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

Review of individual planning in DADHC large residential centres: Summary report

June 2009

Contents

Summary report

1. Introduction

1.1 Residential centres

Over 6,000 people with disabilities in NSW live in the care of disability services. A significant proportion of these people, 28 per cent, live in residential centres.[1]

Residential centres, formerly known as 'institutions', accommodate people with disabilities in congregate settings. Small residential centres accommodate between seven and 20 people on the one site, while large residential centres house more than 20 people on site.

Almost three-quarters (70%) of the people who live in residential centres live in the nine large residential centres that are operated by the Department of Ageing, Disability and Home Care (DADHC). The number of people accommodated in the department's residential centres ranges from 19 people in Grosvenor to 445 people in Stockton.[2]

In 1998, the then Minister for Disability Services announced that the NSW Government had committed to the closure of 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.[3]

In January 2006, the NSW Government released an *Accommodation and Support Paper*. The paper indicated that residential centres would close 'over time', and some residential centres would be redeveloped to provide support for people with complex needs and behaviours. The paper also confirmed that the existing 'no-admissions' policy would remain. The policy requires that prospective new residents are only admitted to the centres in extenuating circumstances, and only with the approval of the Director-General or the Minister.

In May 2006, the NSW Government released a 10-year plan for disability services, *Stronger Together*. This document outlined plans to redevelop two of DADHC's large residential centres – the Grosvenor and Peat Island Centres – and stated that planning for the redevelopment of other sites would be undertaken over the following two years.[4]

[1] DADHC advice, 24 July 2008.
[2] 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 its redevelopment plan stated that it would accommodate 30 people on site – 20 permanent residents and 10 respite residents.
[3] DADHC advice, 17 June 2008.
[4] On 21 January 2009, the Minister for Disability Services issued a media release indicating that he had officially opened the redeveloped Grosvenor Centre.

1.2 Individual planning

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 1993* 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.

The main way in which DADHC seeks to identify and meet the needs and goals of residents is through individual planning, and the development of an annual Individual Plan (IP).

In October 2008, DADHC announced plans to review its *Individual Planning* policy, in line with the directions identified 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 draft of the revised policy in September 2009.

1.3 What did we do?

In 2008, the NSW Ombudsman conducted a review to examine the way services were planned and delivered to meet the individual needs of people living in DADHC's large residential centres. This report provides a summary of observations arising from our review of individual planning in those centres.

We decided to undertake this work following information from our reviews of the deaths of people with disabilities in care, and reports from Official Community Visitors, that raised concerns about individual planning in these centres.

The aim of the review 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 looked at whether DADHC was following its own policies on individual planning, health care, behaviour support, managing risks, financial management, and decision-making and choice. We also looked at how the centres put the policy of individual planning into practice.

Our review incorporated each of the nine DADHC large residential centres, and a total of 60 residents from a mix of cottages and units. The 60 people represented a mix of ages, gender, cultural background, and support needs. The numbers and profile of the residents selected in each residential centre can be found in Appendix 1.

The review process involved looking at the files of residents, meeting with Residential Unit Nursing Managers, day program managers and, where possible and appropriate, the residents.

1.4 What did we find?

Overall, our review 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 the following sections, we outline 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.

2. Key findings

2.1 The individual planning process

Requirements

DADHC's *Individual Planning for Adults in Accommodation Support Services* policy requires

that all residents have an Individual Plan, and emphasises that discussion of the person's goals and wishes are central to the individual planning process. Among other things, the policy requires staff to discuss the individual planning process with the resident using accessible communication, and to review progress in achieving the Individual Plan with the resident every six months.

What we found

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

All residents had a current Individual Plan. However, we had concerns about the quality of the goals for many people. We found that some plans contained instructions for staff or reports about the person's current situation rather than goals for the resident to achieve.

We found that while some progress had been made for most of the residents towards achieving their goals, their progress was often not reviewed. Where staff had identified barriers to achieving some of the goals, such as wheelchair accessibility, we found that these problems 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.

For example, staff had identified that 11 people had unmet needs with regard to their accommodation, such as the need to move to less restrictive accommodation. We found that action was being taken to address these needs for three of the 11 people.

