Performance Audit Report

Large Residential Centres for People with a Disability in New South Wales

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Executive Summary

Executive Summary

The Audit

A performance audit into the provision of residential services for people with an intellectual disability was undertaken by The Audit Office with the Community Services Commission. The audit was suggested by the Commission and requested by the Minister for Community Services following the release of the Lachlan Report (which identified poor practices in a large disability residential centre).

The audit reviewed policies and practices in large government and non-government residential centres to determine if policies and practices protected the human and legal rights, safety and dignity of residents.

The audit was conducted in seven government institutions and three non-government institutions.[1,2] The audit focussed attention on ten practice areas considered critical to protecting the legal and human rights, safety and dignity of residents and assessed the policies and practices in institutions against these criteria. Details of audit criteria are provided in Appendix 6.

Moving from Institutions to the Community

There is broad recognition that institutions are outmoded models of care. Successive state governments have indicated a commitment to closure of large residential centres and their substitution with community based facilities. But the population in these institutions remained more or less the same, providing accommodation for approximately 2,388 people with a disability.

There is now the danger that in these institutions, which are marked for transition to community based facilities, the services and protection will continue to decline due to the lack of attention and funding, thus further aggravating the already poor state of affairs. It is for this reason staff in the centres say *"close us down don't run us down."*

[1] The term institution has been used in this context to describe large residential accommodation centres for people with an intellectual disability that were viewed as part of the audit.
[2] These institutions provided services which were not in *conformity* with the Objects, Principles and Applications of Principles of the Disability Services Act 1993 and had not received funding to implement transition plans.

Government Policy
Disability Services Act

The NSW Disability Services Act was introduced in 1993 along with ten Disability Service Standards. These Standards are based on an interpretation of the Objects, Principles and Applications of Principles set out in Schedule 1 of the Act (listed in Appendix 4).

The Disability Services Act 1993 requires disability services, whether funded (non-government services) or provided by the Minister for Community Services, to be provided in *conformity* with the Objects, Principles and the Applications of Principles of the Act. Services which do not *conform* are required to prepare a transition plan of strategies to be employed by the service to achieve *full conformity* and the funding required to fully implement the plan.

Large residential centres by their very nature can never provide services in *full conformity* with the Objects, Principles and Applications of Principles of the Act. Transition plans for institutions focus on the process of transferring people with disabilities from the existing facility to community based settings (that comply with the requirements of the Government's Accommodation Support Policy of no more than six residents per dwelling).[3]

However, none of the residential centres visited by audit had received funding to implement transition plans. While awaiting funding, these centres are required to *conform as closely as possible* with the Act.

Service Standards

The Disability Service Standards provide an interpretation of *conformity* with the Act. Disability services that claimed to be providing services which meet the requirements of the Act were assessed against these Standards and the Objects, Principles and Applications of the Principles of the Act.

[3] The NSW Accommodation Support Program states that:
It is recognised that in a small number of cases, there might exist circumstances that require the consideration of service configurations which vary slightly from those stated. In such cases, the Minister will consider these special circumstances before deciding whether or not the proposed accommodation support service is eligible for funding under this program. Such special circumstance will be based on the second of Government's fundamental accommodation goals, that persons with disabilities have the right to choose their own lifestyle, as well as have access to the information necessary to allow informed choice. (Ageing and Disability Department *NSW Accommodation Support Program* 1996 page 5).

In contrast, there is no definition, nor measurable criteria for *conforming as closely as possible* until funding for transition is received. Nor are there any criteria which establish the basic requirements for resident safety and protection from abuse. This means that while the Act and the Standards provide measures for the overall quality of service, there are no measures to determine when a centre is simply unacceptable because it is unsafe.

Operational Policies in Government Centres

Policies guide practices. Government centres use the Department of Community Services *Policies for Working with People with Disabilities,* released in January 1996, as centre policies. These policies represent an important development in establishing guidelines for the provision of services for people living in government centres.

Policies cover critical areas necessary to protect human and legal rights, safety and dignity of residents but are deficient in two areas of interest to this audit, fire safety and the management of critical incidents including resident accidents and injuries.

Audit found significant differences in how government centres had approached and progressed the implementation of these policies and the degree of practice compliance with policy directions. However, there are structural limitations in institutional settings which prevent the successful implementation of all Department of Community Services' policies (and thus prevent institutions achieving *conformity* without reconfiguring the accommodation).

Operational Policies in Non-government Centres

Non-government centres face the same difficulties and limitations as government centres in providing quality services in an institutional setting. However beyond this, none of these centres had developed a set of operational policies which was adequate to protect residents. Some non-government service providers had developed a few policies, but they were deficient in coverage (they did not cover the ten critical practice areas) and, or content (did not provide adequate guidance to staff).

Government and Non-government Centres

In most centres, there were deficiencies in the approach to the implementation of policy; staff were either unaware of the existence and content of policies or had not received training to support the implementation of policy.

Ageing and Disability Department

In 1995, the Government established the Ageing and Disability Department, responsible for policies and programs for people with disabilities. The change separated strategic policy, planning, funding, monitoring and evaluation of disability services from service delivery; all were undertaken at the time by the Department of Community Services.

To date, minimal assistance has been provided by the Ageing and Disability Department to guide both government and non-government centres in the development of policies, particularly in critical practice areas.

Monitoring Service Delivery

Information regarding the performance of large residential centres is not readily available. There are no indicators of service delivery or benchmarks against which large residential centres can be judged.

Centre Based Monitoring

Current systems for monitoring residential centres in terms of accountability and ensuring practices comply with policies and Standards are not effective. Accordingly, there is no assurance that deficiencies would be identified by centre management or those external to the centre with the power to intervene.

Practices in Residential Centres

To compare practices to operational policies, the Disability Service Standards and legal requirements, the audit focussed on practices in the ten critical areas. Findings are outlined in Table 1.

