Report under Section 11(c) of the
*Community Services (Complaints
Reviews and Monitoring) Act* 1993

**Review of individual planning in
DADHC large residential centres**

June 2009

Contents

1. Introduction

Under section 11(c) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA), the Ombudsman may monitor and review the delivery of community services.

This report details observations arising from the Ombudsman's review of individual planning in DADHC large[1] residential centres. The review was conducted in 2008.

In December 2008, we provided a draft of the report to DADHC for the department's consideration and comment. On 9 March 2009, we met with senior officers in DADHC to discuss the draft report, and on 27 April 2009, DADHC provided a written response to that report.

Our analysis of the department's response is in section 5. The department's full response to our draft report is attached in Appendix 1.

1.1 Background

The *Disability Services Act 1993* requires services to be provided to 'meet the individual needs and goals of the persons with disabilities receiving services'. Individual planning is the key means for ensuring that services for people with disabilities are tailored to their individual needs and goals, both current and future.

In 2004, this office conducted an audit of individual planning in non-government disability accommodation services. The audit identified areas where individual planning could be improved, such as involving the person with a disability in the planning process, reviewing individual plans, and monitoring progress towards meeting needs and goals. DADHC-operated services were not included in this audit.

In our *Report of Reviewable Deaths in 2006*, we reported that our reviews of the deaths of people who had lived in residential centres, including DADHC-operated centres, raised some concerns about individual planning, including the quality and frequency of community access for residents.

Reports from Official Community Visitors have also raised questions about how well the individual needs and goals of people in large residential centres are being identified and met.

On 24 July 2008, DADHC advised this office that 1,729 people with disabilities were living in 32 residential centres across NSW. Of the total population of people with disabilities who live in care (6,151 people), 28 per cent live in residential centres.[2]

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[1] Large residential centres accommodate more than 20 people on one site. Small residential centres accommodate 7-20 people.
[2] DADHC advice, 24 July 2008.

Most (1,215 people; 70%) of the people who live in residential centres live in the nine large residential centres that are operated by DADHC.[3] The number of people accommodated in the department's residential centres ranges from 19 people in Grosvenor to 445 people in Stockton.[4]

1.2 Aim

The aim of the project was to establish how well the individual needs and goals of people with disabilities living in DADHC-operated large residential centres were being identified, met, and reviewed. In order to do this, we sought to determine:

- current compliance with the department's *Individual Planning for Adults in Accommodation Support Services* policy and other relevant policies, including those on health care, behaviour support, managing risks, financial management, and decision-making and choice; and

- current individual planning practice in DADHC's nine large residential centres.

The review also included consideration of the department's Quality and Safety Framework[5] in monitoring individual planning in the centres.

1.3 Methodology

Our review incorporated each of the nine DADHC large residential centres.[6]

Where possible, we selected a mix of units and cottages in order to obtain a cross-section of resident support needs, such as medical and behaviour support needs, and residence types. We then randomly selected 60 residents from within those units and cottages. These people represented a mix of ages, gender, and cultural background.

Centre	Number of residents selected	Number of units/ cottages selected
Stockton	14	6 units, 2 cottages
Rydalmere	8	3 units, 2 cottages
Marsden (Westmead)	7	5 units
Kanangra (Morisset)	6	2 units, 1 cottage

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[3] Ibid.

[4] DADHC (December 2007) 'Service and Facilities Plan for DADHC operated Large Residential Centres' tender specification.

[5] DADHC monitors its own services through a Quality and Safety Framework, which collects data in relation to 26 key performance indicators.

[6] DADHC also operates Mountview, a residential centre accommodating 16 people in Balgownie. Mountview was not included in our review as it is a small residential centre. At the time of our review, Grosvenor was also a small residential centre, but was included in the review as it will accommodate 30 people on site following redevelopment – 20 permanent residents, and 10 respite residents.

Lachlan (North Ryde)	6	2 units
Peat Island	6	3 units, 1 cottage
Riverside (Orange)	6	2 units, 1 cottage
Tomaree (Shoal Bay)	4	1 unit
Grosvenor (Summer Hill)	3	All units

The review process involved:

- a review of the files of residents, including day program records where applicable;
- discussion with Residential Unit Nursing Managers (RUNMs) regarding the selected individuals and individual planning;
- discussion with day program managers regarding individual planning and the selected individuals; and
- meeting with the individual residents selected as part of the review, where possible and appropriate.

The meetings with the RUNMs and day program managers provided the opportunity for us to clarify the individual planning process in the unit or day program site, as well as the specific planning and support in place for the selected individuals.

To inform our report, we also met with the Western Sydney Intellectual Disability Support Group, People With Disability Australia, and the Office of the Public Guardian.

As part of our review, we sought from DADHC data that the department had collated from its monitoring activities. While DADHC has a system for monitoring services against required legislation and standards – the Integrated Monitoring Framework – this system does not currently apply to DADHC operated services. The department monitors its own services through a Quality and Safety Framework, which collects data in relation to 26 key performance indicators. We sought Quality and Safety Framework data from DADHC in relation to relevant performance indicators, and have included this data[7] in the health care, behaviour support, and individual planning sections of this report.

2. Relevant developments

In 1998, the then Minister for Disability Services announced a commitment to close all government operated and funded large residential centres by 2010. In 2000, a further commitment was made to close 15 of the centres by June 2004.

Eleven centres have closed since 2000, including eight operated by DADHC.[8]

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[7] DADHC provided the Quality and Safety Framework data on 5 February 2008.
[8] DADHC advice, 17 June 2008.

In January 2006, the NSW Government released an *Accommodation and Support Paper*. The paper indicated that residential centres would close 'over time', an existing no-admissions policy would remain, and some residential centres would be redeveloped to provide support for people with complex needs and behaviours.

In May 2006, the NSW Government released a 10-year plan for disability services, *Stronger Together*. This document outlined plans to redevelop the Grosvenor and Peat Island Centres, and stated that planning for the redevelopment of other sites would be undertaken over the following two years.

In relation to the redevelopments of DADHC large residential centres, the department has advised[9] that:

- The Grosvenor Centre is being redeveloped as a specialist centre for people with complex health needs, comprising two 10-bedroom houses for permanent accommodation and a separate 10-bedroom unit for respite clients, of which five places will be for adults and five for children.[10]

- The Lachlan Centre is being redeveloped on site as a small village-style accommodation that will provide specialist services for people with challenging behaviour. The residential centre will be replaced by 10 five-bedroom homes. Each house will be operated individually and any sharing of resources across the houses will be strictly limited.

- The Peat Island Centre will be closed by 2010 and replaced by an aged care village and community-based houses. The aged care village will be built at Hamlyn Terrace, and divided into 10 houses, each of which has 10 beds. The Peat Island Centre replacement of community homes will be four five-bedroom homes located in the community in Wadalba.

DADHC has advised that all of the redeveloped accommodation will be located in proximity to local community services, transport and health facilities. Under the proposed models for Lachlan, Grosvenor, and the Peat Island community homes, residents will receive off site age-appropriate day programs from a non-government provider, and will be assisted to participate in other off site leisure and sporting activities as part of the active support service model. In the small number of cases where residents are unable to leave the site due to their individual support needs it is proposed that non-government staff will deliver appropriate activities on site.

In October 2008, DADHC announced plans to review its *Individual Planning* policy, in line with the directions defined in *Stronger Together* and to reflect the contemporary practice of Person Centred Planning. As part of the review process, DADHC has established a reference group, comprised of external and internal stakeholders. DADHC plans to produce the first

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[9] Information sourced from *Stronger Together*, DADHC advice 22 May 2008, and DADHC advice 17 June 2008.
[10] On 21 January 2009, the Minister for Disability Services issued a media release indicating that he had officially opened the redeveloped Grosvenor Centre.

draft of the revised policy in September 2009.[11]

3.   Resident profile

3.1 Age and gender

We reviewed the individual planning for 28 women and 32 men, most of whom (46 people; 77%) were aged between 30 and 60 years of age. The higher number of men, and people aged 30-60 years, is reflective of the broader population of people living in DADHC large residential centres.

The youngest person included in the review was a nine-year-old boy who lived at the Grosvenor Centre. The oldest person in the review was a 76-year-old man who lived in Marsden.

3.2 Cultural background

Two people in our review (3%) were identified as being Aboriginal, and eight people (13%) had culturally and linguistically diverse backgrounds.

3.3 Support needs

All of the individuals we reviewed had some degree of cognitive impairment; most (39 people; 65%) were recorded as having a severe cognitive impairment. Fifteen people (25%) had a moderate cognitive impairment, while a small number of people were recorded as having a profound (five people), or mild (one person) cognitive impairment.

In addition to cognitive impairment, 23 people (38%) had some form of physical impairment, such as cerebral palsy, that affected their mobility. Twenty-one people (35%) were recorded as having a mental illness, such as depression or schizophrenia. Thirteen people (21%) had a sensory impairment (vision, hearing, or both), and six people (10%) had autism.

The most common health issues for the people in our review were incontinence (34 people; 56%), epilepsy (27 people; 45%), constipation (26 people; 43%), Vitamin D deficiency (21 people; 35%), and swallowing problems (20 people; 33%). Other key health issues included osteoporosis (14 people; 23%), and respiratory infections (10 people; 16%).

3.4 Guardianship

Eleven people in our review (18%) were under formal guardianship. The Office of the Public Guardian (OPG) was appointed for 10 people, and one person had a private guardian appointed. For 46 people, a family member or friend acted as 'person responsible' in relation to medical and dental treatment.

Three people did not have a guardian or an identified person responsible for medical

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[11] DADHC advice, 17 October 2008.

treatment. For these individuals, applications had been submitted to the Guardianship Tribunal for consent as needed.

3.5 Respite

Three of the 60 people in our review had entered the residential centres on respite:

- A 20-year-old woman entered Grosvenor on respite in July 2006 when she became too old to continue residing at Allowah Children's Hospital, and alternative accommodation could not be located. At the time of our review, plans were underway to move the young woman into a DADHC group home in the community during 2008.

- A nine-year-old boy entered Grosvenor in early 2006 on respite until appropriate accommodation could be located. At the time of our review, DADHC was discussing possible accommodation options with a funded service, and meeting regularly with the boy's family to discuss progress and current support.

- A 25-year-old man entered Riverside from a funded group home in southern NSW in November 2006 for six months in order to have a comprehensive medical and behavioural review. The service which had been supporting the man told DADHC that it was no longer able to meet his significant behaviour needs. While DADHC Southern Region had developed plans to move the man back into the community, his psychiatrist had stated that this would be inappropriate given his current behaviour needs. At the time of our review, there were no plans to move the man out of Riverside.

