.5, and a bias factor (intercept) of nearly zero. Thus the null hypothesis  $X^L_i = X^M_i = 1/2$  cannot be rejected.

In twelve cases the consensus is not simply explained by a simple average of the two independent raters, as indicated by the F tests. However, in nine cases the Team Leader is much more influential than the Team Member. This is clearly demonstrated where *rights* is considered. In this question the Team Leader has a weight of 1.08,  $t(8.57, p < 0.001)$  compared with 0.11 for the Team Member. The difference between the Team Member and the Team Leader weights equals -0.96 and is significantly different from zero with a t-statistic of -5.24 ( $p < 0.01$ ). Thus the hypothesis  $\alpha^L - \alpha^M = 0$  can be rejected for this indicator. (Note in this case there is a negative bias factor of -1.01 indicating that the consensus is typically one point lower than the weighted average between the two individuals).

In three cases the Team Member seems to demonstrate more influence but for the indicator concerned with *family member partnership* in the service structure the consensus is not significantly different from the average between the two independent raters with a t-statistic of -1.27. In addition, the indicator concerned with involvement in *self-advocacy* was a two point scale only, had poor variance and was the most infrequently rated indicator with a sample size of only 22 responses. The remaining indicator where Team Members did have most influence concerned involvement with domestic activities in the home. In this case family members appeared to have more influence and the bias error suggests that when the Team Leader and Team Member met for consensus the rating fell by 1.02 points on the scale compared with the average between the two raters. This suggests that the Team Member and the Team Leader brought different information to the consensus and this information reduced the final rating on this indicator.

In five cases the intercept suggests that there is a significant difference from the weighted mean of the ratings from the Team Member and the Team Leader. This shift suggests that the consensus was influential in shifting the rating in each of these cases regardless of the influence of either the Leader or TM.

	$\alpha_0$ Intercept <sup>3</sup>	$\alpha_L$ Leader <sup>4</sup>	$\alpha_M$ Member	R <sup>2</sup>	H <sub>1</sub> t-test <sup>5</sup>	H <sub>2</sub> F-test <sup>6</sup>
Group or 1:1	0.41 (0.27)	0.62** (0.08)	0.23* (0.09)	0.81	-0.40 (-2.66)*	6.21 (0.006)**
Dignity	-0.87 (0.65)	0.95** (0.13)	0.22 (0.14)	0.73	-0.72 (-3.12)**	6.16 (0.006)**
Communication	0.46 (0.48)	0.72** (0.14)	0.10 (0.14)	0.66	-0.62 (-2.54)*	4.24 (0.03)*
Fire Drills	0.67* (0.25)	0.65** (0.09)	0.24* (0.09)	0.90	-0.40 (-2.41)*	4.95 (0.02)**
Medications	-1.14** (0.39)	0.81** (0.08)	0.42** (0.06)	0.86	-0.39 (-3.45)**	7.13 (0.003)**
Strategic Plan	-0.005 (1.33)	0.77** (0.10)	0.22* (0.10)	0.98	-0.56 (-2.97)*	5.21 (0.02)**
Outside Advocacy	0.12 (0.21)	0.74** (0.11)	0.20 (0.12)	0.81	-0.52 (-2.71)*	3.68 (0.04)*
Integration	0.50 (0.30)	0.62** (0.13)	0.19 (0.11)	0.68	-0.43 (-1.99)*	4.88 (0.02)**
Rights	-1.01 (0.57)	1.08** (0.13)	0.11 (0.10)	0.78	-0.96 (-5.24)**	13.71 (.001)**
Self Advocacy N=22	0.16 (0.27)	-0.16 (0.25)	1.00** (0.29)	0.50	1.16 (2.25)*	3.54 (0.05)**
Domestic Activities	-1.02* (0.37)	0.47** (0.10)	0.78** (0.10)	0.84	-0.32 (-2.00)*	5.26 (0.01)**
Family Partner.	1.64* (0.67)	0.16 (0.13)	0.40** (0.14)	0.81	-0.24 (-1.27)	4.08 (0.03)**
Physical Setting	-0.02 (0.37)	0.50** (0.10)	0.49** (0.09)	0.81	-0.007 (-0.04)	0.002 (1.00)