Table 1: Summary of Key Findings in Practice Areas	
Practice Issue	**Government and Non-government Centres**
Behaviour Management	The effectiveness of behaviour management in institutions is limited. Even where management plans are prepared, centres often only achieve behavioural control of residents through medication and containment rather than long term behavioural change.
Management of Incidents Including Injuries and Assaults	Incidents are inconsistently defined, reported, monitored, analysed and are generally not well managed. The largest category of injury to residents is reported to result from resident to resident aggression. The risk factors are poor staff to resident ratios, resident mix, number of residents in the centre, configuration of accommodation, the effectiveness (or existence) of behaviour intervention plans and the centres ability to identify and implement preventative strategies.
Medication Controls and Consent	In government centres, controls over the administration of medication often fail and the legal requirements for gaining consent are often breached. In the non-government centres, medication controls were either non existent or ineffective and the legal requirements for gaining consent for medical treatment were poorly understood and often breached. Across all centres, failure to gain consent for medication, particularly psychotropic, was a problem.
Nutrition, Hygiene and Health Care	All centres had systems for monitoring resident health but recording and monitoring of this information was unreliable and did not assure timely and appropriate intervention. Two non-government centres received donated foods to supplement the menu. Few centres had arrangements for therapy services or nutritional assessments.
Community Access	Community access is still dominated by diversional activities such as group bus rides and group outings with no focus on community integration.
Promoting Access to Family and Friends	In most centres there are no restrictions on visiting hours or formal practices that would prevent family contact and in most cases family contact is supported and promoted by the centre. However, the nature of institutional services mitigates against extended contact.
Privacy and Dignity	Dormitories, open plan bathrooms, common dining and sitting rooms deny residents an acceptable level of privacy. The features of institutional living do not protect and promote dignity.
Individual Service Planning and Skill Development	Most centres are structured to meet management, staff and organisational requirements not the needs of residents. Even when individual plans are prepared, the plans are not always used to provide support to meet the needs of residents. Opportunities for skill development are limited in institutional settings.
Safety	The risk of injury is a major factor affecting resident safety. There is no policy for fire safety procedures in government centres resulting in varied approaches to (and success in) risk reduction. The general response by centres to environmental safety risk facing residents is containment.
Dealing with Complaints and Concerns	Not all centres had established effective procedures for investigating and managing complaints, and families (and residents) were unsure of their rights. Data on complaints is not monitored by Ageing and Disability Department. Families and staff indicated a fear of retribution if they raised concerns or made complaints to service providers.

Assessing Services

Because there was no evaluation methodology for assessing service delivery in large centres, The Audit Office developed criteria and a methodology to test practices in each of the critical areas. This methodology has and will be used by the Community Services Commission and other agencies to conduct evaluations of service delivery.

It was not possible to complete the review of all areas that were included in the original scope of the performance audit. The areas that were not reviewed were staffing levels, competencies and the recruitment of staff to institutions, the management of consumer finances and the audit of service delivery in group homes.

The Audit Office would consider a request to complete the review of the outstanding areas subject to audit commitments and funding.

The Hall for Children

The Hall for Children was one of the centres visited by audit. As a consequence of that review, The Audit Office agreed to the release of working papers prior to the tabling of this report so that the Community Services Commission could complete an Inquiry into that centre. Following that Inquiry, the Minister for Community Services decided to close the centre.

Factors Contributing to Service Delivery

A number of other factors were identified as having an impact on service delivery.

Staffing Issues

Government institutions are a medical model of care and employ only nurses. There is no flexibility to match the mix of staff with the needs of residents. Work arrangements such as shift patterns (and associated costs) have impacted negatively on service delivery and client outcomes.

In non-government centres, recruitment practices can result in inexperienced staff providing residential support to people with an intellectual disability.

Resources

There are no principles to guide resource allocation decisions. The amount of funding an institution receives is based on historical factors not measures such as inputs (eg. needs of residents, salaries, rent, operating overheads), outputs (centre related products) or outcomes (related to the achievement of outcomes).

The effect of this is seen in differing standards of accommodation, staff to resident ratios, access to specialist services, provision of staff training and the provision of day activities.

Physical Condition of Accommodation

The Department of Community Services 1997 property condition audit of its major assets (buildings) identified that large residential centres are in a poor condition and required significant funds (estimated by it to be $22m) to bring them to an acceptable standard. A number of the problems identified relate to resident safety and the basic condition of their accommodation.

This is consistent with audit findings that the physical condition of buildings accommodating residents in large government centres varied from impoverished to acceptable (although still inappropriate).

Respite

People with an intellectual disability can be placed in institutions on a respite or crisis basis.[4] These people, because of their specific needs, can have a detrimental impact on other residents and conflicts can arise.

Advocacy

People with an intellectual disability need access to advocacy support to participate in decision making about the services they receive.

There is significant unmet demand for advocacy services by residents of large centres. The inability of these residents to articulate their feelings, needs and wants without assistance, renders them voiceless and potentially vulnerable consumers.

Guardianship

There are residents in institutions who require the appointment of a guardian to protect their interests. Sometimes the person responsible for making decisions on behalf of the resident has little contact with the resident.

User Pays

Some centres are reluctant to use residents' funds to improve the quality of a resident's life. There appears to be some confusion about which services and goods should be provided by centres and which should be purchased by residents.

Guarantee of Service

It was noted during the course of the audit that a guarantee of continuing care was provided by the Government, through the Minister for Community Services in 1996 to residents of government institutions that were to move to the community. In contrast, residents of non-government institutions did not receive any guarantee of continuing care from the Government.

[4] Respite refers to a short term and time limited break for families and caregivers of people with intellectual disabilities, to assist in supporting and maintaining the primary caregiving relationship, whilst providing a positive experience for the person with a disability.

Conclusions

The report indicates that practices in both government and non-government centres fail to protect adequately the human and legal rights, safety and dignity of residents.