4. Key findings

Our review of the individual planning for 60 people in DADHC's large residential centres has found that substantial improvement is required to ensure that service provision consistently meets departmental policy and complies with disability services legislation. In particular, our review found significant gaps between what is required and what is provided in the following areas:

- the need for a focus on increasing the independence of residents and supporting them to achieve their individual capacities for development;[12]

- providing services in a way that results in the least restriction of residents' rights and opportunities;[13]

- meeting the individual needs and goals of residents;[14]

- ensuring that residents participate in decisions affecting their lives, including the planning and operation of their services;[15]

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[12] *Disability Services Act 1993*, Schedule 1, sections 1(c) and 2(a)
[13] Ibid, Schedule 1, section 1(g)
[14] Ibid, Schedule 1, section 2 (d)
[15] Ibid, Schedule 1, sections 2(k) and 2(o)

- ensuring that residents have access to advocacy support where necessary;[16]

- the need to promote the participation of residents in their local communities through maximum physical and social integration in their communities;[17]

- ensuring that the conditions of the everyday life of residents are the same as, or as close as possible to, norms and patterns that are valued in the general community;[18] and

- ensuring that no single service provider exercises control over all or most aspects of the life of a resident.[19]

We found that implementation of DADHC's individual planning policy in its large residential centres did not consistently result in outcomes that were in line with the stated principles of the policy or disability services legislation and standards. Our review has raised questions about how well DADHC's current individual planning process is identifying and meeting the needs and goals of individuals living in its large residential centres.

We found that significant work is required to ensure that people in DADHC large residential centres are active participants in the planning and delivery of their services. Many of the residents in our review were infrequently involved in decision-making, had a heavy reliance on DADHC for most or all aspects of their lives, had unmet communication needs, and lacked advocacy support.

Our review indicates that within the existing model of service delivery and practice there are significant challenges for DADHC in ensuring the least restriction of residents' rights and opportunities to foster independence. We found low levels of resident involvement in skills development activities, and considerable unmet needs in relation to socialisation and community integration.

We recognise that many staff members in DADHC's residential centres are dedicated to supporting residents to fulfil their potential. However, the current way in which services are planned and delivered can lead to significant challenges in promoting this objective.

In this report, we have outlined our findings with regard to DADHC's work to meet the needs and goals of residents across nine key life domains: decision-making and choice, communication, health care, behaviour support, day programs, community participation and integration, leisure and skills development, finances, and relationships. We have also reported our findings with regard to DADHC's implementation of its individual planning policy.

The following sections outline the findings that we made in our draft report to DADHC.

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[16] Ibid, Schedule 1, section 2(l)
[17] Ibid, Schedule 1, section 2(g)
[18] Ibid, Schedule 1, section 2(b)
[19] Ibid, Schedule 1, section 2(h)

4.1 The individual planning process

Overall, our review indicates that many residents were not active participants in their individual planning process, including the planning for their meeting, and consultation on their needs, goals and wishes.

We found that while some progress had been made for most of the residents towards achieving their goals, their progress was often not reviewed, and barriers to achieving some of the goals were largely unresolved.

All of the residents had some unmet needs, ranging from accommodation and advocacy to relationships and skills development. In the main, we found that staff had identified most of these needs, but considerable work was required to address them.

4.1.1 Requirements and developments

Legislative and policy requirements

A fundamental component of disability services legislation and standards is that each person with a disability receives a service that is designed to meet his/ her individual needs in the least restrictive way. The *Disability Services Act* requires services to meet the individual needs and goals of the people with disabilities receiving services, and to provide opportunities for people with disabilities to reach goals and enjoy lifestyles that are valued by the community.

DADHC's revised *Individual Planning for Adults in Accommodation Support Services* policy was released in 2005, and includes the following key principles:

- staff aim to promote and increase the independence of clients;

- Individual Plans (IPs) enhance the client's life through greater community participation and integration in a way that accommodates the least restrictive approach and demonstrates that the client is socially valued;

- the goals of the IP are based on assessed client strengths and needs and are realistic and achievable; and

- the client, their family and significant others are supported to participate in the development of the IP, and their cultural and language needs will be considered.

DADHC's policy provides the framework for many of the department's other policies and practice requirements, including those concerning health care, risk management, and behaviour support. The policy requires that all residents have an IP.

With regard to planning for the meeting, the policy requires the Keyworker to discuss the IP process with the client using accessible communication, and to plan the IP meeting with the client, family and significant others. Information to be considered during the IP meeting includes intervention plan reviews, a needs assessment or equivalent functional skills assessment, health and medical reviews, and goal suggestions.

The policy emphasises that discussion of the client's goals and wishes are central to the IP process, and states that if the client does not wish to attend the IP meeting, the Keyworker must ensure that their preferences and goals are raised in the meeting.

DADHC's policy requires the Keyworker to monitor the implementation of all interventions and to document the progress. The Manager is to support staff to implement the IP through supervision and unit meetings, and to audit the IP goals and interventions.

The IP is required to be reviewed every six months and modified according to the client's changing needs. The client, their family and significant others are to be involved in the reviews and the Keyworker is to discuss the results of the IP review with the client.

Relevant performance indicators

DADHC's Quality and Safety Framework has two key performance indicators that measure compliance with individual planning. One indicator reviews compliance with key policy requirements across the domains of health care, nutrition, community access, finance, and behaviour intervention. Quality and Safety Framework data, as at February 2008, recorded compliance ranging from 98 per cent in Peat Island and 96 per cent in Grosvenor, to 80 per cent in Rydalmere and 59 per cent in Stockton.[20]

The other key performance indicator measures the percentage of clients that had an IP in place that had been assessed annually and reviewed within the last six months. DADHC's Quality and Safety Framework data recorded compliance ranging from 100 per cent in Lachlan, Grosvenor and Riverside, to 95 per cent in Marsden and 93 per cent in Rydalmere.[21]

Developments

In April 2008, DADHC told us that Metro Residences had commenced improvement of the quality of the individual plans at its centres, including the allocation of a senior nursing position with responsibility for auditing all IPs and training staff, and implementation of an evaluation form that had been sent to all family, friends or advocate participants in the IP meetings. DADHC also told us that Metro Residences would establish a reference group in 2008 to allow external stakeholders to provide input to the overall IP process, and the Resident Panel would be invited to give regular feedback about IPs.[22]

4.1.2 What we found

The individual planning meeting: preparation and participation

Overall, we found that residents were not actively involved in the development of their individual plan:

- Records indicated that 41 of the 60 residents (68%) attended their last IP meeting. Of the 19 people who did not appear to attend their IP meeting, there were reasons on file

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[20] DADHC advice, 5 February 2008.
[21] Ibid.
[22] DADHC advice, 14 April 2008.

for two residents: one had declined to attend as she was eating breakfast as per her routine, and one person had refused to attend as he preferred to go to his day program. Both examples raised questions about whether the needs of the person were adequately considered when planning the meeting.

- While most of the residents attended the meeting, they did not appear to be actively involved in planning for the meeting, or consulted about their potential needs or goals. There was evidence on file that 13 residents (22%) had active involvement in the planning and development of their IP.

- One centre had pictorial representations of the IP process to help residents understand and be involved in the planning.

With regard to input from others, records indicated that the family, friends or other significant people of 20 residents were consulted about potential IP goals ahead of the meeting. Family members of 31 residents (52%) attended the IP meeting, and significant others such as a friend, advocate or guardian attended the meetings of seven people.

When we looked at the information used to inform the IP meeting, we found that the provision or use of assessments and reports was not consistent. In the main, we did not see clear links between this information and the development of the person's IP:

- Few residents (11 people; 18%) had a needs or functional skills assessment on file. Records indicated that none of the people who had a profound cognitive impairment had a needs or functional skills assessment.

- Keyworker summary reports to inform the IP meeting featured on the files of six residents[23].

- Lifestyle and Environment Reviews had been completed for 58 of the 60 residents. We saw links between this assessment and the IP in only one centre.

- Day program reports for the IP meeting were on file for 27 people (48% of those who attended a day program). For 21 people (38%) who attended a day program, a day program representative did not attend the IP meeting and a day program report was not on file.

There were minutes from the last IP meeting on file for 44 people (73%).

Staff raised a number of concerns with us about the existing IP process; the chief area of concern being the amount of paperwork required. Staff told us that the amount of paperwork was onerous, and that there was unnecessary duplication of information. For example, in Hunter Residences, there was an expectation that staff would report monthly progress against each target area as part of the IP process, rather than just reporting against the person's IP goals.

Some of the RUNMs had taken steps to simplify the IP process for staff, including the

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[23] The files of 35 people contained monthly Keyworker progress reports. However, an overall summary report completed by the Keyworker to directly inform the development of the new IP was on file for six residents.

development of IP packages to break down the process into clear stages and outline the forms to be completed at each point.

The individual plans

All residents had a current individual plan document on file. However, the quality of the goals identified in the plans was inconsistent. Some of the documented goals raised questions about whether staff understood the purpose of individual planning and the link between IPs and service delivery:

- The IPs of four people did not include goals. These plans contained broad phrases or instructions that could not be considered to be goals for the person to achieve, such as 'continue with current regime', 'referral as required', and 'continue as is'.

- Some of the goals for 23 people (38%) were instructions for staff rather than goals for the resident, such as 'CRP to be updated', 'report any unidentified challenging behaviours if and when they arise', and 'document all appropriate dental, podiatry, weight, dietician, etc'.

- Some of the goals on the IPs of 19 people (32%) were very broad, and it was not clear how they would be implemented by staff. This included 'opportunity to mix with peers', 'increase recreation activities', and 'maintain and optimise her quality of life by providing access to all appropriate activities and stimulus'.

- Some of the goals for eight people were reports about the person's current situation, such as 'mental health issues have been problematic over the last year. These have received much attention from many professionals. Behaviours have been mainly manageable using current intervention techniques over this new period'.

- Some of the goals for 25 people (42%) were continuations of their current activity, including 'continue to offer opportunities for community access – minimum monthly', and 'maintain current community access'. The IP for one person was a replica of the previous year's plan.

Across the centres, we found inconsistency in how goals were determined, and their perceived purpose. For example, the goals for Lachlan residents were selected from the Lifestyle and Environment Review, comprised four goals, and did not include health care. In contrast, Hunter Residences recorded actions against set life domains[24] as goals, including health care.

In the main, the person or position responsible for assisting the resident to achieve the goal had been identified. The IPs for 46 people (77%) indicated who, or what position, was responsible for making sure the goals were implemented and progressed. Interventions, outlining the tasks required to assist the person to achieve the goal, had been developed for some or all of the goals for 33 people (55%). Most of these also indicated the person or position responsible for action (23 people; 70%).

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[24] Life domains set by Hunter Residences in its IP template included decision-making and advocacy, health and wellbeing, safety/risk management, behaviour intervention and support, communication, family and personal relationships, community participation and integration, leisure and recreation, placement, holidays, and skills.

Information provided by staff indicated that training for staff in individual planning was inconsistent across the centres. Some centres, including Lachlan, Stockton, Rydalmere, and Marsden had dedicated Clinical Nurse Educator or IP Coordinator positions to provide the training, but other centres, such as Riverside, did not.

Implementing the IP and meeting needs

We found that for most of the residents, action had been taken to implement at least some of the goals in their IP. However, where staff had identified barriers towards achieving goals, records indicated that many of these problems remained unresolved:

- Records indicated that action had been taken to progress all of the IP goals for 30 people (50%). For 22 people (37%), work was being undertaken to achieve some of their goals. In a minority of cases (eight people), there was no information to suggest that action was being taken to implement their goals.

- Staff had documented issues that were hampering progress towards achieving the IP goals for 20 people. These barriers included staffing levels and shortages, problems with wheelchair accessibility, and limited or no access to behaviour clinicians. Records indicated that action to address the barriers was occurring for four of the 20 residents (20%).