2.2 Decision-making and choice

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 them to make informed choices are central to disability services legislation and standards.

The *Disability Services Act* requires services to ensure that people with disabilities have access to advocates, when necessary, to allow them to participate in decisions about the services they receive, and to encourage their participation in how their services are planned and delivered.

What we found

Our review found that residents were infrequently involved in making decisions or choices about their lives, including what they wanted to do, how they wanted to live, and who they wanted to be with.

We also found that only two of the 60 residents had the involvement of advocates. It was not clear to us why so few residents had advocacy support. Generally, we found a need for increased involvement of residents in decision-making and considerable unmet and

unidentified need. Our review identified three people who did not have contact with anyone outside of staff, and nine people who had limited family contact.

We found that some 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, which can only be heated once. As a result, there was little scope for residents to eat at a time of their choosing, in addition to existing constraints about where or with whom they could eat.

Communication

Requirements

Disability services legislation requires services to ensure that people with disabilities have the opportunity to communicate, and have adequate and appropriate support to do so. Capacity to communicate is fundamental to identifying and meeting the needs and goals of residents.

What we found

Most of the people in our review needed assistance with communication and relied on means other than verbal language, such as gestures, facial expressions, and body language, to express themselves.

Staff had often identified what support many of the residents needed to be able to communicate and understand information. However, we found that few residents were receiving that support. For example, some residents had tools, such as picture boards, to help them to communicate, but the tools were not being used. In other instances, we found that even though individuals' needs for particular communication support had been identified, there was no indication that this support was being provided or had been planned for.

The impact of unmet communication needs on people with disabilities can be significant. In our review, we identified people whose distress was unable to be determined by staff, who appeared to have minimal input into decisions that directly affected them, and whose 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.

Health care

Requirements

DADHC's *Health Care* policy requires that all residents have an annual health assessment with their GP, the outcome of which is recorded in a health care plan. The policy also requires that staff support residents to participate in the development of their health care plan, arrange appointments with health professionals as required, and review the health care plan at least every three months.

What we found

Some of the people in our review had health problems 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, and that there was comprehensive planning relating to their health needs, involvement of relevant professionals, and responsiveness to changes in the health status of individuals.

We identified some areas where service practice could be enhanced, including making sure that: information provided by staff to GPs is accurate and complete; health care plans are current; and residents are supported to participate in decisions and planning about their health.

Behaviour support

Requirements

DADHC has a number of policies to guide staff in supporting people with challenging behaviour.[5] Among other things, staff are required to meet the person's lifestyle and environment needs before beginning formal behaviour intervention, and to involve the person in the planning to meet their behaviour support needs.

In addition, prior to any use of restricted practices, staff must have approval from the Restricted Practices Authorisation Panel and obtain consent from the resident's appropriate legal decision-maker.

What we found

Most of the people in our review had behaviour support needs, and many of these individuals had significantly challenging behaviour, such as self-harm and physical aggression.

Positively, 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 that they had the involvement of a psychiatrist and/or psychologist.

However, while we found that guardians and family members had been involved in the development of the behaviour support plan for a minority of residents, we found no evidence that the residents themselves had been involved.

We also found that staff had reviewed the lifestyle and environment needs of all of the individuals who required behaviour support. However, action was seldom taken to address the lifestyle and environment needs that staff had identified, such as the need for involvement in meaningful activities, relationships, communication, or a holiday. We found that the unmet lifestyle and environment needs of the people in our review had a significant impact on their behaviour.

[5] DADHC *Behaviour Intervention* policy (February 2003); *Providing behaviour support and intervention for people with an intellectual disability* policy (June 2006); and *The Positive Approach to Challenging Behaviour* policy (June 1997).

Day programs

Requirements

According to DADHC, 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'.[6]

DADHC's information indicates that there are four areas of activity in day programs: skills development, community access, adult education, and leisure and recreation.

What we found

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 Individual Plan.

One of the reasons for the poor links between individual needs and day program planning was understaffing. 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.