Table One: Significance tests for those indicators that show significant results where, \* $p < 0.05$ , \*\* $p < 0.01$  and \*\*\* $p < 0.001$

## Discussion

For twelve of the 29 indicators in the rating form, independent raters were sufficiently different from each other and the consensus ratings that if they were conducting the same evaluation independently of each other they would have produced reports that may have focused on distinctly different variables. Consensus allowed each member of the Evaluation Team to bring their distinct knowledge together, and amend the consensus rating. In five of these cases the *extent* of the difference from the weighted mean between the two independent raters was significant. Thus, new information during consensus may shift the rating either higher or lower depending on the content

<sup>3</sup> Bias factor (intercept) = difference from mean rating of Team Member and Team Leader

<sup>4</sup> Each cell signifies the coefficient and the (standard error)

<sup>5</sup> The difference between  $\alpha^L$  and  $\alpha^M$  with the (*t* statistic)

<sup>6</sup> The F statistic with its relative (significance)

of that information. These results clearly demonstrate that the use of teams that require a consensus at the end of the evaluation process provide a richer source of information that may be more accurate in the long run, than conducting evaluations with just one person.

There is an assumption when using the consensus approach that in a perfect world each member of the Team would have equal influence and one would not dominate the other to the point that the views of one person are completely lost. For 17 of the indicators in the checklist this partnership was suggested to occur *and* each member of the Team had the same level of information for each of those indicators (see appendix one, table 2). It also suggests that for these indicators the members of the Evaluation Team could have separately conducted an evaluation on the same indicators and produced the same results. However, in these cases both members of the Team would have had to ask the same questions, interviewed the same people and witnessed the same observations, probably at the same point in time.

The apparent dominance of the Team Leader in nine of the indicators is difficult to explain. However, experience may be key issue involved in these instances. It may also be the case that some role division may occur during evaluations so that it may be the Team Leader who is checking the fire drills and procedures, and it may be the Team Leader who is checking the Strategic Plan and the Medication protocols and procedures. It is also possible that the Team Leader has a better understanding of what should be in a Strategic Plan. However, even in these three cases the research shows that the Team Member is not without influence when the independent rating forms were compared with each other and the consensus.

Team Leaders show clear dominance in four indicators (rights, communication, dignity and integration). *Rights* and *dignity* may be related in many ways but in others they are not. During evaluations the Team is interested in how staff relate to each person and how they refer to them in written and spoken references. They are also looking for instances where rights may be violated or where people are treated in undignified ways. Furthermore, each home must be able to provide a statement of rights in a manner that is accessible to everyone in the home and/or their family members, guardians and/or advocates. It is unclear why the Team Members are less influential when it comes to these indicators. They should, in theory have heard or seen the same information as the Team Leaders. The same could be said for integration. Communication is an indicator that focuses on individuals who require extra assistance in order to communicate their needs. The relative expertise of the Team Leaders in this case may be a reason why the Team Leader dominated the ratings for this indicator. One Team Leader for instance is an expert in this field and it is possible the Team Member simply deferred to this person during consensus.

Team Members were showing influence in seven of the indicators in table 1, but were more influential than the Team Leaders in three areas. This is most strong when self-advocacy is considered despite the small sample size, poor variance and the two point indicator. It could be an advantage here to extend the *involvement in self-advocacy* question to include a five-point scale. Family members definitely rank *family member partnership in the decision making processes within the service* differently from the Team Leader and seem to have more influence. The almost 1.5 increase in rating points from the weighted average between the independent raters suggests that a great

deal of discussion occurred on this issue during consensus and probably new information was introduced by either or both parties. A similar trend is noted for involvement in domestic activities around the home, although in this case the Team Leader was also influential, yet not as strongly as the Team Member. In this case a reduction in rating score of around one point occurred as a result of the consensus. It may be the case, that family members are much more specific about what domestic activities people can, and perhaps should, be involved with in their own home.