Records indicated that staff had identified most of the residents' unmet needs, and work was underway to address some of those needs. However, we found that considerable work remained to be done to address many of the existing needs of the residents in our review. Records indicated that:

- Twenty-five residents (42%) had unmet needs that the service had identified and was taking action to address. These needs related to community access, social activities, communication, decision-making, exercise, reviews of behaviour support, community placement, and equipment such as a day chair and a wheelchair.

- Thirty-five residents (58%) had unmet needs that the service had identified but had not yet taken steps to address. These needs related to accommodation, behaviour support, communication, community participation, decision-making and advocacy, health care, relationships, and skills development.

- Twenty-eight residents (47%) had unmet needs that the service had not identified. These needs included accommodation, communication, community participation, decision-making, relationships, and skills development. We noted that four of the five residents with a profound cognitive impairment had unmet needs that the service had not identified.

Staff had identified that 11 people (18%) had unmet needs with regard to their accommodation. We found that the work undertaken to meet those needs was inconsistent:

- Staff had recorded the need for six people (10%) to move into less restrictive accommodation, or otherwise indicated that the individual would benefit from living in the community. The IPs for half of the six people included goals of moving into the community, and records indicated that action was being taken to implement those goals.

- Staff had recorded that the accommodation for five people did not meet their needs, due to reasons such as compatibility, space, comfort, transport, and privacy. These unmet needs did not feature in the individual plans for any of these individuals, and there was no information on file to indicate that action had been taken to address those needs.

Needs and goals relating to communication, decision-making, health, relationships, skills development, and community participation are discussed in separate sections of this report.

Monitoring IP implementation

Staff across the centres told us of procedures that had been established to ensure that the IP process was actively monitored, such as use of a systems support officer position for quality assurance, use of IP coordinators to oversight the process, and independent auditing of plans.

In addition, staff across the centres advised of systems in place to ensure that the work of the Keyworker or case manager responsible for developing and implementing the IP was oversighted. We were told that the Keyworker was to raise any problems implementing the IP with their supervisor (either a case manager or the RUNM), and the supervisor was also to identify gaps when monitoring.

However, file information considered in our review suggested that monitoring of IP implementation by Keyworkers, and oversight by their managers, was inconsistent in practice:

- Records indicated that, for 35 people (58%), monthly progress reports written by the person's Keyworker was the main way in which the IP was monitored. We found that some of progress reports appeared to have been interpreted as a report on the person rather than towards achieving their IP goals. For example, 'Recreation & Leisure: likes to wander in yard', and 'Community Access: good'.

- For the other 25 people, there was no information on file to indicate how their IP goals were actively monitored.

- In terms of manager oversight of Keyworker actions to progress the IP goals, records indicated that the IP progress reports for seven people were checked.

Reviewing the IP

We found that practice in relation to IP reviews did not consistently meet DADHC's policy requirements:

- Records indicated that IPs for 21 people (35%) had been reviewed in line with the required six monthly timeframe.

- Few of the residents appeared to be involved in the review of their IP. Of the 21 people whose IP had been reviewed as required, four were present at the review. The family members of two people were present at the review.

- According to file information, the Keyworkers for two people discussed the results of the IP review with them. Both of the residents had a moderate level of cognitive impairment.

The reviews for two people resulted in some change to the IP, such as a goal deleted because the person did not want to do it.

Overall, our findings in relation to IP reviews did not correspond with DADHC's Quality and Safety Framework data. DADHC's monitoring activity found a high level of compliance with the six-monthly review requirement, including full compliance in three centres.

In the main, we found that key assessment documents were reviewed regularly, including the Client Risk Profile and Lifestyle and Environment Review.

4.2 Decision-making and choice

Our review found that DADHC residential centres were not consistently meeting policy requirements regarding decision-making and choice. Residents were infrequently involved in making decisions or choices about their lives, including the services provided and their preferred lifestyle. Concurrently, we found that few residents accessed advocacy support.

4.2.1 Requirements and developments

Legislative and policy requirements

The rights of people with disabilities to participate in the decisions that affect their lives, to choose their own lifestyle, and to have access to information necessary to enable informed choice, are central to disability services legislation and standards.

The Disability Services Act requires services to ensure that people with disabilities have access to advocacy support where necessary to ensure adequate participation in decision-making about the services they receive, and to encourage participation in the planning and operation of services and programs.

DADHC's *Decision Making and Choice* policy in place at the time of our review[25] requires that:

- Clients are to be encouraged and supported to express their views and have them taken into account. The least restrictive approach is to be taken to ensure clients are supported to make as many of their own decisions and choices as possible.

- Clients will be encouraged to make decisions and choices about the individual service they receive, activities that they would like to participate in, and the lifestyle they would like to follow. Clients are to be actively encouraged to choose their place of residence and with whom they reside.

- Staff members are to inform clients of the range of choices available to them using accessible and appropriate modes of communication. Clients are to be actively encouraged and supported where possible to access external services that assist with

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[25] DADHC developed a revised *Decision Making and Consent* policy for the services it operates and funds in July 2008.

development of decision-making skills, such as Self-Advocacy.

- Staff are to actively encourage and support clients so they can be involved in the evaluation of the quality of the individual services they are receiving. Clients are to have opportunity to participate in and contribute to the selection, evaluation, induction and training of direct care staff; development and review of policies; and decision-making forums where decisions are made about the service.

Developments

Rydalmere has started a 'What I Like' group, with the involvement of the Western Sydney Intellectual Disability Support Group, to enable residents to have a greater say in some aspects of their service.

4.2.2 What we found

From file and staff information, 31 people (52%) did not appear to be involved in making decisions or choices about the service they received. Indication of choice or involvement in decisions for the remaining 29 people included refusal or reaction to what was presented to them (such as pushing away food), and basic choices regarding clothing, food, and sensory items.

Although residents appeared to be infrequently involved in decisions about their lives and the service provided, their individual plans rarely included goals to address this:

- The individual plans of 16 people (27%) included goals related to decision-making and choice, such as choosing leisure options out of an activity box, choosing evening meals, visiting the Handymart to make choices, and developing community cards to enable choices when shopping.

- Records indicated that work had been undertaken to address those goals for half of the 16 people.

Two of the 60 people in our review had the involvement of advocates. It was not clear to us why so few residents had advocacy support: we found a need for increased involvement of residents in decision-making, considerable unmet and unidentified need, three people who did not have contact with anyone outside of staff, and nine people who had limited family contact.

We found that there was greater involvement in decision-making for residents who had a mild or moderate level of cognitive impairment:

- A unit and a cottage that accommodated people with verbal communication skills and mild to moderate cognitive impairment held house meetings that provided residents with an opportunity to raise issues.

- Residents with moderate cognitive impairment who lived in the cottages at one residential centre were able to elect which staff member they preferred to work at their house.

- In relation to potential goals, records indicated that the views of most of the 16 people with a mild or moderate cognitive impairment (63%) had been sought. Conversely,

views had been sought from six of the 39 people with a severe cognitive impairment (15%), and none of the five people with a profound cognitive impairment.

We found that some of the aspects of residential centre accommodation affected the capacity of individuals to make decisions or choices. For example, some of the centres used cook/chill meals. We were advised that, in these centres, once the meals have been heated, they could not be reheated. As a result, there was little scope for residents to eat at a time of their choosing. For residents living in the units, we found that decisions about where or with whom they wanted to eat were also constrained.

4.3 Communication

Most of the people in our review required assistance with communication and relied on means other than verbal language to express themselves. We found that the communication needs and preferences of many of the residents had been identified. However, those needs and preferences were being met for a minority of people.

4.3.1 Requirements and developments

Policy requirements

The importance of ensuring that people with disabilities in care have the opportunity to communicate, and are adequately and appropriately supported to do so, is fundamental to disability services legislation, standards and policy requirements, and to identifying and meeting the needs and goals of residents.

By way of example:

- In DADHC's *Individual Planning* policy, the Individual Plan and Individual Plan Review templates require staff to indicate whether the person needs alternative or augmentative communication, and the Lifestyle and Environmental Review template requires staff to identify any issues relating to the expressive and receptive communication needs of the person, and to record recommendations to address those needs.

- Communication is one of the areas listed for consideration regarding potential needs or goals in the suggestion sheet that is sent to families/ guardians and/or advocates, and is one of the domains listed in the Hunter Residences Individual Plan template for discussion in the planning meeting.

- DADHC's *Health Care* policy identifies communication as central to effectively identifying and meeting the person's health needs. The policy states that staff need to facilitate opportunities for communication, support clients to use augmentative or alternative communication systems, and consider the need for communication plans.

The four centres that comprise Hunter Residences use a Communication Profile template to outline the communication needs and preferences of individuals. The four-page Profile provides basic information to staff about the person's expressive and receptive needs, including how the person indicates feelings, yes, no, likes and dislikes.

Developments

DADHC staff are starting to receive training in Inclusive Communication and Behaviour Support (ICABS), which is designed to enhance communication by people with disabilities. This training program introduces a Checklist of Communication Competencies (Triple C) assessment for staff to use to determine the communication skills of individuals and the support they require.

4.3.2 What we found

Most of the people in our review required assistance with communication due to having a severe or profound level of cognitive impairment (44 people; 73%), and/or not having verbal language skills (35 people; 58%). Most of the residents relied on means other than verbal language to communicate, including gestures, facial expressions, body language, and behaviour.

Records indicated that the communication needs and preferences of 40 people (67%) had been identified. This included all of the people from Hunter Residences (30), and five of the six Lachlan residents. We also found:

- Of the 25 residents in the remaining four centres, 14 (56%) did not use verbal language. However, the communication needs and preferences of only five of the 25 individuals had been identified.

- Eight people whose communication needs had not been identified had information on their files that indicated a clear need for this action. This included documents noting staff difficulties in understanding the person, and information that indicated the use of self-injurious behaviour to communicate frustration.

In determining whether residents' communication needs were being met, we considered whether recommended actions had been implemented, whether necessary alternative or augmentative communication tools were used in practice, and whether there was interactive communication between the person and others.

Through consideration of file information and meetings with staff and residents, we found that both the expressive[26] and receptive[27] communication needs were being met for 12 people (20%). Half of these individuals used verbal language. Most of the residents had communication needs that required attention to address:

- Forty-one people (68%) had unmet needs regarding expressive communication, and 45 people (75%) had unmet receptive communication needs. This included people who:
- were reported to have communication dictionaries or use communication boards, but there was no information that indicated that these tools were incorporated into everyday support for them
- had a communication assessment, such as the Triple C checklist, but there was no

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[26] How people express themselves
[27] How people receive information from others

information to indicate any action following that assessment, such as instructions for staff on how to meet the person's communication needs

- had documents such as a behaviour support plan or Individual Plan that made recommendations as to what staff needed to do to meet the person's communication needs, but there was no information that indicated that the recommendations had been, or were planning to be, implemented.

• The IPs of 23 people (39%) included communication-related goals, such as to create a communication dictionary, or to organise a communication assessment. Records indicated that work had been undertaken to achieve those goals for 11 of the 23 people (48%).

The impact of unmet communication needs on people with disabilities can be significant. In our review, we noted people whose distress was unable to be determined by staff, who appeared to have minimal input into decisions that directly affected them, and whose records indicated that their challenging behaviour was related to their communication difficulties. We also noted people whose unmet communication needs had resulted in a decline in their prior skills, such as sign language.

