Official Community Visitors

Annual Report 2004–05 Annual R

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Contents

Official Community Visitor data for 2003–04 and 2004–05 is available. The NSW Ombudsman assumed responsibility for the oversight and co-ordination of the scheme for the first full year in 2003–04. Previously the former Community Services Commission was responsible for the oversight and co-ordination of the scheme.

Case examples are used throughout this report, however names have been omitted to protect people's privacy.

For more information or a copy of the Ombudsman's Annual Report 2004–05, contact the Team Leader, Official Community Visitor Team, on 02 9286 1000, toll free on 1800 451 524, or you can download the report from the Ombudsman's website www.ombo.nsw.gov.au.

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Letter to the Ministers

Minister John Della Bosca

Minister Reba Meagher

Official Community Visitors

The Hon John Della Bosca, MLC
Minister for Disability Services
Minister for Ageing

The Hon. Reba Meagher, MP
Minister for Community Services

Dear Ministers

I am pleased to submit to you the tenth Annual Report for the Official Community Visitor scheme for the 12 months to 30 June 2005, as required under section 10 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

I draw your attention to the requirement in the legislation that you lay this report, or cause it to be laid, before both Houses of Parliament as soon as practicable after you receive it and before Parliament rises.

Yours sincerely

Bruce Barbour
Ombudsman

Message from the Minister

Minister John Della Bosca

Throughout the year, Community Visitors continued to play a major role in the lives of people with a disability – providing independent oversight of how services and supports were being delivered by both government agencies and non government institutions.

Community Visitors were able to identify many issues that impacted upon these people's lives, some of whom are the most vulnerable members of our community.

The fact is, people with a disability are now living longer, ageing carers need more support, and medical advances mean babies born with complex disabilities are more likely to survive, as are people seriously injured in accidents.

With this in mind, the Government and communities at large need to constantly work together to improve the disability service system, and to this end, Community Visitors play a key role.

Once again, the work of Community Visitors was greatly appreciated and contributed enormously to the ongoing well being and quality of life of these people.

This annual report details the important work Community Visitors carried out and reminds us of their vital role in this area of disability support.

I would like to thank all Community Visitors for their dedication and special efforts during the year.

John Della Bosca MLC

Message from an Official Community Visitor

Liz Rhodes

By Liz Rhodes

In reflecting on the last year I feel that the description of it being possible to move a mountain stone by stone, one at a time, sums up the past two years that I have been an Official Community Visitor.

I visit a number of services across two metropolitan regions, including large government and non-government institutions housing a mix of clients. In addition I visit a diverse cluster of boarding houses and a mix of group homes from both the government and non-government sector. This allows me the opportunity to see a number of innovative and imaginative ways in which services are provided and demonstrates that interpretation of the Disability Services Act and Standards varies.

The large residential institutions that I visit are undergoing a number of changes and are continuing to work to improve the lives of the people they care for. Visitors are contributing regularly to discussions about the lives of those clients. This is done both as part of the regular visits and in scheduled meetings with senior management.

Visitors are witnessing at first hand, the development of meaningful activities on an individual and group basis within these institutions. One example is the development of an in-house craft/ activity centre, providing recreation for the clients who live there. This allows for activities to match the interests and abilities of the clients. It also caters for the people who are more frail and ageing to enjoy recreation that best suits their needs. It is wonderful seeing the interest and pride that people have in themselves now this has been established. Smiles on the faces of people who have a range of communication skills demonstrate the success of the program.

People who live in licensed boarding houses do not have access to the lifestyles we take for granted, and so the Visitor's approach must differ. As some of the clients who live in this type of care are wary of any new person in their lives, it understandably takes time to win their trust and respect. Ways of identifying and resolving issues to improve the quality of their lives are not always immediately evident.

As an example, a number of men who live in a boarding house were requesting fresh and varied fruit as part of their meals, which the management had been providing infrequently and in quite limited amounts. As part of the Visitor's discussions with management, this request was agreed to, and the men are now enjoying more variety in their diet.

The time that I have spent visiting has reaffirmed to me that the scheme, with its capacity to allow Visitors to negotiate and raise issues on behalf of residents and people in care, is vital. Having an independent person, whose clear aim is to make a difference and enhance the quality of life of people who sometimes have no other voice to request support or change, is necessary.

Being a Community Visitor brings its own rewards in seeing the differences that can be made to the lives of people we visit.