It is hoped that as more evaluations are completed for this study comparisons can be made in terms of particular Team Leaders and the experience of Team Members in the evaluation process. In some cases for instance, Team Leaders are also family members of people with disabilities and bring quite a different set of skills and knowledge to the process compared with Team Leaders who have come from a purely professional background. Furthermore, particular indicators could ask the members of the Team for more specific descriptions or rationales of why particular ratings were made. In other words, what specific knowledge did they have about a particular indicator that may be different from the other member of the Team. For example, did the Team Leader or Team Member physically check the medication procedures and report to the other member of the Team, did they fail to report to the other person prior to consensus or did they both review the procedures together? There could also be space to record whether the individual felt they had enough information to be successfully rating a particular item.

As the research progresses there will also be space to compare the type of dwellings that are under review and the composition of the group within a home. For instance, are the flats for one or two individuals who are semi-independent producing more variation in ratings than homes for people with very high support needs in larger environments? Or are homes for older, “retired” individuals producing more or less variation in the ratings between individual team members when compared with each other and the consensus?. Furthermore, the tenure of the staff who are supporting individuals may have an influence on the views of the individual team members. A larger sample of cases can address many of these questions.

As noted in the introduction, this study could be limited by the type of rating form that was used. The interpretation of particular indicators may be multifaceted because issues such as *rights* concern more than just posting a rights statement on the wall or searching for instances when rights may be violated. Even in this latter case the views of individual members of a Team may vary. However, it is also suggested that it is extremely difficult to create rating forms for a process that is developmental in nature. Issues such as *rights* can be complex and this provides the richness of information Teams use to assist services in developing positively for the good of the people they support.



## References

- Cummins, R.A. (1996). The domains of life satisfaction: an attempt to order chaos. *Social Indicators Research*, 38, pp. 303-28.
- Cummins, R.A. (1998). *Measuring subjective life quality by proxy response*. Paper presented at the Australian Society of the Study of Intellectual Disability National Conference, Adelaide, South Australia, 28 September 1998.
- Cummins, R.A. (2005). Moving from the quality of life concept to theory. *Journal of Intellectual Disability Research*, 49(10), pp. 699-706.
- Giangreco, M.F., Edelman, S.W., Luiselli, T.E., and MacFarland, S.Z.C. (1996). Support Service Decision making for students with multiple service needs: Evaluative data. *Journal for the Association of Persons with Severe Handicaps (JASH)* 21 (3), pp. 135-144.
- Hatton, C. (1998). Whose quality of life is it anyway? Some problems with the emerging quality of life consensus. *Mental Retardation*, 36 (2), pp. 104-115.
- SAMS, (2007). *The SAMS Manual: Values, Protocols, Processes, Procedures and Resources*. In house publication.
- Schwartz, C. and Rabinovtiz, S. (2003) Lifes satisfaction of people with intellectual disability living in community residences: perceptions of the residents, their parent and staff members. *Journal of Intellectual Disability Research*, 47(2). Pp. 75-84