Factors contributing to this situation are the absence of minimum criteria for the protection of residents' human and legal rights, safety and dignity, inadequate policies to direct service delivery, the absence of staff training to reinforce practices, low levels of supervision and the absence of effective monitoring systems to trigger a response to service deficiencies.

Even where policies have been developed to guide practices, the nature of institutional care (the environment renders some policies ineffective), inadequate implementation, inadequate monitoring of practices and lack of compliance results in the centre's failure to protect people living there.

Other factors which are more difficult to remedy are those inherent to institutional models of care. These include the whole of life, umbrella approach to the delivery of services, the custodial and impersonal nature of care, the segregation of institutions from the community, the inability of institutions to provide a home-like environment and the inability of institutions adequately to address the physical, emotional, social and skill development needs of residents.

These features of institutional care mean that even if centres met the requirements of basic safety and rights, institutions could never meet the individual needs of people with a disability or provide the quality of life envisaged by the Disability Services Act 1993.

Even though community opinion on the movement of people from institutions to community based settings is polarised, the Government's position on providing services for people with an intellectual disability is to provide services necessary for people to achieve their maximum potential.

The Government recognises that people with an intellectual disability can not achieve their maximum potential while they remain in an institution.

It is acknowledged that considerable cost is involved in implementing the recommendations of this audit. The cost involved in moving people from institutions to community based settings is substantial. In the meantime, while people remain in institutions it will be necessary to ensure that they live in a safe environment. This too will involve considerable cost.

The findings of this audit make it clear that the safety of people with an intellectual disability is jeopardised when living in institutions. Service providers and the Government have a legal duty of care to take all reasonable steps to protect these people from foreseeable harm. The failure to do so leaves them exposed to legal actions for damages. For this reason too, it is imperative that the Government act urgently on the recommendations of this report to protect the rights and safety of people with an intellectual disability. In the short term, the immediate safety of people residing in institutions must be addressed and as soon as possible.

It is the mark of a developed and just society that provides care for those who can not care for themselves.

Recommendations

The recommendations of this report, unless otherwise indicated, concern large government and non-government residential centres for people with an intellectual disability providing services which do not *conform* with the Objects, Principles and Applications of Principles of the Disability Services Act 1993 and have not received funding for transition.

The recommendations present both long term changes for large residential centres (awaiting funding for transition) and short term, interim measures to address service deficiencies while awaiting transition.

Transition to *full conformity* for a large residential centre can take from 5 to 7 years to complete as indicated by their transition plans. In order to protect the human and legal rights, safety and dignity of residents during that time, recommendations should be implemented immediately concerning:

- mechanisms to protect people living in institutions including service improvements to reduce the congregate nature of the accommodation and to monitor service quality
- the reduction of service inequities.

The Community Services Commission has indicated that it will follow up and monitor the implementation of recommendations of this report.

Reconfigure Institutions

In regard to transition of large residential centres, it is recommended that:

Funding

1.1 The Government fund the transition of large government and non-government residential centres for people with an intellectual disability to enable services to be provided in *full conformity* with the Objects, Principles and Applications of Principles of the Disability Services Act 1993.

1.2 By way of Regulation to the Disability Services Act 1993, a target date of 7 years from the date of tabling this report be considered for the complete transition of all institutions.

An implementation timetable should be prepared to diminish the effect of uncertainty that currently exists in centres targeted to reconfigure to community based accommodation, and allow centres properly to plan service delivery up to, and following, moving to the community.

Children's Services

1.3 As a priority, the Government consider the movement of children under the age of 18 years currently in institutional care to community based settings that match individual need.

Interim Recommendations for Service Improvement

The following are interim but essential measures to address deficiencies while awaiting transition:

No Admissions Policy

2.1 The Government consider a policy for institutions, to ensure that no more people are placed into these (non-conforming) institutions (government or non-government), even on a respite or crisis basis.

The Ageing and Disability Department should ensure that any persons needing crisis or respite accommodation should be assisted to obtain admission to non-institutional residential centres.

As an immediate safeguard to protect the rights of any person for whom institutional placement is proposed, such decisions should only be made by the Guardianship Board (as an independent substitute decision maker) in the case of adults, and by the Minister for Community Services in the case of children, where it can be demonstrated that such placement is the only available option to meet the person's needs. This decision making authority should not be delegated, and should be provided through legislative amendment if necessary.

Service Standards

In regard to protecting the rights, safety and dignity of resident in large residential centres, it is recommended that:

Conforming as Closely as Possible

2.2 The Ageing and Disability Department define the requirements for large residential centres to *conform as closely as possible* to the Objects, Principles and Applications of Principles, pending implementation of transition plans. This definition should:

- include baseline criteria for the protection of residents basic human and legal rights, safety and dignity in the 10 critical practice areas detailed in Appendix 7. Centres must be required to meet this criteria within 12 months
- a staged approach reflecting progressive service improvements each year.

The definition of *conforming as closely as possible* should not be restricted to service enhancements that are cost neutral.

Funding Agreement

2.3 The baseline criteria for resident safety and protection be included in the 1997/98 funding agreements with non-government centres and service contracts with the Department of Community Services. These criteria should be used to judge service delivery and where centres do not meet the baseline criteria within 12 months, funding should be withdrawn.

Progressive service improvements which allow centres to *conform as closely as possible* should be identified by the centre (involving residents and their families) in conjunction with the Ageing and Disability Department and incorporated into annual funding agreements or service contracts.

2.4 Ageing and Disability Department consider the application of the baseline criteria for resident safety and protection to all accommodation services (institutional or community based) through funding agreements.

Protection for Individuals

It is recommended that:

Guardianship

2.5 Service providers identify and refer to the:

- Guardianship Board residents who may need a guardian. Attention should be paid to those residents whose behaviour or medical needs require significant or intrusive treatment, and residents who have no involved family who can act as "person responsible."
- Department of Community Services any children who have not had substantial contact with their parents over the past 12 months.