Message from the Ombudsman

Mr Bruce Barbour
NSW Ombudsman

Official Community Visitors play an important role in monitoring the quality of care provided to more than six and a half thousand children and people with a disability who live in government and non-government residential services in NSW. My staff often refer to Visitors as the 'eyes and ears' of the Ombudsman because they are able to see and hear first hand what people living in these services are experiencing.

In her message in this report, Liz Rhodes speaks of the innovative and imaginative ways in which services strive to improve the care and circumstances of residents. I join with the Visitors in acknowledging the work of community service providers. However, this report also demonstrates the critical role played by Visitors in identifying when services are not meeting the needs or protecting the human rights of residents.

This year Visitors and staff from my office have increasingly worked together in addressing concerns about services, including pursuing significant systemic issues affecting people in care. I would like to thank the Visitors for their willingness to work with my staff and for their ongoing endeavours in identifying and resolving a broad range of concerns about service provision.

Bruce Barbour
Ombudsman

Year in summary

Visitable services

Official Community Visitors visit accommodation services for children, young people, and people with a disability that are operated, funded or licensed by the Department of Community Services (DoCS) or the Department of Ageing, Disability and Home Care (DADHC), and where residents are in full-time care. At 30 June 2005, there were 1,218 visitable services in NSW accommodating 6,538 children, young people and people with a disability.

Visits conducted

During the year, Official Community Visitors made 2,776 visits to 987 visitable services, representing 81% of the total number of visitable services.

Services to children and young people

There are 119 out-of-home care services that are visitable, accommodating 263 children and young people. During the year, Visitors made 363 visits.

Services to children and young people with a disability

There are 73 visitable services, accommodating 395 children and young people with a disability in out-of-home care services. During the year, Visitors made 238 visits.

Services to adults with a disability

There are 962 visitable services accommodating 4,910 adults with a disability. During the year, Visitors made 2,175 visits.

Services to adults in licensed boarding houses

DADHC reports that there are 57 licensed boarding houses accommodating up to 1,058 adults with a disability. During 2004-05, Visitors made 288 visits to 970 residents.

Key issues about service provision

Visitors reported 2,810 concerns about service provision during the year. Of these, 1,365 (49%) were recorded as resolved. Visitors report to the Ombudsman using various categories, and the major service provision concerns for all services were:

- implementation and development of plans to meet the individual needs of residents (Individual Planning) — 432 (15%)
- nutrition, hygiene and health care — 325 (16%)
- environment and facilities — 283 (10%)
- management response to service concerns — 242 (9%)

Other frequently raised matters concerned residents' access to family and friends, behaviour management, access to community facilities, and residents' safety in care.

Our role

Objectives and legislative framework

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and Regulation established the Official Community Visitor scheme to monitor the quality and conduct of accommodation services for children, young people and people with a disability in care in NSW. The Minister for Disability Services and Minister for Community Services appoint Official Community Visitors on the recommendation of the Ombudsman for up to six years. The NSW Ombudsman oversees and coordinates the scheme.

The Visitors and the Ombudsman work together to resolve problems on behalf of residents, and to promote their legal and human rights.

Visitors must have appropriate knowledge and expertise in community welfare, and be skilled in problem solving. They are independent of the Ombudsman, and must not be employees of the Department of Community Services or the Department of Ageing, Disability and Home Care.

The 2004-05 year began with 18 Visitors; two left during the year, and another 12 Visitors joined the scheme. The 2005-06 year will start with 28 Visitors.

The Visitors' functions are to:

- inform the Minister and the Ombudsman about the quality of accommodation services
- promote the legal and human rights of residents
- act on issues raised by residents
- provide information
- help resolve complaints.

The Ombudsman's functions in relation to the scheme are to:

- recommend eligible people to the Minister for appointment as Visitors
- determine priorities for the services provided by Visitors
- investigate matters arising from Visitors' reports
- convene meetings of Visitors
- report to the Minister.

Visitable services

A *visitable service* under CS-CRAMA is an accommodation service operated, funded or licensed by the Department of Community Services or the Department of Ageing, Disability and Home Care, and where residents are in full-time care.

In June 2005 there were 1,218 services in NSW accommodating 6,538 children and young people, people with disabilities, and people in licensed boarding houses.