Community participation and integration

Requirements

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;
- support people to develop social networks and to participate in decision-making in the community; and
- promote the ability and valued status of individuals when supporting their participation in and integration into the community.

What we found

Our review raised questions about whether residents have adequate and meaningful participation in, and integration into, their community. We found that for many people, access

[6] DADHC website, www.dadhc.nsw.gov.au/dadhc?People+with+a+disability/Day+Programs.htm.

to the community was infrequent, heavily reliant on DADHC staff, and largely comprised group outings with other residents.

Two of the 60 people in our review did not appear to have any access to their local community, while many residents had three hours per week or less. Less than half of the residents had been on a holiday in the previous two years.

Access to the community for many people primarily involved a group bus outing to a specific location such as a park or reserve, eating a meal, and then returning to the centre. Reliance on this form of outing raised questions about what action was being taken by the department to ensure that residents had meaningful participation and integration in their community, and socialisation with people outside of the centres.

We found that for most of the residents their access to the community was heavily reliant on DADHC staff. Consequently, community access was frequently affected by staff availability, and many residents were highly dependent on the department for their community integration, socialisation, and freedom.

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

Leisure and skills development activities

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.

What we found

We found that many of the residents in our review had considerable amounts of free time: day program attendance and outings into the community totalled 10 hours per week or less for almost half of the 60 people.

Common activities included walks in the grounds of the centre, relaxation, therapy, listening to music, and watching TV. For more than half of the residents, group activities were dominant, including group events for large numbers of residents, such as church services.

We found that few residents had been consulted about their activity or skills development

needs or wishes.

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

It was also of particular concern that, at one centre, there had been a reduction in residents' opportunities for skills development, which involved the cessation of numeracy and literacy skills courses.

Finances

Requirements

DADHC policies that guide staff in meeting the financial management and equipment needs of residents[7] include requirements that the person is consulted in the development of their Annual Budget, and their fortnightly expenditure is reviewed at the IP review.

DADHC's policies also state that the department is responsible for the provision of aids and appliances for clients living in the accommodation services it operates, primarily through the Aids for Individuals in DADHC Accommodation Services program. In addition, the policies state that the Household Operating Account should be used for low cost aids and appliances to support residents, such as shower chairs, and the General Ledger Account should be used to purchase low cost resident transfer aids such as slings.

What we found

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.

While many family members were consulted regarding the development of the person's budget, we found that only two residents had been consulted.

The finances of five people had been used to purchase aids or equipment or were used on things that 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.

[7] *Aids for Individuals in DADHC Accommodation Services* policy (December 2005); and *Managing Client Finances in DADHC Residences* policy (November 2005).

Relationships

Requirements

The *Disability Services Act* requires that services recognise the importance of preserving 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, family, friends, advocates and guardians.

What we found

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. More than half of the residents did not appear to have any contact with people outside of their family, co-residents or paid staff. Three people did not appear to have contact with anyone outside of co-residents and staff.

Factors affecting the ability of staff to meet individual needs

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. These centres had to access these services through their local Community Support Teams (CST), and reported extensive delays in accessing these 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. 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.

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 adverse impact on residents. This was particularly the case in relation to how much contact residents could have with the community, and what progress could be made towards achieving the goals in their Individual Plan.

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.

Accommodation and restrictions

We found that the ability of staff to meet the individual accommodation needs of residents was hampered by the congregate setting of the large residential centres.

The number of people per bedroom depended on the particular unit and the support needs of the individual. At least 15 residents shared a bedroom with between one and three other people. Some residents spent most of their day with the same people.

We also found that the structured routines of the centres impacted on the ability of staff to meet the individual needs of residents, as well as the ability of residents to say how they wanted support to be provided, and when. The structured routines included set times for activities such as meals, personal hygiene, and outings.

The ability of residents to move around their unit and the centre more broadly depended on the particular centre in which they lived. Most of the centres had restrictions, such as some locked units, 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. Restrictions may be warranted for some individuals. However, the nature of congregate accommodation such as large residential centres means that individuals who do not require this level of support are also affected by the restrictions.