Community Visitors should monitor individual needs in relation to guardianship, and report to the Community Services Commission where appropriate action has not been taken.

Advocates

2.6 The Ageing and Disability Department ensure that there are sufficient advocacy services to meet the needs of people living in institutions. The provision of additional services should be considered in the context of the NSW Advocacy Development Plan.

Centre Policies

It is recommended that:

Policy Development

2.7 The Ageing and Disability Department:

- provide policy guidance on baseline criteria referred to in 2.2
- assist centres to develop their own policies that reflect the baseline criteria
- review policies developed by centres to ensure they meet baseline criteria.

Policy Gaps

2.8 The Department of Community Services include in its *policies for people with disabilities* practice requirements regarding:

- fire safety
- reporting and investigating critical incidents and injuries involving residents.

Monitoring Service Delivery

It is recommended that:

Ageing and Disability Department

2.9 The Ageing and Disability Department establish:

- baseline criteria for service delivery described in 2.2 to be stipulated in funding agreements with non-government organisations and service contracts with the Department of Community Services
- requirements for information in relation to consumer outcomes and the performance of services against the baseline criteria and progressive service improvements. These requirements should be stipulated in the funding agreements and the service contracts
- a program of independent audits of large residential centres to enable the Department to verify self assessments
- a system for independently reviewing and monitoring the use of psychotropic medication in large residential centres
- a system to enable the Department to monitor complaints about service delivery in large residential centres.

2.10 In relation to the institutions reviewed as part of the audit, the Ageing and Disability Department should monitor the implementation of service improvements to meet the deficiencies identified by audit.

2.11 The Government undertake a review of the effectiveness of service monitoring by the Ageing and Disability Department within 2 years from the date of tabling this report.

2.12 Information on individual centre practices and systemic issues arising from the functions of the Community Services Commission including Community Visitors should be provided to the Ageing and Disability Department. Such information should be used to monitor services and considered in assessing annual funding.

Department of Community Services

2.13 The Department of Community Services establish a system for monitoring services in large government residential centres that consists of :

- regular reporting based on performance indicators that monitor performance against baseline criteria and consumer outcomes stipulated in service contracts with the Ageing and Disability Department
- centralised monitoring of information at the executive level (such as standardised reports and complaints) to allow early identification of systemic problems and service benchmarking.

Residential Centres

2.14 Each residential centre establish a system of monitoring service delivery that consists of:

- collecting and analysing data on practices in critical areas
- regular reporting to key stakeholders on key aspects of service delivery including performance against funding criteria and practices in critical areas
- positions descriptions that clearly indicate to staff responsibility and accountability for the quality of care.

Service Improvements

It is recommended that:

User Pays

2.15 Ageing and Disability Department provide policy guidance which:

- clarifies the goods and services to be provided by the centre within the fee structure
- outlines a process for centres to employ for identifying user pay options
- outlines accountability mechanisms for the use of consumer funds.

Service Improvements

2.16 Large residential centres should implement steps to meet better the needs of individuals, while awaiting implementation of transition plans, such as:

- reducing congregation by limiting the size of resident groupings for activities and promoting alternate accommodation models using existing facilities

- moving day activities off site into the community or arrange for residents to attend community based day activities
- providing greater opportunities for resident skill development through improved training programs and access to facilities to practice skills acquired.

Resident Rights

2.17 Centres should provide printed information to residents, family members, advocates and other representatives which outline the obligations and responsibilities of the centre, and the legal rights and responsibilities of residents and their representatives. This information should include the details of organisations who can provide further assistance.

Improving Equity in Service Delivery

In order to rectify some of the inequities developed over the years, as a consequence of financial assistance to residential centres being determined by historical grant levels without regard to equity or the results of service provision, it is recommended that:

Allocation of Resources

2.18 The Ageing and Disability Department introduce a funding system for non-government centres which allocates funds according to the assessed needs of residents and agreed outcomes to be achieved.

Funding to non-government centres should be reviewed against this model and adjusted accordingly.

Addressing Inequities

2.19 The Department of Community Services should develop a rational approach to the distribution of funds to its government centres.

2.20 The Department should also review the allocation of funding to each large government institution to address inequities in :

- staff to resident ratios
- access to specialist services
- condition of accommodation
- resources available for staff training
- provision of day activities.

Accommodation Standards in Government Centres

2.21 The Government, as a priority, make available sufficient funds to implement recommendations in the Department of Community Services' property condition audit that relate to issues of resident safety and the basic condition of accommodation in large residential facilities.

2.22 In determining priorities for refurbishment of large residential centres, consideration be given to:

- bringing the standard of accommodation for residents to an acceptable level
- decreasing resident groupings to reduce congregation within large residential centres. This includes the size of the groups in shared sleeping arrangements, size of groups using same living facilities (bathrooms, dining areas, sitting rooms).

However, further expenditure should be avoided where it would prolong the existence of institutions as a model of care.

Improving the Effectiveness of Service Delivery

It is recommended that:

2.23 The Department of Community Services examine the opportunities for improving service delivery in large residential centres that would result from:

- changes in staffing arrangements from 8,10 and 12 hour shifts to 8 hour shifts in all centres
- changes in staffing mix (nurses are employed in large government residential centres when employment of residential care workers or assistants would sometimes be appropriate).

Response to the Report

The Public Finance and Audit Act 1983 stipulates that at least 28 days before tabling a performance audit report, the Head of the authority and the responsible Minister are to be provided with a summary of findings and proposed recommendations in relation to the audit.

In accordance with the Act a full copy of the proposed report was provided to the Directors-General of the Departments of Community Services and Ageing and Disability and to the Minister for Community Services and Minister for Disability Services, as the responsible Minister, on 21 May 1997.

In subsequent discussions with the Minister's Office, The Audit Office was advised that the Minister's Office would coordinate a response to the report. On 13 June 1997 the Chief of Staff of the Minister's Office advised The Audit Office that there will be no response from either the Minister's Office nor the Departments.