Powers and obligations of Official Community Visitors

Official Community Visitors have the authority to:

- enter and inspect a service at any reasonable time
- talk in private with any resident or person employed at the service
- inspect any document that relates to the operation of the service
- report on matters relating to the conduct of the services.

While undertaking their work, Visitors are required to respect residents' privacy, seek residents' views before inspecting relevant documents, where possible, and only disclose confidential information when there is a good reason.

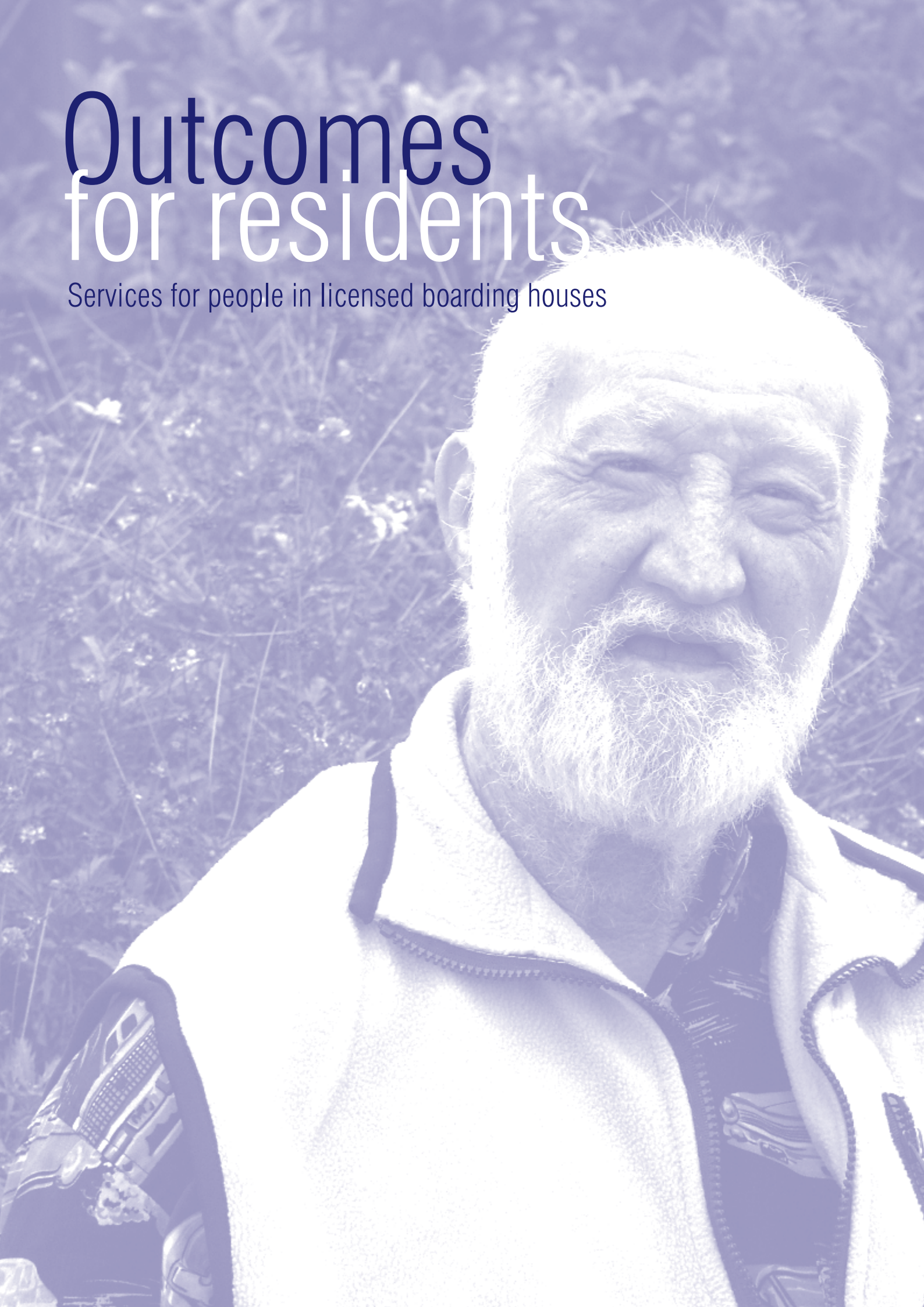
In coordinating the scheme and allocating resources, the Ombudsman focuses on people who are least likely to complain and protect their own interests, and ensures that information and resources are used as effectively and efficiently as possible. The Ombudsman uses reports from Visitors to assist monitoring the accommodation services sector and to determine priorities for resolving individual and systemic issues for people living in full-time care.