4.4 Health care

Some of the people in our review had health concerns that required ongoing support and regular review, including incontinence, epilepsy and dysphagia. Overall, we found that the health care needs of residents were being met, including comprehensive planning, involvement of relevant professionals, and responsiveness to health changes.

We identified some areas where service practice could be enhanced, including the quality of the information provided to GPs, reviews of health care plans, and involvement of the resident in the planning to address their health needs.

4.4.1 Requirements

Policy requirements

The latest version of DADHC's *Health Care* policy was released in March 2007. The policy clearly links key health care reviews and plans in with the individual planning process. The policy requires that:

• the client is supported to meaningfully participate in the development of their health care plan;

• all clients will have an annual health care assessment conducted by their GP, the outcome of which is documented in their health care plan;

• when a client requires the involvement of a health professional to achieve a health-related goal, the Keyworker arranges an appointment or requests a service;

• the health care plan is reviewed at least three-monthly or whenever there is a change in the client's health status; and

- prior to the IP meeting, the person's key health intervention plans and risk assessments, including the nutrition and swallowing risk checklist and Client Risk Profile, are reviewed.

Relevant performance indicators

DADHC's Quality and Safety Framework has two key performance indicators relating to health care. One indicator measures the percentage of clients that had a comprehensive health care plan in place that had been updated prior to the annual IP meeting and reviewed within the last three months. As at February 2008, DADHC's Quality and Safety Framework data recorded compliance ranging from 100% in Kanangra and Riverside to 82% in Rydalmere and Marsden.[28]

The other key performance indicator measures the percentage of clients that had an annually completed nutrition and swallowing risk checklist. DADHC's Quality and Safety Framework data recorded compliance ranging from 100 per cent in Tomaree, Lachlan, Grosvenor and Riverside, to 85 per cent in Marsden.[29]

4.4.2 What we found

In the main, health issues were identified and addressed. We found that all of the residents had some form of health care plan, the health care planning documents in many cases were comprehensive, and there were some sound links between health care planning and risk management.

We noted examples of positive practice in meeting the health care needs of residents, including support to assist residents to quit smoking; consideration of particular health issues of relevance to an Aboriginal man; responsiveness to health concerns (such as over- and underweight); and referrals to appropriate professionals, including allied health providers and specialists.

However, our review identified some gaps in the planning undertaken to meet the health needs of residents. From records we examined:

- There was evidence that one of the 60 residents had been involved in the development of their health care plan. For the other residents, there was no information on file to indicate that they had been supported to participate, or that a representative had been consulted.

- In relation to the annual comprehensive health assessment, staff are required to record key health information for the GP to refer to during the assessment. For 19 people in our review (32%), this information had either not been recorded (10 people), or the information was inaccurate or incomplete (nine people). File information indicated that three people had not had a comprehensive health assessment in the previous 12 months.

- For 13 people (22%), the nutrition and swallowing risk checklist either did not identify

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[28] DADHC advice, 5 February 2008.
[29] Ibid.

all of the person's risks (eight people), or there was insufficient information to indicate the actions to be taken to address the risks (six people).

- Health care plans for 10 people had not been reviewed. For a small number of people (four), key health documents had not been updated to reflect a change in the person's condition, despite indications on the plans that they had been reviewed. For example, the health care plan for one man continued to record that he needed a helmet for seizures although he no longer experienced seizures and had not worn a helmet for an extended period of time.

- For a small number of people (three), their files indicated that they required referral to a specialist health provider such as a psychiatrist or gastroenterologist, but there was no record that this had occurred.

Records indicated that the health care plans for the six Riverside residents had not been reviewed. We note that our findings in this area did not match the results of DADHC's Quality and Safety Framework. DADHC's monitoring activity found full compliance with health care plan reviews at Riverside.

4.5 Behaviour support

Most of the people in our review had behaviour support needs. We found that the majority of people with behaviour support needs had a current behaviour intervention and support plan in place that was implemented and reviewed, and had the involvement of a psychiatrist and/or psychologist.

However, our review identified that two key policy requirements regarding behaviour support had not been consistently met: involvement of the resident, and addressing lifestyle and environmental needs.

Our review has also raised questions about the adequacy of access by Riverside residents to behaviour clinicians.

4.5.1 Requirements and developments

Policy requirements

DADHC has a number of policies to guide staff in supporting people with challenging behaviour, including *Providing behaviour support and intervention for people with an intellectual disability*, *Behaviour Intervention*, *Managing Client Risks*, and *The Positive Approach to Challenging Behaviour*.

The policies require that:

- lifestyle and environment requirements are addressed in the person's IP prior to formal behaviour intervention;
- the client and the people important to them are involved in the development of any positive behaviour intervention;

- the behaviour intervention plan is monitored, and reviewed at least quarterly (including restricted practices); and

- the use of a restricted practice has approval from the Restricted Practices Authorisation Panel and is used with positive behaviour support practices; and where consent is required for a restricted practice, this is obtained from the appropriate legal decision-maker.

Relevant performance indicators

In relation to behaviour support, DADHC's Quality and Safety Framework has two key performance indicators to measure compliance. One indicator measures the percentage of clients that had an annually approved Restricted Practice Authorisation Plan, if restricted practices were used as part of their daily support. DADHC's Quality and Safety Framework data, as at February 2008, recorded compliance ranging from 100 per cent in Tomaree, Lachlan, Rydalmere, Marsden and Riverside, to 67 per cent in Peat Island and zero in Grosvenor.[30]

The other indicator measures the percentage of eligible client referrals for internal DADHC services (such as behaviour support) that were not serviced. Quality and Safety Framework data recorded that all eligible client referrals were serviced in Lachlan and Grosvenor, but 32 per cent of referrals at Rydalmere and 27 per cent of referrals at Peat Island were not serviced.[31]

Developments

The majority of the DADHC residential centres have access to in-house psychologists. In some cases, this service is shared between centres, such as Rydalmere and Marsden. However, staff at Lachlan and Riverside must make requests for behaviour support from psychologists attached to the local Community Support Teams. At the time of our review, Riverside did not have the involvement of a psychologist.

4.5.2 What we found

Most of the residents in our review (47, 78%) had behaviour support needs. Three-quarters of the 47 residents (35 people) had significantly challenging behaviour, such as self-injury, assaults, physical aggression, and/or property destruction.

We found that most of the behaviour support practices within the centres largely matched the policy requirements:

- A large proportion of the people with behaviour support needs (39 people; 83%) were receiving psychotropic medication. Records indicated that for over two-thirds of these individuals (27 people), the medication was used to treat an identified mental illness or a health issue such as epilepsy.

- The files of 12 people indicated that they received psychotropic medication for

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[30] DADHC advice, 5 February 2008.
[31] Ibid.

      behaviour management purposes only. All of these individuals had a current Behaviour Intervention and Support Plan (BISP), and all but one person had the continuing involvement of a psychiatrist.

- Almost all (94%) of the 47 people with behaviour support needs had a current BISP. In the main, records indicated that the BISPs were implemented (32 people; 72%) and that BISP implementation was monitored (35 people; 74%). For 30 people, a psychologist monitored BISP implementation.

- Most (39 people; 83%) of the residents with behaviour support needs had the involvement of a psychologist.

- Records indicated that restricted practices were used in relation to 14 of the 47 people (30%) with behaviour needs. This mainly comprised the use of PRN psychotropic medication, but also included seclusion, restricted access, and/or physical restraint. In the main, the restricted practices had been authorised as required (13 people; 93%), and had been reviewed in line with the required timeframe (10 people; 72%).

We noted positive examples of behaviour support on the files of some residents, such as the removal of restricted practices following a change in behaviour and/or environment, and the use of behaviour strategies rather than medication.

Records indicated that the behaviour support needs of 12 of the 47 people (26%) had reduced or ceased. For example, the behaviour needs of one woman with complex mental health issues had reduced significantly following the involvement of the Statewide Behaviour Intervention Service, changes to her environment (own room, downstairs from other residents, near the staff room), changes to her lifestyle (large amounts of 1:1 activities and community access), and modification of psychotropic medications by her psychiatrist.

However, we found that policy requirements regarding lifestyle and environment needs and the involvement of the resident in the development of their BISP were not being consistently met for most of the people who had behaviour support needs.

Records indicated that the guardian or family members of six people were involved in the development of their BISP. There was no evidence on file that any of the residents with behaviour support needs were involved.

Lifestyle and environment needs

Lifestyle and environment needs are required to be addressed in the person's IP prior to formal behaviour intervention. Lifestyle and environment reviews had been conducted for all of the individuals with behaviour support needs. However, records indicated that action was being taken to address the identified issues for only nine people (19%).

The unmet needs identified by staff in the lifestyle and environment reviews were extensive, involving accommodation, communication, community participation and integration, decision-making and choice, and skills development. The particular issues identified were wide-ranging. For example:

- With regard to community participation and social integration, staff identified that some

residents had unmet needs for socialisation or joining social groups, had no opportunity to develop meaningful relationships outside of their residence, had no contact with people in the community other than family, and/or needed a holiday.

- In relation to skills development, staff identified through a lifestyle and environment review that some individuals needed to build their self-esteem, commence literacy classes, and/or be involved in training in self-care and personal care skills to do things more independently.

Action to address the lifestyle and environment needs of the people who required behaviour support appeared to be less common for those who had a severe or profound level of cognitive impairment. Records indicated that both of the people with a profound cognitive impairment who required behaviour support had unmet lifestyle and environment needs, as did 21 of the 30 people (70%) with severe cognitive impairment and behaviour needs.

We found that the unresolved lifestyle and environmental issues of the people in our review had a significant impact on their behaviour support needs:

- The BISP for one man stated that his behaviour, including face slapping, hitting, pulling staff to the ground, and smashing crockery, was an attempt to communicate needs such as boredom, anxiety, and excitement. The man's IP included some goals to address his communication needs, such as the use of Makaton. However, there was no record on file of work undertaken to achieve those goals.

- The BISP for one woman stated that she had a high amount of down time when in the unit, and that this was likely to be contributing to boredom and challenging behaviour. It recommended the inclusion of more meaningful activities to supplement her daily routine. This recommendation had been carried over from the previous BISP (from 2004), and records indicated that the issues were continuing. However, the need for more meaningful activities was not addressed in her IP. The BISP included a skills development plan, but there was no record on file of action taken by staff to implement that plan.

- Positive behaviour support practices documented for one man noted that he should be given assistance to increase his expressive communication skills, and that it was important for staff to assist him in helping with household tasks. There was no information on file to indicate that these recommendations had been carried out, despite the man's parents having expressed frustration with the lack of progress in changing his behaviour.

Staff at the Lachlan Centre used the lifestyle and environment review to feed directly into the IP goals. We did not see a clear link between the lifestyle and environment review and the IP in the other centres.

File and staff information raised questions about the adequacy of access to behaviour clinicians for Riverside residents. Three Riverside residents in our review had restricted practices in place that had interim (short-term) authorisation only. The restricted practice documents for these residents recorded that only interim authorisation could be provided due to the lack of access to psychologists to review the behaviour management strategies. Records

also indicated that the restricted practice authorisation was overdue for review. We note that our findings did not correspond with DADHC's Quality and Safety Framework data, which recorded full compliance with restricted practice requirements at Riverside.