1. Introduction

1.1 Introduction

This report focuses on the provision of services to people with an intellectual disability living in large residential centres operated by government and non-government providers in NSW.[5] The primary purpose of the audit was to review policies and practices in these centres to determine if the human and legal rights, safety and dignity of people with an intellectual disability are protected in these residential settings. The audit was requested by the Minister for Community Services.

This audit follows from the report of an investigation by the Community Services Commission into complaints about the use of exclusionary time out at the Lachlan Residential Centre, an 87 bed residential centre operated by the Department of Community Services, North Ryde.[6]

The Lachlan investigation reported widespread and unregulated use of abusive practices (such as confinement and containment) to control the behaviour of residents. The report indicated that policies and guidelines regulating the use of these practices were either non-existent or unclear and were inadequate and dramatically out of line with laws and human rights standards.

The Commission also reported that the failure of management to induct and train staff adequately and to monitor practices had contributed to the standard of care at the Lachlan Centre. Policies and guidelines that did exist were:

> *...misunderstood, misapplied, ignored or simply unknown by staff and management at the Lachlan Centre.*[7]

Following release of the report, the Auditor-General agreed to conduct a performance audit, in conjunction with the Community Services Commission, of residential centres for people with an intellectual disability to determine if similar practices were occurring elsewhere.

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[5] The definition of intellectual disability used in the report refers to people with a significantly lower than average intellectual capacity and deficits in social and adaptive function in such areas as communication, social, daily living skills and mobility.

[6] The Community Services Commission September 1995 *The Lachlan Report Exclusionary Time-out or Solitary Confinement?*

[7] ibid page 10

Details of the audit objectives and audit scope are provided in Appendix 1. Only institutions providing services that did not *conform* with the Objects, Principles and Applications of Principles of the Disability Services Act 1993 and had not received transition funding to change to community based services were selected to be included in the audit. Ten sites were visited by audit, each site accommodating at least 50 residents.

1.2 Acknowledgment

The Audit Office and the Community Services Commission gratefully acknowledge the co-operation, assistance and contribution provided by:

- residents of the centres visited, their families and friends
- parent associations
- staff, management and the Boards of the residential centres included in the audit
- Community Visitors
- advocates and advocacy programs
- the Office of the Public Guardian and the Office of the Protective Commission
- representatives of the peak consumer associations
- liaison officers nominated by the Ageing and Disability Department, the Department of Community Services and the Centres visited to assist the audit team during each of its site visits.

1.3 Cost of the Audit

The cost of the audit is shown separately for The Audit Office and the Community Services Commission.

Audit Methodology

The total cost of developing the audit methodology was $163,759 (this includes $23,820 attributable to the Community Services Commission).

Cost of the Audit

The Audit Office

Direct salaries costs	$204,751
Overheads charged on staff time	$ 54,474
Value of unpaid overtime(at standard time rates only)	$ 59,096
Consultant	$ 2,500
Travel and Incidental	$ 6,521
Printing	$ 7,000
Total Cost	**$334,342**

Community Services Commission

Direct salaries costs	$188,015
Overheads charged on staff time	$ 40,022
Value of unpaid overtime (at standard time rates only)	$ 16,848
Travel and Incidental	$ 3,261
Printing	$ 7,000
Total Cost	**$255,146**

Cost of Auditing Each Centre

The average cost of auditing each residential centre was $34,744 ($20,817 cost to The Audit Office and $13,927 cost to the Commission).

2. Disability Services in NSW

2.1 Disability Services in NSW

There have been substantial changes in the way that disability services have been funded and provided in NSW over the last decade.

Large scale institutions were once the main model of care, both in Australia and overseas for people with an intellectual or physical disability and people with a psychiatric illness. Such centres provided whole of life care, from birth to death, for residents. However since the 1960s institutional models have been considered unable and unsuitable to meet the needs of people with a disability.

In the past, services in NSW were provided by Fifth Schedule Hospitals serving both people with an intellectual disability and people with a psychiatric illness.[8] In 1983 the report on the *Inquiry into Health Services for the Psychiatrically Ill and the Developmentally Disabled* (the Richmond Report) called for the separation of these services and the eventual movement of residents from large institutions to the community.

Other changes to the way services were delivered in NSW arose from the transfer in 1989 of responsibility for these centres from the Health portfolio to the former Department of Family and Community Services (later renamed the Department of Community Services).

This also marked the movement from the traditional "medical models" of care and treatment by medically trained staff (doctors, nurses) to residential models based on "family" units. These new models recognised the rights of people with an intellectual disability to experience the same outcomes as ordinary citizens through increased community integration and improved personal competencies.[9]

With greater understanding and recognition of the rights of people with an intellectual disability, community based services became increasingly popular. Accommodation support services moved away from large institutions to a range of accommodation options such as group homes or individual support.

[8] Fifth Schedule Hospitals were psychiatric facilities providing services to people with a psychiatric illness and people with an intellectual disability under Schedule V of the NSW Public Hospitals Act 1929.

[9] Criminal Justice Commission 1995 *Report into Allegations of Official Misconduct at the Basil Stafford Centre page 67-8.*

In recent years there have been a number of reports on abuse of people with an intellectual disability residing in institutions. In some cases these reports detail assaults and deliberate mistreatment of residents by staff. However, other reports indicate the abuse is systemic in nature, in that it is a product of the way the centre operates.

This includes features of institutions which result in harm to, or neglect of, resident welfare, personal development or security. Systemic abuse can result from the inaction of individuals or the lack of suitable policies, procedures and practices. The inability of institutions to provide residents with positive lifestyles as well as meet the physical, social and emotional needs of residents can lead to the systemic abuse of individuals residing there. [10]

Currently, supported accommodation for people with an intellectual disability is provided by the Department of Community Services and non-government agencies in a range of residential options.