The Ombudsman has established an Official Community Visitor Team within the Community Services Division. The Team has responsibilities for:

- the day-to-day operation and administration of the scheme
- supporting and assisting Visitors to respond to matters for people living in visitable services
- facilitating a coordinated response between Visitors and the Ombudsman to individual and systemic concerns affecting residents of visitable services, including identifying those requiring Ombudsman complaint action in consultation with Ombudsman complaints staff
- working strategically with Visitors and other Ombudsman teams to promote the scheme as a mechanism for protecting the human rights of people in care.

Outcomes for residents

Services for people in licensed boarding houses



Outcomes for residents
Services for people in licensed boarding houses

DADHC licenses boarding houses under the *Youth and Community Services Act* 1973 (YACS Act) to provide accommodation for people with disabilities. Licensed boarding houses operate as private-for-profit businesses. Boarding house proprietors are not funded to provide services and charge residents for rent, meals and other basic amenities. In addition to its licensing and monitoring role for boarding houses, DADHC funds Home Care and other agencies to provide support services for residents, such as personal and health care and community participation activities.

DADHC reports there are 57 licensed boarding houses in NSW, accommodating up to 1,058 residents. During 2004-05 Visitors visited 970 residents. Residents of licensed boarding houses have a variety of support needs, including intellectual and psychiatric disabilities, alcohol related brain damage and physical disabilities such as Huntington's chorea.

Although there are a small number of licensed boarding houses compared to all visitable services, most accommodate a large number of people in a congregate setting. Licensed boarding houses are a recent addition to the Ombudsman's jurisdiction, so additional visiting resources have been allocated to increase understanding of them, and the issues for residents.

During 2004-05, Visitors raised 127 concerns, which is a 39% decrease from the 208 concerns reported last year. The decrease in the total concerns reported by Visitors reflects a change to the way Visitors identify and report issues of concern about boarding houses. As the scheme consolidates its understanding of the licensed boarding house sector, the way Visitors are identifying and reporting concerns has changed. In their initial visiting to boarding houses in 2003-04, Visitors were more likely to report issues of concern in accordance with the Disability Services Standards.

However, licensed boarding houses are not required to meet these Standards and operate under the conditions specified by the YACS Act and their licence. For example, boarding houses are not required to develop and implement individual plans for residents or to follow DADHC guidelines about the recruitment and training of staff, as are disability services.

Visitors also report that uncertainty about the enforceability of licensing conditions further limits their ability to report and assist the resolution of issues of concern for residents of boarding houses. The Ombudsman is aware of these limitations and is monitoring and discussing with DADHC how it monitors and licenses boarding houses.

The average number of concerns reported per boarding house was two. Visitors reported that licensed boarding houses resolved 45 issues, and that 18 issues were unable to be resolved. It is concerning that a Visitor reported that 16 of these unresolved issues were in one licensed boarding house, and that the proprietor made no effort to attempt to resolve them. For all other unresolved issues, the Visitors are continuing to monitor how services are taking action.

Figure 1: Two year comparison of data for visitable services for residents of licensed boarding houses

	2003-04	2004-05
Number of services	62	57
Number of residents	970	970
Number of visits	411	288
Number of issues reported	208	127
Average number of issues per service	3.4	2
Number of issues resolved (%)	65 (31%)	45 (35%)

Major issues by subject, number and percentage

Environment and facilities – 35 (28%)

Services should be provided in clean, well-maintained premises. Visitors identified 35 cases where the physical environment and condition of premises was inadequate. The concerns reported by Visitors included unclean premises, furniture and premises requiring replacement or refurbishment, inadequate heating and lighting, the limited size of communal living areas and lack of privacy. Some of these issues can be difficult to resolve as they may require capital expenditure or directly relate to licensing conditions. For example, 37 of the 57 licensed boarding houses operate under a license issued prior to 1995 which does not require these boarding houses to meet minimum conditions concerning the number of residents per room (other than the distance between residents' beds) or to meet requirements for internal recreation areas.

Nutrition, hygiene and health care – 32 (25%)

People living in care depend on services to ensure that their meals are varied and nutritious, and that their health and medical needs are addressed promptly. Visitors identified 16 instances of inadequate meals. Some of these concerns were about residents not being able to access food or beverages between scheduled meal times, meals being served at inappropriate times, and residents not being provided with either a variety or choice of food.