4.6 Day programs

Most of the people in our review attended a day program that was operated by DADHC on site at their residential centre.

We found that the needs, goals and wishes of residents rarely informed the planning or provision of their day program. Our review also identified that day program services for most of the residents were not based on, or linked to, their IP.

4.6.1 Requirements

Departmental requirements

DADHC's website states that day programs provide 'purposeful day activities that are valued by clients and community members, that are based on a person's Individual Plan and that promote learning, skill development and enable access, participation and integration in their local community'.[32]

According to DADHC's information, there are four areas of activity in day programs: skills development, community access, adult education, and leisure and recreation.[33] There are currently no policies or standards that have been developed in relation to the provision of adult day programs.

Developments

Commitments under the *Stronger Together* 10-year plan include a significant increase in the number and range of day programs. DADHC has advised that the broad policy direction for DADHC-funded day programs will be based on a continuum of age appropriate services.[34]

However, while DADHC-operated day programs are progressively being outsourced to the non-government sector, this does not include the day programs that operate within DADHC's residential centres. DADHC staff operate all of the day programs located on site in departmental residential centres.

As noted, DADHC has advised of plans to redevelop three of its residential centres: Peat Island, Lachlan, and Grosvenor. The department has advised that plans for the proposed accommodation include funding for offsite day programs that are skills and age appropriate, linked to residents' individual plans, and operated by non-government organisations.[35]

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[32] DADHC website, www.dadhc.nsw.gov.au/dadhc/People+with+a+disability/Day+Programs.htm
[33] Ibid.
[34] DADHC advice, 10 July 2008.
[35] DADHC advice, 17 June 2008.

During our review, DADHC day program staff told us about changes that were underway or planned for on site day programs. Of note, we were told that the day programs at Hunter Residences and Rydalmere/ Marsden were in the process of completing restructures that had taken over three years. Key changes as a result of the restructures included a move to non-nursing staff, incorporation of residents' IPs into day programs, and a greater focus on the communication needs of residents and their involvement in decision-making.

4.6.2 What we found

All but four of the 60 residents in our review attended some form of day program or day activity. For the majority of people (44 people; 79%), this involved attending a day program on site only. Seven people attended on site and off site day programs, and five people participated in off site day programs or other activities only, such as school or activities with workers from a post-school options service.

We were able to ascertain through file or staff information how often 47 people attended their day program or activity, and most attended 15 hours per week or less (27 people; 57%).

The day programs mainly comprised group activities (32 people; 57%). Residents were involved in a mix of passive activities, such as watching videos and listening to music, and active options, such as craft and gardening.

Our review raised questions as to the adequacy of the work undertaken in day program services to identify and meet the needs of residents, particularly those operating on site in DADHC's residential centres. Overall, work to identify the goals, needs or wishes of residents appeared to be inconsistent and infrequently involved the person concerned:

- Records indicated that six people were consulted about their day program involvement or the service provided. Staff had conducted an assessment, such as a likes and dislikes checklist or a needs assessment, on 10 people.

- File information indicated that 20 people (36%) chose what day program activities they would participate in, primarily through refusal to attend. Refusal to attend did not appear to prompt a review of the person's individual plan or day activities.

- For 33 people (59%), there was no indication through file, staff or resident information that they had been involved in decisions about what day program they would attend, who they would attend with, what activities would be offered, or what activities they would participate in.

In addition, we found that day program activities were rarely based on or linked to the person's IP:

- Seven people (13%) had a goal in their IP that was linked in some way to their day program, school, or post-school options program.

- For 21 people who attended a day program (38%), a day program representative did not attend the IP meeting, and a day program report was not on file.

At the time of our review, there were significant gaps in staffing across the on site day programs: Hunter Residences was operating with a 60 per cent vacancy rate, while

Rydalmere and Marsden day programs were operating at approximately 50 per cent regular staff, with some casual staff.

File and staff information identified issues of accessibility associated with the on site day programs for some residents. In one centre, a resident in a wheelchair was unable to attend the day program as the path to the day program site was considered to be inaccessible. In another centre, the location of some day programs at a considerable distance from the residential units reportedly made it difficult for people with mobility difficulties, particularly in poor weather. Information suggested that the issues of accessibility were compounded by a lack of wheelchair-accessible vehicles.

4.7 Community participation and integration

Our review has raised questions about whether residents have adequate and meaningful participation in and integration into their community. We found that for many people in our review, access to the community was infrequent, heavily reliant on DADHC staff, and largely comprised group outings with other residents.

Our review also found that few residents were involved in decisions regarding their access to, and involvement in, the community.

4.7.1 Requirements

Legislative requirements

Meaningful participation and integration in the community of people with disabilities is central to disability services legislation and standards.

The Disability Services Act requires services to promote the participation of people with disabilities in the life of the local community through maximum physical and social integration in that community.

At a minimum, the Disability Services Standards require services to:

- assist people, through skills development and their individual plans, to identify, participate and maintain involvement in activities and programs in the community

- provide appropriate support and monitor the outcomes of individuals' participation in and integration into the community

- support people to develop social networks and to participate in decision-making in the community

- promote the ability and valued status of individuals when supporting their participation in and integration into the community

Developments

In relation to Hunter Residences, DADHC has advised that community access, participation

and integration for residents is a priority, and each RUNM is expected to develop strategies that will facilitate and enable individual 1:1 outings for each person on a regular basis. In addition, the RUNM is expected to identify any barrier impacting on an individual's community participation opportunities and put actions into place to address the barriers.[36]

DADHC told us that Metro Residences would focus on this area during 2008, with the aim to increase the quantity and quality of community access for residents.[37]

4.7.2 What we found

Our review has raised questions about the extent to which DADHC residential centres comply with disability services legislation and standards regarding community participation and integration. In particular, our review indicated that work is required to enable residents to have 'maximum physical and social integration' in the community, have meaningful involvement in community-based activities and programs, and participate in decision-making in the community.

Records indicated that all but two of the 60 residents had some form of community access.[38] However, we found that for many people in our review, access to the community was infrequent:

- We were able to establish the amount of community access for 45 residents. Of these 45 people, more than half had access to the community for three hours per week or less (23 people; 51%).

- Records indicated that 24 residents (40%) had been on a holiday in the last two years.

The main way in which residents accessed the community was in groups. Of the 52 people for whom this information could be identified:

- Forty people (77%) accessed the community as part of a group of residents most or all of the time. Only nine people appeared to have mainly individual community access.

- The community access for at least 30 people (58%) primarily comprised group bus outings to locations such as parks and reserves for a meal (morning or afternoon tea, or lunch) and return to the centre.

Community access for many of the residents (38 people; 66%) was heavily reliant on DADHC staff. Twenty people accessed the community through family members, an off site day program, or through paid providers.

File, staff and resident information indicated that few residents were involved in decisions regarding their access to, and involvement in, the community. Eight people appeared to have a say in what they did, two people chose who they went with, and four people had a say in

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[36] DADHC advice, 14 April 2008.
[37] Ibid.
[38] In calculating community access, we included attendance at community-based activities such as an external day program, regular home stays, and school.

when they went.

We found that community integration and participation goals were included in the IPs of many residents, but the work undertaken to implement the goals was largely inconsistent:

- Forty people (67%) had a goal in their IP that related to community access. Records indicated that work had been undertaken to achieve those goals for just over half (22 people).

- The need for a holiday was included as an IP goal for 19 people (32%). According to file information, action was being taken to implement those goals for 10 people (53%).

Staffing was the dominant factor that appeared to impact on residents' community participation, including availability overall, availability on certain shifts, new staff, Registered Nurses not on shift, or inconsistent staffing. File and staff information indicated that community access was also affected by:

- perceptions that staff on P-plates were unable to drive DADHC vehicles;

- lack of resources to meet the needs of some people on community access, such as two staff to one person;

- lack of, or inadequate access to, wheelchair-accessible vehicles;

- perceptions that paid holiday providers were unable to meet the needs of some residents, or did not present value for money;

- perceptions that Assistants-In-Nursing could not take residents with epilepsy on outings due to the need to administer medication;

- the individual's behaviour or health; and

- lack of appropriate equipment (such as a wheelchair, or pole for PEG feeding).

Some centres had employed additional positions to increase community access (or specifically targeted at community access), such as Lachlan, Rydalmere, and Grosvenor. We also noted positive actions in relation to community access, including 1:1 outings to the Royal Easter Show, involvement of Lachlan residents in sports that involve people with and without disabilities from the centre and the community, and involvement of Tomaree residents in a fishing program that had commenced through the Department of Sport and Recreation.

4.8 Leisure and skills development activities

Staff had identified that many of the residents needed to develop skills, such as meal preparation, literacy, laundry, and travel. However, we found that the action taken to address the residents' needs, such as providing the opportunity for them to learn and practise those life skills, was inconsistent. Our review raised questions about the extent to which there was a focus on increasing the independence of people living in DADHC residential centres.

4.8.1 Requirements

One of the key principles of the Disability Services Act is that people with disabilities have

the right to realise their individual capacities for physical, social, emotional and intellectual development.

The Disability Services Standards require that services:

- focus on producing good outcomes for people with disabilities, including increased independence;

- encourage and support individuals to participate in the range of activities enjoyed by other members of the community; and

- provide opportunities to individuals to learn and practise life skills that promote independence.

4.8.2 What we found

File and staff information indicated that many of the residents in our review had considerable amounts of free time. Combined, day program attendance and outings totalled 10 hours per week or less for 27 people (45%), and between 11 and 20 hours per week for 14 people (23%).

Leisure activities

Common activities included walks in the grounds of the centre, 'relaxation', therapy, listening to music, watching TV, and 'table activities'. The activities of 16 people (27%) were largely limited to meals, hygiene, therapy, and walks on the centre grounds.

For 31 residents (52%), group activities were dominant. Most of the centres provided on-site group events or activities for large numbers of residents, such as Christian Hour and activities in a recreation hall. We found that some external services were brought into the centres, such as a harpist, music therapist, Pets as Therapy, and Macquarie Community College.

In order to identify resident goals, wishes or needs regarding activities, staff typically completed a checklist of recreational or activity likes and dislikes (34 people; 57%). Nine residents had been consulted in some way regarding their activity needs or wishes, and the family members of eight people had been consulted.

In one unit, occupational therapy students had conducted sensory trials with residents to establish what activities would work best for individuals, and their preferences. However, while the trials were completed, file and staff information indicated that there had been no outcome from that work. The development of a sensory activity package had been flagged in one resident's file, but this had not progressed.

The IPs of 35 residents (58%) included goals related to leisure activities, such as to increase the person's leisure options, or to purchase a stereo and some music. For most of the people (25 people; 71%), we found that action had been taken to implement those goals.

Skills development activities

File and staff information indicated that staff had identified the need for, or likely benefit of,

involvement in activities such as meal preparation, laundry, housekeeping, and travel for 44 residents (73%).[39] However, our review indicated that work had been undertaken in response to this need for only half of these individuals.

For most of these 22 people, skills development had been included in their IP (11 people), or there was some form of skills development plan on file (three people). For 10 of the 22 people, their involvement in skills development activities was at their day program.