Table 2: Summary of Disability Residential Services in NSW
➭ Over 1 million persons in NSW have some form of a disability [11]
➭ Approximately 1825 people live in 17 large government residential centres [12]
➭ Approximately 563 people live in 30 large non-government residential centres[13]
➭ Approximately 1055 people live in 219 government group homes[14]
➭ Approximately 1260 people live in 286 non-government group homes [15]
➭ Approximately 201 children under the age of 18 live in large residential centres[16]
➭ In 1995/96 $226.71m was provided by the Ageing and Disability Department to the Department of Community Services for disability accommodation and support services and $20.24m in grants to non-government providers. [17]

[10] Examples of reports on abuse in institutions include Department of Community Services report into Baringa Centre, 1994 and Unit 6 Marsden Centre, Western Sydney Developmental Disability Service, 1994; Queensland Criminal Justice Commission Report into the Basil Stafford Centre, 1995, Community Services Commission Report on the Lachlan Centre, 1995; R. Conway report on Abuse and Adults with Intellectual Disabilities Living in Residential Services, 1996; and the Community Services Commission Report on the Hall for Children, 1997.

[11] Australian Bureau of Statistics. Disability, Ageing Carers, 1993, AGPS, Canberra.

[12] Briefing on transition Funding for Large Congregate Services, ADD 24.2.97 (Large residential services are defined as having resident population of 20 or more).

[13] ibid.

[14] Community Living Supported Accommodation for People with Disabilities Department of Community Services 1996 Appendix 1.2.

[15] Ageing and Disability Department Minimum Data Set 1995.

[16] ibid.

[17] Department of Community Services Annual Report 1995/96 p.120 and Ageing and Disability Department Annual Report 1995/96 p.20.

2.2 Major Reforms in Disability Services

The most significant recent changes to the provision of disability services in NSW are summarised in Table 3.

Commonwealth / State Disability Agreement

The Commonwealth/State Disability Agreement (CSDA) was signed in 1991. The CSDA is an arrangement between State, Territory and Commonwealth governments covering the funding and administration of employment, accommodation and support services for people with a disability.

In NSW, under the Agreement, the Commonwealth Government assumed administrative responsibility for 24 State run employment services for people with disabilities and transferred to the State approximately 331 funded accommodation support and day programs.

This Agreement is due to expire in June 1997 and State and Commonwealth parties have entered negotiations for the next CSDA.

In addition, commencement of the CSDA was conditional on the enactment of legislation which was complementary to the Commonwealth's Disability Services Act 1986. This was achieved with the introduction of the NSW Disability Services Act in 1993.

Disability Services Act 1993

The NSW Disability Services Act seeks to ensure that people with a disability have access to services which:

- help them achieve their maximum potential
- promote integration of people with disabilities into the community
- promote positive outcomes and images
- are innovative and well managed.

The Disability Services Act covers disability services funded or provided by the Minister for Community Services. The Act requires all services, in order to receive financial assistance, to be either providing services in *conformity* with the Principles and Application of Principles set out in Schedule 1 of the Act or *conforming as closely as possible* (refer Appendix 4 Principles and Applications of Principles under the Disability Services Act 1993).

Table 3 : Major Reforms in Disability Services in NSW	
1983	*Inquiry into Health Services for the Psychiatrically Ill and the Developmentally Disabled* the 'Richmond Report', called for the separation of services for people with a developmental disability and people with a psychiatric disability; and the eventual closure of large institutions in favour of community based facilities.
1986	Commonwealth Disability Services Act introduced. National Disability Service Standards translated the Principles and Applications of Principles of the Disability Services Act.
1989	Developmental Disability Services transferred from the Health portfolio to that of the Department of Family and Community Services (renamed Department of Community Services).
1991	The Commonwealth/State Disability Agreement (CSDA) was signed by all Heads of Government. The Agreement provided for the rationalisation of roles and responsibilities for disability services between jurisdictions.
1993	NSW Disability Services Act (DSA) introduced. This legislation is complementary to the DSA 1986 and established Principles and Applications of Principles for service delivery. The Community Services Complaints, Appeals and Monitoring Act (CAMA) introduced. The Community Services Commission and the Community Services Appeals Tribunal established. NSW Disability Service Standards (DSS) translated the Principles and Applications of Principles contained within the Disability Services Act into performance standards for services.
1994	Under the Disability Services Act, the Minister for Community Services must ensure that services (provided or funded) conform with the Objects, Principles and Applications of Principles contained in the Disability Services Act. Services self assessed conformity. Services which do not conform are required to *conform as closely as possible* and prepare a transition plan to outline what needs to be done to achieve conformity. Services submit transition plans for assessment by the Ageing and Disability Department
1995	The Ageing and Disability Department established. Planning and budget for government and non-government disability services was transferred to the Ageing and Disability Department from the Department of Community Services. The Department is responsible for strategic policy, planning, funding, monitoring and evaluation of disability services. The Community Visitor Scheme established in July. Forty Community Visitors appointed to visit 877 residential services in NSW.
1996	First round of transition funding commenced
1997	Final commitment of transition funding