Visitors also reported eight concerns about poor attention to dental care. These were successfully resolved by Visitors negotiating with proprietors that they arrange for residents to buy and use toothbrushes and make appointments for dental treatment.

Hungry at night?

A Visitor reported that residents of a licensed boarding house were not provided with access to food or beverages between the 5 pm evening meal and breakfast at 7.00 am the following day. The Visitor was able to successfully negotiate with the proprietor that residents be given a light snack and beverage at 7.00 pm.

Management of residents' funds – 14 (11%)

Residents pay rent and board to proprietors for their accommodation, meals and other basic amenities. Many of the residents of boarding houses have their funds managed by the Office of the Protective Commissioner, under formal financial management orders, to ensure payment of financial commitments and to reduce the risk of exploitation. Some residents rely on boarding house staff to manage the money available to them after the costs of their board and lodging are deducted from their pension. In some cases, boarding house proprietors are required to keep financial records about the money given to residents for items such as cigarettes, medication and other expenses. Visitors identified seven examples where boarding houses did not maintain adequate records about residents' funds and had poor systems for informing residents about their account balances. Visitors also reported seven cases where residents had problems accessing their own bank accounts.

An uncertain future for residents

The Deputy Ombudsman visited a licensed boarding house in regional NSW after a Visitor reported that many of the residents had very high support needs that were not being addressed. The residents' needs related to the severity of their disabilities, age and related mobility problems, and behaviour support issues associated with their dual diagnosis of mental illness and intellectual disability. The Visitor also raised concerns that the boarding house staff were unable to identify and respond to the complex needs of the residents and that the level of support and supervision provided by staff was inadequate. The Deputy Ombudsman met with the proprietor of the boarding house and DADHC regional staff to discuss the concerns and action to address them. There have been some improvements to the residents' situation in the boarding house, including improvements in the capacity of staff to provide support for the residents. The Ombudsman, in consultation with the Visitor, is continuing to monitor the action taken by the boarding house to address the situation.

Cheaply, cheerfully

The Visitor to a licensed boarding house raised concerns with the proprietor about the condition of the premises. The buildings were old and in desperate need of refurbishment. The proprietor agreed with the Visitor but advised there were insufficient funds to make any significant changes. The Visitor worked with the proprietor to investigate low cost improvements, and over a one year period, the boarding house made significant improvements, including painting the living areas, installing heating and carpeting, and buying some new furniture. In addition, the proprietor arranged for one of the residents to provide artworks for decoration.

Free to make a complaint

Visitors to a licensed boarding house made a complaint to the Ombudsman about the conduct of the proprietor and staff of the boarding house, including that they shouted, intimidated and threatened residents who made complaints about the accommodation and support they received. The Ombudsman referred these serious allegations to DADHC, which initiated a review of the boarding house. In consultation with the proprietor, DADHC developed an action plan to address the issues of concern and has worked with the proprietor to implement the plan. The Ombudsman and Visitor have monitored the effectiveness of the implementation of the action plan and observed some improvements in the situation of the residents and how the proprietor responds to complaints and concerns raised by residents. Our monitoring will continue until the action plan is fully implemented

Outcomes for residents
Services for children and young people

There are about 10,000 children and young people in NSW who are placed in out-of-home care (OOHC) because of serious abuse or neglect. Most children and young people in OOHC are placed with relatives or foster families.

However, a relatively small number of children and young people are placed in residential services because special supports and programs are required to meet their complex, high needs. DoCS has parental responsibility for the majority of these children and young people and, in the main, arranges placements for them in funded and fee for service non-government agencies. During the year DoCS closed two of its three residential facilities for children and young people (family group homes) and now directly operates only one residential facility for children and young people.

Each year some visitable services cease functioning and new services start up. In 2004-05 the number of visitable OOHC services increased by eight, to 119 services, accommodating 263 children and young people.

The Ombudsman allocates more visiting resources for children and young people in OOHC because they are particularly vulnerable and require a higher level of monitoring of the quality of their care. During 2004-05, Visitors made 363 visits to children and young people living in visitable OOHC services. This is a significant increase of 81 visits compared to last year.