There had been some reductions in residents' opportunities for skills development, including:

- One resident had a goal in her IP to cook pikelets weekly, and the unit in which she lived had a functioning kitchen. However, at the time of our review, the kitchen was unable to be used due to the need to accommodate a resident in the area nearby.

- Some residents at Lachlan previously attended the local TAFE to do cooking, but this had been discontinued due to safety concerns about sharp implements.

- There was a teacher who ran numeracy and literacy skills courses at Kanangra, but this had been discontinued.

- One of the units at Marsden was initially intended as a stepping-stone to the community, designed to enable training in living skills. However, at the time of our review, meals were provided for residents through the week. On weekends, meals were either cooked in the unit or residents went out for meals. Staff told us that they set household tasks for residents to assist with, such as folding things, and putting things away.

We found that people who had a physical disability and/or a severe or profound level of cognitive impairment were much less likely to be involved in skills development activities than those without a physical disability, and/or with a mild or moderate cognitive impairment.

Records indicated that 22 people (37%) had a say as to what leisure or skills development activities they would participate in, 11 people (18%) chose when they would participate, and three people chose who they would participate with. Choice was demonstrated largely through resident refusal to participate in certain activities or in certain environments, such as noisy areas or activities with a lot of people.

4.9 Finances

We found mainly positive practice on the part of DADHC staff in identifying and meeting the financial needs of individuals. However, our review identified two aspects where service practice could be improved: involvement of residents in decisions about the use of their funds, and payment for aids and equipment.

4.9.1 Requirements

DADHC has two policies that guide staff in meeting the financial management and equipment

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[39] We did not include communication, social, and decision-making skills in our consideration of skills development activities as they are considered separately in other sections of this report.

needs of residents. The *Managing Client Finances in DADHC Residences* and *Aids for Individuals in DADHC Accommodation Services* policies require that:

- DADHC staff complete an Annual Budget when developing the client's IP, and ensure that consultation occurs with the client, their family, advocate, guardian and/or financial manager in its development.

- DADHC is responsible for the provision of aids and appliances for clients living in the accommodation services it operates.

- The client's fortnightly expenditure is reviewed at the IP review.

4.9.2 What we found

Overall, we found that support provided regarding residents' finances largely matched policy requirements:

- There was an annual budget on file for almost all of the residents (57 people; 95%)

- In the majority of cases, the person's budgeted expenditure appeared to match their routine and involvement in activities (52 people; 87%).

- For the majority of the residents, we found that consideration had been given to using the person's funds to improve their quality of life (52 people; 87%). In the main, this was demonstrated through holidays, but also included massages, paid day outings/ community access, a new bed, dining out, magazine subscriptions, a leather armchair, music, and a stereo. Five people had funds available to improve their quality of life, but we did not see evidence that this was considered to any significant degree. This included a number of people with $20,000 - $85,000 in trust.

We identified two specific aspects where service practice could be improved: involvement of residents in decisions about the use of their funds, and payment for aids and equipment.

Records indicated that two residents had been consulted in the development of their budget. Many family members were consulted in the development of the person's budget (29 people; 48%), regardless of whether or not the person was under the Office of the Protective Commissioner.

Information on file indicated that the finances of five people had been used to purchase aids or equipment or were used on things DADHC had responsibility to pay for through other accounts. This included the purchase of a wheelchair, a sling, and a shower chair, and payment of approximately $600 a year on 'transport costs' for weekly unit bus trips.

4.10   Relationships

Overall, we found that the majority of residents had family contact, and staff put substantial effort into supporting residents to regain and maintain contact with their families. However, outside of family relationships, we found that few residents had relationships with others.

4.10.1 Requirements

The Disability Services Act requires that services recognise the importance of preserving the family relationships and the cultural and linguistic environments of people with disabilities. The Disability Services Standards require that services:

- Support individuals to develop and maintain relationships, including social relationships with other members of the community

- Support and encourage individuals to maintain contact and involvement with their family, friends, advocates and guardians

- Minimise any impediments to contact between, and impose no restrictions on contact with, individuals and their family members, friends, advocates and/or guardians

4.10.2 What we found

Relationships with families

In relation to family contact, records indicated that the majority of the residents had some contact with their families (54 people; 90%).

For most people, the frequency of contact with their families was weekly to monthly, and was in person on or off site, or via phone contact with staff. Fifteen of the 54 people (28%) had infrequent contact with their families:

- Four people had less than annual contact.

- Eleven people had six to 12-monthly contact with their families; the contact for five of these families solely comprised telephone calls with staff.

We found that staff made a significant effort to locate lost family members, and to support residents to regain and maintain contact with families. This included sending cards and flowers on birthdays or Mother's Day, developing fridge magnets with a photo, and regular phone calls. Records indicated that staff continued to contact families even where the family member was reported to be reluctant to initiate contact or visit the person.

The IPs of 13 people (22%) included goals related to maintaining or extending family contact. We found that this goal was being implemented for eight people. For the five people whose goals related to family contact had not been implemented, file information indicated that two were external visits to siblings that had been hindered by staffing constraints.

For two people, changes in their residential placement had negatively impacted on their contact with family. One man who used to see his sister twice a year had not been able to see her since he moved to a different centre; and another man who moved from a group home to a centre in a different region was no longer able to stay at his parents' house on fortnightly weekends.

Relationships with others

For the majority of residents (49 people; 82%), we did not see evidence, through file or staff information, of particular relationships outside of family. For at least 11 people, information on file indicated that they did not necessarily enjoy or seek out the company of co-residents.

For example, references included descriptions of individuals as a 'loner' or 'isolative', 'tends not to interact with people she lives with', 'does not see peers as equals', and 'prefers staff contact'.

We found that nine people had friends either at that centre or at a previous centre they had lived in, and two people had intimate relationships (not with each other). For the 11 people (18%) who had a friendship or intimate relationship, staff generally supported those relationships in some way. For example, we noted positive examples of practice by staff in relation to supporting the two people who had intimate relationships. This included the involvement of a psychologist to determine potential risks to the individuals, whether informed consent was being provided, and how privacy and safety needs could be met.

Thirty-four people (57%) did not appear to have any contact with people outside of their family, co-residents or paid staff. For the other 26 people, contact included an external day program or school (14 people), holiday providers (nine people), guardians (five people), and advocates (two people).

Of the six people who did not have any contact with family members, half did not appear to have contact with anyone outside of staff. Two of these people had a public guardian appointed, and the other person had an advocate. Contact between these three individuals and their guardian or advocate was six to 12-monthly.

The IPs of 15 people (25%) included goals related to developing relationships outside of their residence. For eight of these people, the goal involved investigating options for a paid 1:1 community access provider, joining a club, or strengthening existing friendships through specific outings. Records indicated that these goals were being implemented for seven of the 15 people (47%).

Cultural relationships

Of the two people who were identified as being Aboriginal, records indicated that the cultural needs of one person had been considered, and staff had taken steps to try to locate the man's mother and link him to members of the local Aboriginal community through art activities. The cultural needs of the other person did not appear to have been specifically considered, although staff continued to take steps to maintain family contact.

Of the eight people who had culturally and linguistically diverse (CALD) backgrounds, file information indicated that the cultural needs of two people had been considered, including links to Greek festivals and attendance at a Greek Orthodox church. The parents of both these residents were actively involved.

4.11 Factors impacting on ability to meet individual needs

4.11.1 Access to services

Our review indicated that access to allied health and psychological services was inconsistent across the centres. While most of the centres had allied health practitioners and psychologists on staff (or shared those services between residences), Lachlan and Riverside did not. Those

centres had to access these services through their local Community Support Teams (CST), and had reportedly experienced problems associated with this.

Lachlan staff told us that the Quality and Safety Framework process had helped their residents obtain improved service through the local CST as it had identified that there were some serious gaps in relation to access behaviour support and allied health services.

Access to CST services by Riverside residents continued to be problematic at the time of our review, particularly in relation to obtaining behaviour assessment and support. Riverside staff told us that they were receiving inconsistent advice about whether residents could obtain services through the local CST or not. We saw the negative impact of these access issues on the residents of Riverside, including the use of outdated behaviour support plans and restricted practices.

Rydalmere staff told us that access to behaviour intervention and support services had improved since psychologists had been appointed to each unit. Staff reported that under the previous system there was at least a 12-month wait to see a psychologist, but the system was now responsive. One of the locked units in Rydalmere had monthly clinical meetings involving the RUNM, case manager, and psychologist.

Some staff reported difficulties in meeting the needs of residents due to delays in obtaining a response from the Office of the Protective Commissioner to requests for expenditure approval. This had affected requests for important supports such as a specific reclining chair to meet the needs of a person with significant physical impairments.

4.11.2 Staffing and access to training

We identified considerable gaps in staffing and/or low staffing levels in some centres and units, particularly in Lachlan, Riverside, and Stockton. Our review found that gaps in staffing, or staffing constraints, had an impact on residents, particularly in relation to community access and the implementation of IP goals.

We found that training for staff was inconsistent across the centres. We were advised that some centres had dedicated Clinical Nurse Educator positions to provide training in areas such as individual planning, but other centres, such as Riverside, did not.

4.11.3 Accommodation

The number of people per bedroom depended on the particular unit and the support needs of the individual. At least 15 residents shared with one to three other people. We note that some residents tended to be with the same people in their room, their unit, at the day program, and on outings.

The ability of residents to move around within their unit and around the centre more broadly depended on the particular centre in which they lived. Tomaree residents were able to move around the grounds, including into other units, while most other centres had some restrictions. Some units were locked, requiring staff authority and intervention to enable entry or exit. In units that were not locked, there were often other restrictions, such as locked wardrobes, and/or fridges.

Four of the 30 people who lived in Hunter Residences had moved within or between centres. The freedom for one increased considerably with his move from a locked unit in Stockton to his own room in Tomaree. The man had difficulties sleeping when he was living in Stockton, but this had been resolved with the move.

The centres followed structured routines, with set times for activities such as meals, personal hygiene, and outings.

5. DADHC's response to our findings

DADHC's full response to our findings is attached (Appendix 1).

DADHC has advised of action taken since our review, including significant progress towards filling day program positions, and the allocation of a behaviour clinician position at Riverside.

However, the department's response does not outline a clear plan for addressing the findings in this report.

For example, DADHC has not indicated how it will address findings relating to:

- the lack of action taken to address residents' lifestyle and environment needs; and
- the continuing problems with the development and quality of individual plans (despite an existing system for oversighting and monitoring the plans and the individual planning process).

In a number of areas, where information has been provided by DADHC in response to the key findings, insufficient detail has been given about how the department will address the issues identified: particularly in relation to social integration; skills development; and resident participation and involvement in planning and decision-making.

Our review has shown that there is a critical need in DADHC's large residential centres to involve residents in decisions that affect them and in the planning and delivery of services and support to meet their needs. It is concerning that DADHC's response on this issue primarily focuses on staff encouraging residents' families and significant others to provide support to enable residents to participate. While it is appropriate for families and significant others to be involved in this process with the consent of the residents, this does not detract from DADHC's responsibilities to directly provide this kind of assistance, as required in disability services legislation.

In relation to many of the issues identified in our report, DADHC's response refers to the changes to service provision which will occur with the closure and redevelopment of the large residential centres. The department has told us that the expected changes include a move to day programs operated by funded services, and the development of accommodation models that incorporate individual bedrooms, maximise residents' independence and choice, and enhance opportunities for involvement in local communities and activities. However, we note that current plans for redevelopment focus on less than half of DADHC's large residential centres and there are no detailed plans for the closure or redevelopment of the other centres,

including the largest centres of Stockton and Rydalmere.