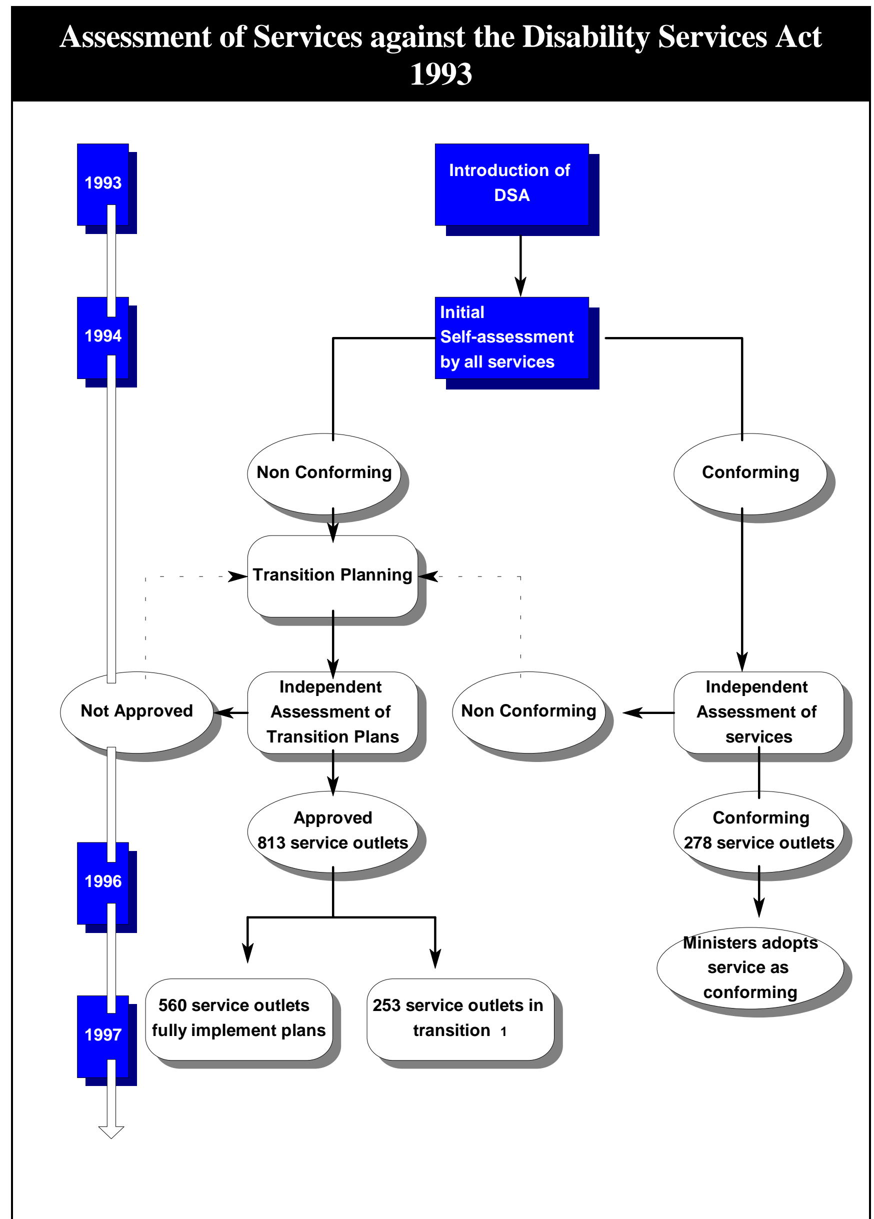
NSW Disability Service Standards

The NSW Disability Service Standards were established following the introduction of the Disability Services Act. The Disability Service Standards are ten performance standards which are an interpretation of the Principles and Applications of Principles of the Act. These Standards are based on the national standards (from the Commonwealth Disability Services Act) and include additional requirements regarding the maintenance of family relationships and the protection of human rights and freedom from abuse (Refer Appendix 5 NSW Disability Service Standards).

The Disability Service Standards are used to assess whether services are provided in *conformity* with the Objects, Principles and Applications of Principles of the Disability Services Act.

Assessment of Services

The following diagram outlines the assessment process following the introduction of the Disability Services Act.



Source: *Ageing and Disability Department Self Assessment Guide March 1997*

Note 1: Includes 17 government institutions with 1825 residents and 30 non-government institutions with 563 residents. The audit sample was selected from this group.

Transition Plans

Those services which indicated conformity with the Disability Services Act were assessed independently on behalf of the Ageing and Disability Department by consultants.

As at July 1996, 278 services were deemed to be conforming as the result of these assessments. Approximately 813 other services did not conform and were required to submit transition plans to the Minister.[18] These plans contain strategies to be employed by the service to achieve *conformity* with the Objects, Principles and Applications of Principles and the Disability Service Standards and funding needed to achieve conformity.

The allocation of transition funding to 339 service outlets (221 service outlets did not need additional funding to implement plans) has resulted in 560 of the 813 service outlets achieving *conformity*. 253 service outlets (of which 17 are large government services and 30 are large non-government services) have not received transition funds and are required to *conform as closely as possible* with the Disability Services Act until funding is provided to allow transition to the community.

Conforming as Closely as Possible

There is no definition of what *conforming as closely as possible* means in terms of either standards of service delivery (there is no definition of the concept in the Disability Service Standards) nor service outcomes to be achieved.

Audit's contribution to the definition of *conforming as closely as possible* is the identification of baseline criteria to protect the rights and safety of residents living in institutions and represent the minimum acceptable standard for service delivery. These follow the ten critical practice areas and are outlined in Appendix 7.

Large Residential Services

Key features of institutions prevent them from ever being able to provide services in *full conformity* with the Objects, Principles and the Applications of Principles of the Disability Services Act. For example two of the Principles state that:

> *Persons with disabilities have the right to live in and be part of the community (Principle b)*
>
> *Persons with disabilities receiving services have the same right as other members of Australian society to receive those services in a manner which results in the least restriction of their rights and opportunities (Principle g)*

[18] Ageing and Disability Department Annual Report 1995-96 page 20.

Institutions also do not comply with the requirements of the Government's Accommodation Support Policy. For these services, transition plans were prepared to achieve *full conformity* focussing on moving to the community and the funding required to implement the plan:

> *.....based on use of a single family dwelling, or other regular community dwelling that is, a facility having the smallest residential grouping possible, with no more than six residents (maximum) in any one dwelling.*[19]

[19] Ageing and Disability Department NSW *Accommodation Support Program Policy and Guidelines* page 4.