## Appendix 1

	$\alpha_0$ Intercept <sup>7</sup>	$\alpha_L$ Leader <sup>8</sup>	$\alpha_M$ Member	R <sup>2</sup>	H <sub>1</sub> t-test <sup>9</sup>	H <sub>2</sub> F-test <sup>10</sup>
Personal Planning	-0.03 (0.26)	0.44** (0.16)	0.55** (0.1609)	0.891	0.11 (0.35)	0.08 (0.92)
Link personal goal to service goals	0.06 (0.25)	0.61** (0.08)	0.37** (0.07)	0.88	-0.23 (-1.75)	1.63 (0.21)
Support is 1:1 on personal goals	0.24 (0.48)	0.43** (0.13)	0.49** (0.12)	0.63	0.06 (0.31)	0.20 (0.82)
Service user partnership	-0.02 (0.47)	0.58** (0.12)	0.42* (0.15)	0.72	-0.15 (-0.63)	0.21 (0.81)
Maori / cultural	-0.03 (0.51)	0.46* (0.18)	0.51** (0.12)	0.78	0.08 (0.31)	0.09 (0.91)
Staff Training	-0.16 (0.29)	0.60** (0.09)	0.45** (0.10)	0.87	-0.15 (-0.84)	0.74 (0.49)
Privacy	-0.05 (0.77)	0.67** (0.17)	0.32* (0.15)	0.52	-0.35 (-1.30)	0.88 (0.43)
Age Appropriate	-1.13 (0.77)	0.47** (0.17)	0.54** (0.12)	0.57	0.33 (0.74)	0.06 (0.94)
Choice at home	-0.17 (0.48)	0.58** (0.11)	0.45** (0.12)	0.70	-0.13 (-0.72)	0.27 (0.77)
Choice housemates	0.05 (0.13)	0.38** (0.13)	0.61** (0.13)	0.97	0.23 (0.95)	0.45 (0.64)
Harmony in home	-0.51 (0.67)	0.41* (0.15)	0.74** (0.18)	0.64	0.33 (1.20)	0.84 (0.45)
Complaint procedures	-0.51 (0.59)	0.67** (0.09)	0.42** (0.10)	0.72	-0.25 (-1.31)	0.93 (0.41)
Civil Defense preparedness	0.38 (0.69)	0.56** (0.11)	0.35** (0.11)	0.59	-0.21 (-1.25)	0.92 (0.41)
Crisis Procedures	-0.19 (0.32)	0.55** (0.09)	0.49** (0.08)	0.88	-0.06 (-0.41)	0.16 (0.85)
Record Keeping	-0.24 (0.41)	0.44** (0.11)	0.59** (0.09)	0.80	0.14 (0.81)	0.45 (0.04)
Transport	0.02 (0.42)	0.50** (0.14)	0.47** (0.12)	0.77	-0.03 (-0.11)	0.05 (0.95)
Physical Setting	-0.02 (0.37)	0.50** (0.10)	0.49** (0.09)	0.81	-0.007 (-0.04)	0.002 (1.00)

Table Two: Significance tests for those indicators that show non-significant results in both *t* test and F tests. \* $p < 0.05$ , \*\* $p < 0.01$

<sup>7</sup> Bias factor (intercept) = difference from mean rating of Team Member and Team Leader

<sup>8</sup> Each cell signifies the coefficient and the (standard error)

<sup>9</sup> The difference between  $\alpha^L$  and  $\alpha^M$  with the (*t* statistic)

<sup>10</sup> The F statistic with it relative (significance)

## Appendix 2

### Rating Form for Team Leaders

ONE OF THESE FORMS NEEDS TO BE COMPLETED FOR EACH HOUSE EVALUATED

FILL OUT EACH SECTION

1. **SERVICE TYPE** i.e. the primary service being delivered, Circle one:

Residential

Family/whanau

Other: \_\_\_\_\_ (State)

2. **SERVICE NAME (LEGAL ENTITY)** .....

**ADDRESS:** .....

**DATE OF EVALUATION VISIT** ...../...../.....

**SAMS TEAM LEADER** .....

3a. **Service Users.** Men/boys: \_\_\_\_\_ Ages \_\_\_\_\_ Retired: # \_\_\_\_\_

(Numbers) Women/Girls: \_\_\_\_\_ Ages \_\_\_\_\_ Retired: # \_\_\_\_\_

Maori: \_\_\_\_\_ Pakeha/European: \_\_\_\_\_

Pacific Island: \_\_\_\_\_ Asian: \_\_\_\_\_ Other: \_\_\_\_\_

3b. **Number of high needs service users:** physical \_\_\_\_\_ Behavioural/mental health: \_\_\_\_\_  
Other: \_\_\_\_\_