Visitors identified 386 issues of concern during 2004-05, which is a decrease of 63 issues compared to last year. The resolution rate of issues has increased by 4% compared to last year, and is the highest of all visitable service types. This is encouraging, reflecting an improvement in the response of services to problems in service provision.

Figure 2: Two-year comparison of data for visitable services for children and young people

	2003-04	2004-05
Number of services	111	119
Number of residents	266	263
Number of visits	282	363
Number of issues reported	449	386
Average number of issues per service	4	3.2
Number of issues resolved (%)	215 (48%)	201 (52%)

Major issues by subject, number and percentage

Individual planning, including plans for leaving care – 81 (21%)

Services are required to develop plans that are tailored to the needs of each child and young person and that guide staff in their care and support of residents. Services, in consultation with DoCS, are also required to develop transition plans to assist residents who move to new services, and after-care plans for young people who are leaving care. Satisfactory transition planning for children and young people moving to new services is vital, considering the frequent placement changes that characterise the circumstances of this highly vulnerable group.

Good planning, and the effective implementation of plans, are critical to a person in care's development, care, safety and stability. Visitors reported that services had not developed any of these plans for 20 children and young people, and, in 55 other cases where plans existed, they were inadequate to meet the needs of the child or young person. Services resolved 44 (54%) of these individual planning issues.

Environment and facilities – 35 (9%)

Services should be provided in clean, well-maintained premises. Visitors report that some non-government services use rented premises, which can frequently change. Visitors identified 13 cases of buildings in poor condition. The service environment lacked any home-like qualities in another 19 cases. Visitors report that services resolved only 13 (37%) of these concerns.

Management responsibility – 32 (9%)

Services should have clear processes for developing and reviewing operational policies and procedures, and for staff recruitment and training. Visitors identified 18 examples of services with poor staff recruitment practices and inadequate staff training opportunities. Visitors report that services resolved 20 (63%) of these matters.

Family and friends – 31 (8%)

Services are responsible for helping children and young people in care to maintain their relationships with family and friends. Visitors identified 16 situations where services restricted residents' access to their family or friends, and another 14 examples where staff took insufficient action to support such access. Visitors report that services resolved 21 (68%)of these concerns.

Safety – 17 (4%)

Services are required to ensure the safety of children and young people in care. Visitors identified 14 instances of the failure of services to protect children from abuse and assault, usually by other residents. This is of serious concern considering the majority of children and young people are placed in OOHC because of previous abuse or neglect. Visitors report that services took appropriate action in nine (53%) of these cases. The remaining issues relate to services with inadequate safety and behaviour management systems and procedures and poorly trained and supervised staff. Visitors continue to monitor these services as their systems, documentation and staff training are revised.

Under one roof

DoCS is phasing out a type of service called the family group home. This used to involve placing children with married couples in houses provided by the department. The Visitor to one of the few remaining family group homes was concerned about the consequences of DoCS policy for two sisters who had lived in care with the same house parents for most of their lives. DoCS told the house parents they would have to move out and the young women would have to live independently because they were over 18. All four were very distressed, as they had grown to love each other as a family. The house parents were also concerned about the younger sister's ability to live independently because she had a learning disability. The Visitor and the Ombudsman raised these issues with DoCS, which then assisted the family to find a rental property so they could continue to live together. DoCS also decided to continue supporting the younger sister to find training and supported employment.

DoCS acts to address serious concerns

During a visit to a non-government OOHC service, a resident spoke to a Visitor about being unsafe because of a fear of being assaulted by another resident. The Visitor reported this concern to the senior management of the service, along with concerns about inadequate supervision, poor medication management, inadequate emergency procedures, limited quantities of food available in the house and the impoverished physical environment. Immediately following the visit, the Visitor contacted the DoCS Helpline to report the risk of harm concern about the resident. DoCS contacted the Visitor shortly afterward to advise that it was acting on the report and that is intended to initiate a review of the service. The Visitor reports that the young person who felt unsafe was transferred to another placement and that, since the DoCS' review, there have been improvements to the quality of care and the physical environment of the service.

Outcomes for residents
Services for children and young people with a disability

Some children and young people with a disability cannot be cared for in their family home and are placed in services provided or funded by either DADHC or DoCS. Some families seek alternative accommodation for children because of their high physical or medical needs. Other families do so because the children's behaviour is difficult to understand or manage. This type of care is regarded as 'voluntary' OOHC. Some children with a disability who may have experienced abuse or neglect are placed in OOHC following Children's Court action and a parental responsibility order.