6. Conclusion

Our review identified that important needs of individuals in DADHC residential centres were not being identified or met. Of particular significance were unmet needs and goals regarding residents':

- involvement in decisions that affect them;

- ability to communicate with others and have their views heard;

- participation in and social integration into their community; and

- opportunity to develop and practise life skills to increase their independence.

These are important human rights that underpin disability services legislation and standards, and related DADHC policies. In reality, what these shortcomings mean is that the ability of these individuals to have control over their own lives and to fulfil their potential is significantly restricted.

The gaps between the requirements and practice in these critical areas raise questions about the adequacy of DADHC's current individual planning process for meeting the individual needs and goals of residents. They also raise questions about the capacity of the current model of service provision, particularly large residential centres, to ensure full compliance with these fundamental rights.

DADHC's review of its individual planning policy and process is a timely opportunity for the department to reform service planning and provision to people living in its residential centres, by putting the residents at the centre of that process.

7. Recommendations

1. By 30 August 2009, DADHC should develop a comprehensive action plan that details the steps it will take in the next 12 months to address the issues identified in this report. The action plan should clearly articulate the department's response to the following issues:

    a) Improve individual planning

    In particular, DADHC should indicate how it will:

    (i)   improve the quality of IPs (section 4.1)

    (ii)   ensure IP goals are implemented and action is taken to address barriers to implementing goals (4.1; 4.2; 4.3; 4.5; 4.7; 4.8; 4.10)

    (iii)   identify and address the unmet needs of residents, including accommodation needs and unmet needs identified through lifestyle and environment reviews

(4.1; 4.5)

    (iv)   ensure that IPs are reviewed (4.1)

    (v)   effectively monitor and oversight individual planning (4.1)

b) Foster resident involvement and participation in decisions and choices

In particular, DADHC should indicate how it will:

    (i)   provide clear information and support to residents to enable them to understand the individual planning process (4.1)

    (ii)   ensure that residents are active participants in their individual planning process, including the planning for their meeting, and consultation on their needs, goals and wishes (4.1)

    (iii)   foster and facilitate residents' participation in decisions affecting their lives, such as the planning and operation of their services (4.2 and 4.1; 4.3; 4.4; 4.5; 4.6; 4.7; 4.8; 4.9; 4.10)

    (iv)   ensure that residents have access to advocacy support, where necessary (4.2)

    (v)   clearly identify the communication needs of residents and ensure that those needs are met (4.3)

    (vi)   ensure that day program service provision for individual residents is informed by their needs, goals and wishes, and linked to their individual plans (4.6)

    (vii)   ensure that DADHC does not exercise control over all or most aspects of the lives of residents (4.1; 4.2; 4.6, 4.10)

    (viii) provide services in a way that results in the least restriction of residents' rights and opportunities (4.1; 4.2; 4.3; 4.5; 4.6; 4.7; 4.8; 4.10, 4.11)

c) Increase the independence of residents

In particular, DADHC should indicate how it will:

    (i)   provide opportunities to individuals to learn and practise life skills that promote independence (4.8)

    (ii)   improve the involvement of residents in meaningful activities (4.8 and 4.5; 4.6; 4.7)

    (iii)   ensure that the conditions of everyday life of residents are the same as, or as close as possible to, norms and patterns that are valued in the general community (4.2; 4.3; 4.7; 4.8; 4.10; 4.11)

      (iv)   improve accessibility for residents using wheelchairs (4.6; 4.7)

d) Foster relationships and community integration

In particular, DADHC should indicate how it will:

      (i)   promote and support the participation and integration of residents in their local communities, including increasing the amount of meaningful involvement of residents in community-based activities and programs (4.7; 4.8; 4.10)

      (ii)   support residents to develop social networks (4.7, 4.10)

e) Comply with departmental policy

In particular, DADHC should indicate how it will:

      (i)   ensure that accurate and complete information is provided to GPs to facilitate the annual comprehensive health assessments (4.3)

      (ii)   ensure that practice at Riverside complies with behaviour intervention and restricted practice requirements, including reviews of restricted practice authorisations and behaviour management strategies (4.5)

      (iii)   ensure that Quality and Safety Framework data accurately reflects practice (4.1; 4.4; 4.5)

2. In developing the action plan, DADHC should detail:

    a) the timeframes and positions/ persons responsible for each action

    b) how the department will monitor the implementation of the action plan and evaluate its effectiveness

    c) the communication and training strategy for staff, residents and significant others

3. DADHC should ensure that the findings from this report are considered in its review of the *Individual Planning* policy.

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner

Appendix 1

DADHC's response to our draft report

DADHC

Department of Ageing, Disability & Home Care

► **Office of the Director-General**

Mr Steve Kinmond
NSW Ombudsman
Level 24, 580 George Street
SYDNEY NSW 2000

AHI09/1145
Your ref: ADM/5809P03

Attention: Ms Kathryn McKenzie, Senior Investigation and Review Officer

Dear Mr Kinmond   Steve

Individual Planning in the Department of Ageing, Disability and Home Care's (DADHC) Large Residential Centres (LRCs)

I refer to the request for a written response to your draft report on Individual Planning in DADHC LRCs, *Planning to meet the needs and goals of individuals in DADHC residential centres.*

Please find enclosed the response from the Large Residential Centres and Specialist Supported Living Directorate (LRCSSL) in relation to the report.

Should you have any further queries, please contact Mr Peter Gardiner, Executive Director, LRCSSL on 9842 2444.

I trust this information is of assistance.

Yours sincerely

Ethel McAlpine

Ethel McAlpine
A/Director-General

24 · 4 · 09

Encl.

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Response to the NSW Ombudsman's Individual Planning review in DADHC operated LRCs 2008

In December 2008 the Deputy Ombudsman Mr Steve Kinmond wrote to the Director-General regarding a preliminary review of Individual Planning (IP) in DADHC operated Large Residential Centres (LRCs).

In March 2009, the Executive Director of Large Residential Centres and Specialist Supported Living (LRCSSL) and the Chief Executive Officers of Hunter and Metro Residences met with you and the Senior Investigation and Review Officer, Ms Kathryn McKenzie to discuss the report. Following this meeting, it was requested that DADHC provide a written comment to the findings in the review.

Key Findings

4.1 The Individual Planning process

Overall our review indicates that many residents were not active participants in their individual planning process including planning for their meeting, and consultation on their needs, goals and wishes.

We found that while some progress had been made for some of the residents towards achieving their goals, their progress was often not reviewed, and barriers to achieving some of the goals were largely unresolved.

All of the residents had some unmet needs, ranging from accommodation and advocacy to relationships and skills development. In the main we found that staff had identified most needs, but considerable work was required to address them.

- Most residents require support from others to participate actively in the planning process due to communication and cognitive challenges.

- Significant others, such as family, friends, person responsible, advocates and volunteers are encouraged to attend the annual IP Meeting and six monthly review to support the individual resident. Many families are ageing but the LRCs have been encouraging the residents' siblings to step up to the person responsible role. Where they cannot attend annual IP meetings or the six month review, they are supported to participate in decision making and planning through the mediums of teleconference, email, phone calls and written reports. These mediums are also used on a daily basis to provide information and to engage in decisions around daily lifestyle.

- A change in skill mix within the LRCs has resulted in a greater proportion of Assistants in Nursing who often have no disability background or training, particularly in the area of IP this has created challenges. Significant resources are being invested in supporting these staff to develop an understanding of the IP process.

4.2 Decision Making and Choice

Our review found that DADHC residential centres were not consistently meeting policy requirements regarding decision making and choice. Residents were infrequently involved in making decisions and choices about their lives, including the services provided and their preferred lifestyle. Concurrently we found that few residents accessed advocacy support.

- Residents with severe and profound cognitive impairment face significant challenges in making decisions and choices about their service options without support. The Inclusive Communication and Behaviour Support (ICABS) training program, which increases staff skills in communicating with residents, has been provided to approximately 30 per cent of LRC staff, with a significant proportion still to be trained.

- Informal advocacy in decision making and choice is encouraged through families, friends, person responsible, advocates and volunteers. The Office of the Public Guardian (OPG) and the Office of the Protective Commissioner (OPC) provide formal advocacy in areas of their delegation.

- External advocacy services are limited in being able to support people in LRCs around choices in everyday living. The provision of advocacy services can be sourced around specific issues with priority given by advocacy services for issues such as accommodation. Funding for advocacy services for LRC residents is considered in the LRC redevelopment program.

4.3 Communication

Most of the people in our review required assistance with communication and relied on means other than verbal language to express themselves. We found that the communication needs and preferences of many of the residents had been identified. However, those needs and preferences were being met for a minority of people.

- DADHC recognises that communication support is important if residents are to be able to participate in IP and making decisions and choices. ICABS training for staff and Makaton training for residents and staff is provided through the Learning and Development Program and ICABS training is prioritised in the Learning and Development program in LRCs. The recruitment of speech pathologists will assist in achieving improvements in communication support for residents.

- It is also recognised that behaviour is often the communication medium for some residents. Recognising the purpose of the behaviour and supporting the individual to express their wishes in a more appropriate way is supported through behaviour intervention support (BIS) plans.

- Training programs have been developed and implemented to increase the skills of Assistants in Nursing and Enrolled Nurses in understanding the purpose of challenging behaviour and managing that behaviour.

- Although communication needs and preferences were often identified, DADHC is aware that further work is required to source augmentative

communication tools to support communication between the individual and others.

4.4 Health Care

Overall we found that the health care needs of residents were being met, including comprehensive planning, involvement of relevant professionals, and responsiveness to health changes. We identified some areas where practice could be enhanced, including the quality of information provided to GP's reviews of health care plans, and involvement of the resident in planning to address their health needs.

- The majority of people living in LRCs have complex and recurrent health care needs. As with IP generally, communication and cognitive challenges require the support of others to assist the individual to participate in health care planning.

- Annual health reviews by nursing staff to inform the General Practitioner (GP) or Medical Officer prior to the annual health assessment are a requirement.

- Some LRCs face challenges in sourcing GP services to ensure that timely annual Health Assessments are undertaken.

4.5 Behaviour Support

We found that the majority of people with behaviour support needs had a current behaviour intervention and support plan in place that was implemented and reviewed, and had the involvement of a psychiatrist and/or psychologist. However, our review identified that two key policy requirements regarding behaviour support had not been consistently met: involvement of the resident, and addressing lifestyle and environmental needs. Our review has also raised questions about the adequacy of access by Riverside residents to behaviour clinicians.

- A large number of people in LRCs exhibit challenging behaviours. As with IP generally and health care planning, communication and cognitive challenges require the support of significant others to support the individual to participate in behaviour support planning.

- A behaviour clinician employed by the Metro North Region Behaviour Intervention and Support team has now been based at the Lachlan Centre to overcome difficulties in accessing services. Riverside Centre has also been allocated a behaviour clinician position.

- BIS training is being provided for direct-care staff through the Learning and Development Program in LRCs.

4.6 Day Programs

The report found that most people attended a day program on site operated by DADHC and that the needs, goals and wishes of residents rarely informed the provision of day programs and that services were rarely linked to the Individual Plan.