4. **Staffing hours: (House per fortnight)** \_\_\_\_\_  
(vocational/retirement at home hours if any) \_\_\_\_\_

5: **Number with a current individual plan (regardless of condition):** \_\_\_\_\_

6: **Is a recommendation pending for individual plan/IP process etc? Yes No**



**C.1 Service user partnership**            1            2            3            4            5

*The service enables partnership with disabled people (processes are implemented that involve service users in: Policy development; staff selection and review; internal monitoring)*

- 1=No formal involvement
- 2=Occasional informal involvement in some processes
- 3=Regular informal or occasional formal involvement in some processes
- 4=Regular formal involvement in most processes
- 5=Formal involvement in all processes
- Formal**=policy and procedures detail involvement and this is implemented

**C.2 Family/guardian partnership**    1            2            3            4            5

*The service enables partnership with significant others (processes are implemented that involve family/whanau/guardians &/or advocates in: Policy development; staff selection and review; internal monitoring)*

- 1=No formal involvement
- 2=Occasional informal involvement in some processes
- 3=Regular informal or occasional formal involvement in some processes
- 4=Regular formal involvement in most processes
- 5=Formal involvement in all processes
- Formal**=policy and procedures detail involvement and this is implemented

**D.1 Involvement with Maori/lwi**    1            2            3            4            5

Strongly

Nil      Token      Some      Encouraged      Encouraged

- 1=Maori issues are no not appear important or relevant to the service.
- 2=The service has some understanding of cultural needs but no formal processes, poor/no training, few/no Maori staff, and no contact with local lwi
- 3=The service has attempted to cover some of the points in 5 but only beginning to formalise.
- 4=The service attempts to cover many of the points in 5
- 5= Ideally - Maori issues and practices are strongly encouraged within the service. Contact with local lwi is established and functional. Formal processes are documented and training in Treaty and cultural issues recorded as completed. Maori staff are specifically employed to work alongside Maori service users.

**E.1 Staff training**                            1            2            3            4            5

Insufficient      Barely meets      Okay      Good      Advanced

Needs

**E.2 Retention:** List the number of months or years (state which) each staff member has Worked in the house (if known, if not known write "NK")

Staff one: Level 4/house leader \_\_\_\_\_      Staff four: \_\_\_\_\_

Staff two: Next most hours \_\_\_\_\_      Staff five: \_\_\_\_\_

Staff three: \_\_\_\_\_      Staff six: \_\_\_\_\_

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**F.1 Privacy respected**  
*(Confidentially respected, documentation secured, own bedroom, private use of telephone, mail respected, physical privacy respected (bathroom/toilet, bedroom: doors kept closed, people knock and wait for answer etc, individuals not “discussed” publically)*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**F.2 Rights protected**  
*(A statement of rights is readily available and accessible to all stakeholders. It includes information on seeking formal advocacy and how to make a formal complaint.*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**F.3 Age appropriate**  
*(Staff and managers treat and refer to people in manner appropriate to their age. The décor of the home and the activities that are encouraged in the home (and outside) are age appropriate, with the exception of the distinct choices of the individuals themselves).*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**F.4 Dignity respected**  
*(Dignity refers to the manner in which people are treated and referred to by others. Individuals are presented in a dignified way, privacy in bathrooms and bedrooms is respected, guidance with regard to sexual expression is encouraged).*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**G.1 Choice (generally at home)**  
*(e.g menus, roster, outings, clothing, bedtimes, bath times)*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**G.2 Choice of house mates**  
*(New people introduced gradually and move in with acceptance of all concerned, family and/or guardians involved in process)*

	<b>Not at all</b>	<b>Poorly</b>	<b>Okay</b>	<b>Well</b>	<b>Very Well</b>
	1	2	3	4	5