Children and young people with a disability may be placed in DADHC accommodation services or with DADHC or DoCS funded or fee for service non-government services.

There was a significant decrease this year in the number of children and young people with a disability in care, and in the number of services providing accommodation for them. During 2004-05, there were 395 children and young people with a disability living in 73 visitable services. In 2003-04 there were 467 such children and young people living in 99 services. The Ombudsman allocated additional visiting resources to all services for children and young people, including those with a disability, because of their high needs and vulnerability. During 2004-05, Visitors made 238 visits.

Visitors identified 328 issues, representing an average of 4.5 issues per service. Visitors reported that 153 issues (47%) were resolved, which is a 4% improvement on the resolution rate achieved by services last year.

Figure 3: Two-year comparison of data for visitable services for children and young people with a disability

	2003-04	2004-05
Number of services	99	73
Number of residents	467	395
Number of visits	328	238
Number of issues reported	309	328
Average number of issues per service	3	4.5
Number of issues resolved (%)	133 (43%)	153 (47%)

Major issues by subject, number and percentage

Individual planning – 51 (16%)

The Disability Service Standards and OOHC Standards require services to develop and implement individual plans, including behavioural plans where necessary, to meet the many needs of children and young people with disabilities. Service staff should be trained and supported to understand and implement individual plans. Visitors identified 27 cases where individual plans existed, but were inadequate. In another 12 cases services were not effectively implementing the plans. Visitors report that services resolved 24 (47%) individual planning issues.

Nutrition, hygiene and health care – 32 (10%)

Some children and young people with a disability are very frail, and depend on services to protect them from infection and poor health. Visitors identified 14 cases where there were no systems to identify risks to the health of children and young people, and 11 where services were not providing a healthy lifestyle. Visitors reported that services resolved 23 (72%) of the health care matters they identified.

Management responsibility – 36 (11%)

The diverse, high needs of children and young people with a disability emphasise the need for appropriately and relevantly skilled and trained staff to support them. Visitors identified 28 instances of poor recruitment, unsatisfactory staff, or staff who were inadequately trained. Visitors reported that services resolved 25 (69%) staffing and related issues.

Environment and facilities – 28 (9%)

Visitors identified 19 cases of buildings in a poor or unhygienic condition, and another nine where the service environment did not have any home-like qualities. Visitors reported that services improved the environment and facilities in only eight (29%) of these cases.

Safety – 25 (8%)

Services are required to ensure the safety of children and young people in care. In 14 cases, Visitors identified inadequate strategies to minimise the risks for residents, for example, in relation to emergency or fire precautions or disability access. In seven cases, services had inadequate procedures for protecting children from abuse and assault, usually by other residents. Visitors reported that services resolved only 10 (40%) of these concerns. Visitors continue to monitor services, in consultation with the Ombudsman OCV Team, to address all these identified issues.

From care to caravan

A Visitor attended a case conference for a young man with a physical disability who was soon to leave a DoCS funded service to live independently. During the conference DoCS staff told the resident he had not taken enough action to find his own accommodation. The Visitor was concerned that the attitude and manner of DoCS staff to the young man appeared to be intimidating and bullying. When the Visitor spoke to the young man later, the young man said he had made several attempts to find accommodation, but did not really know how to go about living independently.

Shortly after the meeting the Visitor was informed that DoCS moved the young man temporarily to a caravan park and that he had restricted access for his wheelchair in this accommodation. When the Visitor discussed these concerns with staff from the funded service and asked for more information about the care plan for the young man, the staff said that DoCS had instructed them not to provide the plan to the Visitor.

The Visitor discussed the concerns about the behaviour and decisions of DoCS staff with the Ombudsman OCV Team and reported the behaviour of DoCS staff to the DoCS Helpline as an allegation of abuse. The Visitor also made a formal complaint to the Ombudsman about the placement of the young man.

The Ombudsman informed the funded service and DoCS that the Visitor has legislative authority to access documents such as a care plan and it was subsequently provided.

The Ombudsman monitored DoCS plans for the young man's move to supported living. DoCS, in consultation with DADHC, developed plans and made relevant and appropriate arrangements for the young man's short term support and care pending confirmation of arrangements for his long term accommodation. Ombudsman monitoring of DoCS plans also confirmed that a DoCS caseworker was having regular contact with the young man and had developed a positive, supportive relationship with him.