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- At the time of the audit the day program service in LRCs was undergoing a restructure from a nursing staff model to a community worker model. A large number of vacancies in the day program services created challenges in being able to provide adequately for individual needs. Day program services at that time emphasised leisure and recreation for groups to enable the majority of residents to attend and gain a service within the limited resources available.

- Since the report, significant progress has been made in filling day program positions at Metro and Hunter Residences. This has enabled increasing linkages between day programs and the IP processes.

- LRCs will continue to source external day program services or workshop placements as opportunities arise.

- The DADHC project to reauspice the 30 DADHC-operated day programs located in the community is well advanced and is scheduled to be completed by the end of 2009. Consideration could be given to a feasibility study to extend this project to include day programs in LRCs in 2010.

- Referring people in LRCs to the new day programs could be considered once the Pre-Qualified process for eligible service providers has been completed. However, as this client group has not been included in the 2008/09 funding, allocations places would need to be funded within existing funding for LRCs.

- As LRCs are closed or redeveloped into specialist services, it is anticipated that day program services will be provided by external, non-government organisations.

4.7 Community Participation and Integration

We found that for many people in our review, access to the community was infrequent, heavily reliant on DADHC staff, and largely comprised group outings with other residents. Our review found that few residents were involved in decisions regarding their access to, and involvement in, the community.

- Frequency of community access opportunities is impacted in LRCs by limited resources in regard to staff and vehicles. Even so, community access and integration activities remain a priority.

- To enable more people to have an opportunity for community access, group events are used in addition to individual outings to maximise resources.

- Large numbers of residents have complex mobility needs requiring special vehicles and often two people to support them.

- External providers have been sourced in some LRCs on a fee for service basis to support community access and integration opportunities.

- Volunteer organisations such as the Stockton Centre Foster Grandparents Scheme, Tomaree Links to Community, local churches, community education facilities and community drama groups also facilitate community access opportunities.

- Client holidays, organised through external providers on a fee for service basis, has seen advances in opportunities in some LRCs.

- Targets have been developed for increased community access. Data is collected at each of the LRCs on community access, with a project underway to ensure consistency of the data across all the LRCs.

4.8 Leisure and Skill Development activities

We found that action taken to address the residents' needs such as providing the opportunity for them to learn and practice life skills was inconsistent. The extent to which there was a focus on increasing the independence of people was questioned.

- Previously, LRCs employed a large number of staff with program officer qualifications and expertise that facilitated the development of skill building programs, monitoring of these programs and the training of staff in this area.

- Assistants in Nursing, often with an aged care background rather than a disability background, have a focus on maintaining skills rather than skill building. With the change in skill mix in LRCs and the inability to recruit experienced disability staff with experience skills and experience in skill development programs, it is acknowledged that there has seen a reduction in emphasis on skill development activities.

- The ageing client population has seen an emphasis on maintaining current skills and independence addressing health, mobility and behaviour needs rather than introducing new skills.

- Day program services are working toward enhancing skill building programs in addition to leisure and recreation programs.

4.9 Finances

We found mainly positive practice on the part of DADHC staff in identifying and meeting the financial needs of individuals. However, our review identified two aspects where service practice could be improved; involvement of residents in decisions about the use of their funds, and payment for aids and equipment.

- Communication and cognitive challenges require the support of significant others to support the individual to participate in decisions around finances. Significant others such as family and persons responsible are consulted in this area. Where a formal financial guardian is appointed decisions are referred. The OPC, when acting as the banker for a resident is also consulted.

- Since 2007, Aids for Individuals In DADHC Accommodation Services (AIDAS) funding is allocated to LRCs annually for the purchase of aids and equipment for individuals. All residents have equitable access to the funds but there are a large number of people with mobility challenges and equipment needs. Given the cost of equipment submissions, all the required items for an individual cannot always be met from this fund.

4.10   Relationships

Overall, we found that the majority of residents had family contact and staff put substantial effort into supporting residents to regain and maintain contact with their families. However, outside family relationships, we found that few residents had relationships with others.

- Residents are encouraged to build relationships with other residents and community members through participation in group, leisure and recreation activities.

- In the past there has been limited documentation of the friendships and networks amongst residents of the LRCs. As part of the planning process for the future closure or redevelopment of LRCs, these relationships are being documented and considered as an integral part of future planning.

4.11   Factors impacting on ability to meet individual needs

Access to allied health and psychological service at Lachlan and Riverside Centres were identified.

- Since the review, a behaviour clinician employed by the Metro North Region Behaviour Intervention and Support team has now been based at the Lachlan Centre to overcome difficulties in accessing services. Riverside Centre has also been allocated a behaviour clinician position.

Large numbers of staff vacancies at Lachlan, Riverside and Stockton Centres were identified.

- An ageing staff demographic in LRCs has seen an increase in staff leaving the service.

- The international shortage of nurses creates challenges in being able to retain and recruit qualified Registered and Enrolled Nurses in LRCs.

- Recruitment action for all nursing categories is ongoing.

- Traineeships for Assistants in Nursing are provided in partnership with Registered Training Organisations at Metro and Hunter Residences in an effort to build a disability workforce. Elective modules in the traineeships are taken from the Disability Certificate III training package.

- Vacancies across the LRCs are covered by a combination of casual, agency staff and overtime staff. Efforts are made to replace all shift shortages or failures. The use of regular casual staff can result in staff who are familiar with the residents being allocated to provide the service.

Inconsistent training for staff, with no allocated Clinical Nurse Educator (CNE) at Riverside and Peat Island Centres was identified.

- The CNE position at Riverside Centre has now been advertised and should be filled shortly.

- Contrary to the report, Peat Island Centre has two CNEs.

Large units in some LRCs identified accommodation limitations resulting in more than one person per bedroom, structured routines and minimal flexibility for individual residents.

- The LRC environment, by its large congregate nature, limits choice and individual accommodation environments in some areas. The redevelopment project for LRCs is an attempt to control the limiting effects of LRCs by creating small community-living environments that will provide for improved privacy, maximise independence for individuals and enhance the flexibility of routines and services.

- The LRC planning project over the next 12 months will identify future models that incorporate individual bedrooms and staffing support models that maximise independence and choice for residents.

RECOMMENDATIONS

1. **How DADHC might respond to the issues raised in this report, with particular reference to:**

a) **improving the level of involvement by residents in decision making and planning**

- The LRCs will implement an instruction to staff that all residents should attend the IP annual meeting and six monthly review meeting unless they indicate a wish not to attend. This decision by the resident and how it is expressed will be documented.
- Key workers will be asked to demonstrate that timely contact with families and significant others has occurred to encourage attendance and contribution to the planning process.
- Families and significant others will be encouraged to support residents to participate in decisions in all aspects of their life including health care planning, behaviour support, day programs, community participation and integration activities, leisure and skill development activities, finances and relationships.
- To facilitate participation in the planning and decision making process, LRC staff will continue to support and encourage significant others through mediums such as teleconference, email, visits, phone calls and providing written documentation.
- Staff education in areas relevant to IP will emphasise communication supports, documentation, decision making and choice.
- The ongoing roll-out of Inclusive Communication and Behaviour Support (ICABS) and Makaton training, and continued sourcing of augmentative communication aids will enhance communication support to the residents.
- Communication aids and other enhancements relevant to individual residents' needs are being developed on an ongoing basis.
- LRC staff will be asked to increase efforts to source external advocacy services for those people that have no significant other in their life to support them in decision making and choice.

- Residential unit nurse managers will be asked to review activities of daily living and routines to provide greater flexibility for individuals to exercise choice within their environment.
- Individual client communication profiles will be reviewed to ensure that the information supports a receptive environment around decision making and planning.

b) improving community participation and social integration

- As plans proceed for the closure and redevelopment of the LRCs, the accommodation and staffing models developed will enhance opportunities for residents to be part of local communities and involved in local activities.
- Within the limits of the budgets for vehicles and staff, the LRCs will continue to provide more opportunities for residents to access and be part of the community. Consistent capture and analysis of community access data across all LRCs is already being implemented.
- The effective and efficient use of available vehicles will continue to be reviewed and monitored.
- The effective and efficient use of staff resources to support community access opportunities will continue to be reviewed and monitored.
- Training for staff about IP will emphasise the importance of community participation goals and document achievement of those goals.
- LRC managers will continue to try to source non-government organisations (NGOs) to provide community access and holiday opportunities on a fee for service basis.
- Local and volunteer groups will be used to facilitate community integration activities.

c) fostering greater independence and skills development

- Opportunities will be developed for individuals to develop skills during normal daily activities.
- Day program services are moving toward increasing skill development programs.
- Skill development training for staff will be prioritised in future Learning and Development programs.

d) achieving greater levels of involvement of residents with a severe or profound cognitive impairment

- The strategies that are described in the section on improving resident involvement in decision making and planning also relate to this point. Of particular importance is the need to look at the increased use of augmentative communication systems.
- The new models developed under LRCs future planning will result in smaller groups of people with severe or profound cognitive impairment living together. This should result in greater opportunities to enhance communication and involvement for residents.

e) improving accessibility for people using wheelchairs

- Environmental enhancements within the maintenance and capital works programs will continue on the LRC sites. This includes pathways, ramps, wheelchair transport and access to facilities such as the swimming pool.
- The LRCs will continue to look for better vehicle options that facilitate and support client mobility needs.
- The closure and redevelopment of the LRCs will be in line with community standards for wheelchair access and the specific needs of the residents of that service.

f) improving the availability of, and access to, services and training for residents and staff at Riverside

- The Riverside Centre has a Memorandum of Understanding with Bloomfield Hospital that allows nursing staff to attend relevant training and professional development on a fee for service basis. It is anticipated that current recruitment should overcome the difficulties in releasing staff to attend the training.
- An external training provider has been contracted to provide a training and support program for residential unit nurse managers and registered nurses with the view to ensuring better supervision, mentoring and training to other nursing staff.
- Improved responses to recruitment should assist in the filling of vacant direct-care positions as well as key support roles of Nurse System Support Coordinator, Nurse System Support Officer and Clinical Nurse Educator.
- Riverside Centre uses the model consistent with the group homes of obtaining therapy and other support for residents from the DADHC Community Support Team. There have been difficulties accessing services due to the overall demand on the services. A behaviour clinician will shortly be allocated to the Riverside Centre. Psychiatrist, dietician and speech therapist services have been purchased on a fee for service basis by the centre.

2. Whether DADHC should include the day programs that it operates on site in departmental residential centres as part of the adult day program reforms under _Stronger Together_.

- As plans proceed for the closure and redevelopment of the LRCs, external day programs run by NGOs will be funded to provide day program services as part of the new models.
- Current planning under _Stronger Together_ seeks to address the issue of day program services for people living in group homes or with their families.

3. The scope for DADHC to ensure that its individual planning process includes consideration as to whether community based or other alternative accommodation is a more appropriate option and, if so, that appropriate follow up takes place

- Within the current IP practices where clients, families and significant others identify an interest in living in other accommodation, efforts are made to

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achieve this. Residents are referred to the Regional Placement Committees and considered and prioritised with all people identified with an accommodation need. A person who already has a secure placement in the LRC is not as high a priority as a person in the community who is in crisis and/or blocking a respite bed.