**G.3 Harmony in the home**  
*(how well do people get along?)*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**G.3 Complaints process**  
*(There is a complaints procedure that is accessible and available to all staff and stakeholders. All stakeholders understand how the complaints process works. The system has been used successfully in the past. There is no fear of recrimination)*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**H.1 Augmented Communication**  
*(For individuals who require assistance with alternate forms of communication, (e.g. sign, pic systems, communication books etc). The systems are well documented in individuals files and accessible to all staff and significant others (family, friends, frequent visitors etc). Staff are trained in each individuals particular form of communication. Communication is a feature of the individuals personal plan.*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**I.1 Fire/earthquake drills**  
*(Fire and earthquake procedures are visible and understood by all, fire drills are practiced at regular intervals and records are easily accessible, fire safety equipment is available, accessible, in good condition, and checked regularly. Staff understand how to use equipment)*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**I.2 Civil emergency preparedness**  
*(There are Civil Emergency procedures that are up-to-date and understood by all stakeholders. The service has a plan for such emergencies. The home has at least one weeks food provisions, water is stored and refreshed at regular intervals, the home has a civil emergency kit (torches, matches, first aid, batteries, radio etc), Pandemic Planning has been considered and/or documented).*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**J.1 Crisis procedures**  
*(Staff understand what to do in crisis. Appropriate procedures are noted and are accessible. Emergency contact numbers are easily accessible. Individual files contain risk assessments and actions to be taken (including behaviour support plans). Risk assessments are reviewed at regular intervals, incident reports are completed appropriately, they are up-to-date and responded to by management. Incidents are reported and discussed at staff meetings)*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**K.1 Medication procedures**  
*(Medications are securely stored at all times, staff are trained in medication competency, specific training is provided where needed, each medication chart is appropriately completed and is medication stored in blister packs (ideally) or separated from others as appropriate. Errors are appropriately recorded in incident forms and appropriate procedures taken in the event of errors)*

	<b>Very Poor</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**L.1 Record keeping**  
*(Records are clear and concise. Personal files contain and up-to-date photograph, emergency information, risk assessments, support needs and/or care plans, personal plans, recent and relevant medical information (e.g. visit to dentists and doctors in past year), current financial information if relevant. Personal files do not contain information that is best archived and information is easy to find and process. Daily notes are kept and are sufficient, relevant and clear. House and agency information is accessible, concise and clear)*

	<b>None</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**M.1 Strategic Plan**  
*(The service has an up-to-date Strategic Plan and is able to link the plan to the resources noted in personal plans)*

	<b>Very Poor</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**N.1 Physical setting**  
*(The physical setting is in good repair, spacious, sufficient for the needs of the people who live there (e.g. wheelchair accessibility etc.), well heated, in a regular neighbourhood, indistinguishable from other houses in the area, close to main centres etc)*

	<b>Very Poor</b>	<b>Poor</b>	<b>Okay</b>	<b>Good</b>	<b>Excellent</b>
	1	2	3	4	5

**O.1 Transport**  
*(Vehicles are provided as needed, use of public transport is encouraged where this is possible, staff have relevant licenses, security while transporting individuals with behaviour support needs is considered, relevant restraint documentation is in personal files where this is relevant)*

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
	1	2	3	4	5

**P.1 Involved in domestic activities at home**  
*(Individuals are involved in the domestic activities of the home wherever possible. Staff encourage involvement and do not tend to do things themselves simply because it is quicker or easier, staff attempt to minimise failure and take corrective actions at appropriate times (e.g. remake a bed after the person has left for the day). Individuals are involved in tasks the enjoy most)*

**Q.1 Are external advocates needed  
for one or more individuals  
where there is currently none**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

*(E.g. no family members involved in person's life, and/or is formal external advocacy needed in some situations)*

**Q.2 Are one or more individuals  
involved in self-advocacy activities**  
(E.g. *People First*)

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If none, is this due to:

**Ability** \_\_\_\_\_ **Choice** \_\_\_\_\_ **Other** \_\_\_\_\_