A positive experience

The Visitor to a service for young people with a disability reported the service had introduced an innovative, community based model of care and support for the young people, all of whom had high physical and medical needs. On the Visitor's invitation, the Deputy Ombudsman visited the service to meet with residents, staff and senior management. The Deputy Ombudsman valued the opportunity to see and hear about a better practice service initiative that was achieving very good outcomes for the highly vulnerable residents.

Outcomes for residents
Services for adults with a disability

The majority of visitable services in NSW are for adults with a disability. Many residents have an intellectual disability and need varying levels of staff support throughout their lives. Services are provided by DADHC or non-government services funded by DADHC. Different types of disability services include:

- large institutional facilities – usually comprising several units on one site; units can accommodate up to 25 people.
- community based group homes – usually ordinary houses in local communities, accommodating up to 6 residents. Most adults with a disability are placed in group homes.
- individual support – approximately 120 adults with a disability are housed in single accommodation options

During 2004-05, there were 962 services for adults with a disability (not including licensed boarding houses), which is an 8% increase compared to last year. The increased number of services results from an increase in the number of funded accommodation placements and the continuing government policy to relocate people living in large residential facilities to community based group homes because the large institutional facilities do not comply with the *Disability Services Act* principles and standards.

Disability services accommodate a total of 4,910 adults with a disability. Approximately 2,000 people are still living in large government and funded non-government institutional facilities. Visitors made 2,175 visits to these services and identified 1,969 concerns, reporting that services resolved 966 of them(49%).

Figure 4: Two year comparison of data for visitable services for adults with a disability

	2003-04	2004-05
Number of services	879	962
Number of residents	4,925	4,910
Number of visits	2,511	2,175
Number of issues reported	2,133	1,969
Average number of issues per service	2.4	2
Number of issues resolved (%)	791 (37%)	966 (49%)

Major issues by subject, number and percentage

Individual planning – 275 (14%)

Visitors identified 109 cases where services had not developed any plans to guide staff in supporting residents, and another 97 cases where plans existed but were inadequately implemented.

There was an increase in the number of overall issues concerning adults with a disability that services resolved in 2004-05 – from 37% in 2003-04 to 49% this year. It is concerning, however, that services resolved only 126 (46%) of the individual planning problems. Individual plans are the primary way for services to identify and meet the specific needs of people in care and to enhance their quality of life and development.

Nutrition, hygiene and health care – 257 (13%)

Some adults with a disability have significant health and medical problems and are very frail. They depend on services to protect them from infection and poor health. Visitors identified 96 instances of inadequate systems to identify people with health risks. In 52 other cases services had identified specific health needs or concerns but did not address them. There were 49 instances of residents being malnourished. Visitors reported that services resolved 121 (47%) of the nutrition, health and hygiene concerns they reported.

Environment and facilities – 195 (10%)

Services should be provided in clean, well-maintained premises. Visitors identified inadequate conditions in 166 cases, and another 47 where the service did not provide a home-like environment. Visitors reported that only 67 of these concerns were resolved. Most related to improving the physical facilities.

Management responsibility – 149 (8%)

Services should have relevant policies and procedures for staff recruitment, support and development and for providing consistent, quality services. Visitors identified 105 cases of poor recruitment practices and inadequate training opportunities. In 20 cases they identified inadequate procedures to respond to serious breaches of policy guidelines, such as failure to implement individual plans or respond to serious incidents involving residents. Visitors reported that services resolved 65 (44%) of these. The majority of unresolved issues concerned services' poor staff recruitment and training.

Behaviour management – 138 (7%)

Some people with a disability have mental health problems or have difficulty communicating, and so may express their feelings through their behaviour. This can present services and service staff with challenges in their response to adults with a disability, and emphasises the need for services to have in place good systems and practices concerning individual planning, staff training and support, and incident response and management. In particular, services are required to assess the circumstances of people in care and to develop and implement relevant plans to ensure that the person, other residents and staff are safe, and to assist the person learn other ways to communicate their needs. Visitors identified 42 issues where behaviour management plans existed but were inadequate, and a further 54 issues where services were not monitoring the effectiveness of these plans. In 20 cases, even though services had identified that there were issues of concern about residents' behaviours, they had no plans in place to manage the behaviours. Visitors reported that services resolved only 54 (39%) of the behaviour management issues they identified.