DADHC's response to our findings

In response to our draft report, DADHC advised that there are a number of significant challenges that impact on service provision in its large residential centres, including:

- a change in staff skill mix within the centres, involving greater employment of Assistants in Nursing who often have no disability background or training, and a move away from staff with expertise in the development and monitoring of skill building programs;
- staff and vehicle constraints, including an ageing staff demographic in the centres and an international shortage of nurses;
- the complex mobility needs of many residents; and
- the congregate nature of the large residential centre environment, which limits choice and individual accommodation environments in some areas.

DADHC told us of action taken since our review, including significant progress towards filling day program positions at Metro and Hunter Residences, the appointment of a behaviour clinician based at the Lachlan Centre, and the allocation of a behaviour clinician position at Riverside.

In relation to improving the skills of staff, DADHC advised that it provides traineeships for Assistants in Nursing in partnership with Registered Training Organisations at Metro and Hunter Residences, and is investing significant resources to support these staff to develop an understanding of the IP process. In addition, the Learning and Development Program provides ICABS[8], Makaton[9], and behaviour support training for direct care staff.

[8] The Inclusive Communication and Behaviour Support (ICABS) program is designed to enhance communication by people with disabilities.

In relation to staff at Riverside, an external training provider has been contracted to provide a training and support program for Residential Unit Nursing Managers and registered nurses with the view to ensuring better supervision, mentoring and training to other nursing staff.

DADHC told us that it would:

- encourage families and significant others to support residents to participate in decisions in all aspects of their lives;
- ask staff to increase efforts to source external advocacy services for those people who have no significant other in their life to support them in decision-making and choice;
- ask Residential Unit Nursing Managers to review activities of daily living and routines to provide greater flexibility for individuals to exercise choice within their environment;
- continue to look for better vehicle options that facilitate and support client mobility needs;
- use local and volunteer groups to facilitate community integration activities; and
- develop opportunities for individuals to develop skills during normal daily activities.

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

DADHC did not indicate how it will address a number of the key findings. It is not clear, for example, how the department will ensure that action is taken in response to identified lifestyle and environment needs. In addition, DADHC did not indicate how it will respond to 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.

Where information has been provided against the key findings, DADHC provided insufficient detail in most areas about how the department will address the issues. This is particularly in relation to social integration, skills development, and resident participation and involvement in planning and decision-making.

DADHC's response in relation to many of the issues identified in our report referred to the change to service provision that will occur with the closure and redevelopment of the centres. The expected changes include a move to day programs operated by funded services, and 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 centres. There are no clear plans for the closure or redevelopment of the other centres, including the largest centres of Stockton and Rydalmere.

---

[9] Makaton is a key word signing system used with people who are unable to speak or whose speech is difficult to understand.

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 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 very 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 whether it is possible to uphold these fundamental rights within large residential centres.

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, with the resident at the centre of that process.

Recommendations

Following consideration of our findings and DADHC's response to our draft report, we have made the following recommendations. In forming the recommendations, we have had due regard for the need to ensure that:

- the issues from our review are addressed and residents' outcomes improved;
- there is a clear framework for DADHC to report its progress; and
- we take into account relevant work by the department that is underway or planned.

We will monitor DADHC's progress in relation to our recommendations, including the development of the department's action plan and its implementation.

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 Individual Plans

(ii) ensure Individual Plan goals are implemented and action is taken to address barriers to implementing goals

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

(iv) ensure that Individual Plans are reviewed

(v) effectively monitor and oversight individual planning

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

(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

(iii) foster and facilitate residents' participation in decisions affecting their lives, such as the planning and operation of their services

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

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

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

(vii) ensure that DADHC does not exercise control over all or most aspects of the lives of residents

(viii) provide services in a way that results in the least restriction of residents' rights and opportunities

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

(ii) improve the involvement of residents in meaningful activities

(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

(iv) improve accessibility for residents using wheelchairs

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

(ii) support residents to develop social networks

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

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

(iii) ensure that Quality and Safety Framework data accurately reflects practice

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

a) the timeframes and positions/ persons responsible for 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

Table 1: Number of residents and units/ cottages selected per centre

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
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

Resident profile

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.

Cultural background

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

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%).

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

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.