3. Characteristics of Institutions

Findings

- **Institutions are unsuitable and unable to meet the needs of residents and can not provide services in *full conformity* with the Objects, Principles and Applications of Principles of the Disability Services Act, or meet the requirements of the Accommodation Support Policy and international human rights instruments.**

- **The policy of de-institutionalisation has not resulted in the movement of all residents of institutions to community based facilities.**

- **The failure to adequately fund transition has:**
  - ◊ **further delayed the movement of residents from institutions into alternate models of care**
  - ◊ **prevented residents from receiving community based accommodation services which conform with the Disability Services Act.**

- **The absence of funding to complete the transition of institutions and the absence of a deadline for the devolution of all institutions has created an uncertain future for all parties.**

3.1 Characteristics of Institutions

Institutions are characterised by:

- their segregation from the community
- the age of the buildings (there are no "new" institutions and the majority of institutions were founded in the early 1900's)
- the large population of residents which they accommodate
- structured routines
- congregate living arrangements.

All centres visited by audit had characteristics that are typical of large institutions. All provided a range of services on the one site such as accommodation, leisure and recreational activities, day activities and medical and dental care. A profile of centres visited by audit is provided in Appendix 2.

Most government institutions adopt a "medical" model of care. These models employ nursing staff in a direct care role with emphasis on tending to the physical needs of people. All non-government centres previously followed the "medical" model but now employ a mix of medical and non medical support staff.

Residential accommodation is arranged in units (single or double storey accommodation blocks averaging 20 to 40 people living together as a group). Bedrooms are single, double or dormitory style. Most units have common dining rooms, common recreation rooms, open plan bathrooms, and fenced courtyards. Other common features are crowded conditions, showers without curtains, toilets without doors, locked kitchens and locked access doors

Many residents of institutions had lived there for the major part of their lives and had not enjoyed the benefits of living in the community.

The following table outlines the major differences between the opportunities available to people with a disability living in an institution to opportunities available living in the community.

Table 4: Comparison of Opportunities Community Life vs. Institutional Life

	Community	Institution
Individual choice:		
◊ What you wear	✓	×
◊ What food you eat	✓	×
◊ Leisure activities	✓	×
Opportunity to make friends and pursue relationships	✓	×
Freedom of movement	✓	×
Privacy	✓	×
Attended community based education or employment activities	✓	×
Specifically for children		
◊ Maintaining family relationships	✓	×
◊ Access to their own toys, free play, sports	✓	×
◊ Environment that supports the developmental, physical and emotional needs of children	✓	×

Lack of Personal Space and Privacy

In most centres there are no areas available for residents to use in private to entertain visitors or friends or to get away from other residents. Only those few residents who have their own bedrooms can achieve any degree of privacy.

Routines and Meeting Collective Needs

People who live in institutions are subjected to routines needed for organising large groups of people such as regimented times for meals, sleeping and ablutions. The collective needs of the group, rather than those of the individual, drive service delivery.

Table 5: Typical Weekday Routine for Residents

6.00 am	Wake up
6.00-7.00	Shower and dressing
7.00-7.30	Breakfast in unit dining room
7.30-8.00	Personal hygiene and grooming (teeth, hair, shave)
8.00-9.00	Time on unit
9.00-12.00	Attend Day Program onsite
12.00-1.00	Lunch in unit dining room
1.00-1.30	Return to Day Program onsite
3.30-4.00	Day Program finishes and return to unit
4.00-5.30	Time on unit or occasional outing
5.30-6.00	Dinner in unit dining room
6.00-7.00	Change into pyjamas. Personal hygiene
7.00-8.00	Time on unit
8.00	Supper on unit
9.00 pm	Bed

** Day Programs are not normally conducted on Saturday and Sunday.*

> *Don't do much after lunch. Showers at 4.30, then put pyjamas on getting ready for bed. TV at 5pm. Watch TV and movies. Would like to try something different.*
>
> Resident

Standard of Accommodation

The majority of institutions were constructed in the early 1900's to cater for a large population of people with an intellectual disability and people with a psychiatric illness. Most show signs of decay with the standard of accommodation varying across sites. Some government centres had refurbished large dormitories and created smaller "units" of 6 to 8 residents to provide more privacy, or had refurbished bathrooms whilst other centres struggle to maintain a standard of accommodation that is fit for habitation.

Personal Possessions

It is difficult for residents of institutions to have personal possessions due to the risk of damage or disappearance. Residents, staff and families all agreed that institutions have little success in protecting personal possessions even clothes.

Location of Institutions

Most large residential centres are physically separated from communities by being located on the outskirts of the main residential and commercial centres, or otherwise separated by major roads.

Segregation of this nature leads to a loss in social connection for residents. The isolation prevents residents from easily accessing community facilities like going shopping or to the movies or making friends outside of the centre. Residents rely on the centre to arrange outings in the community or the community comes to visit residents at the centre eg. religious ceremonies held on site.

3.2 De-institutionalisation Policy

.

Successive state governments have indicated a commitment to de-institutionalisation (that is closure of large residential centres and the establishment of community based residential units).

In 1988 the statewide plan for disability centres targeted four centres (Collaroy Hospital, Macquarie Hospital, Strathallan Centre and Riverside Centre) for closure by June 1988.[20] Only Collaroy closed with residents moved into community based services. The other three centres continue to operate today.

The second, and last, closure of a large government residential centre was the Riverglade Centre in 1994[21].

Despite this policy few people have been assisted to move to the community. In 1991, around 1900 people were accommodated in institutions operated by the Department of Community Services[22]. Currently, the population is around 1825 (a decrease of 75). This decrease can be explained by the movement of residents (92) from the Riverglade Centre and natural attrition (death). In fact the population has remained stable because of continued admissions to institutions.

[20] Developmental Disability Services A Strategy for First Class Services Department of Health NSW January 1988

[21] Evaluation Report on the outcomes for the former residents of the Riverglade Centre Department of Community Services 1995

[22] Department of Community Services Corporate Plan 1992-1994 published 2.12.91

Reconfiguration of institutions to community based services is now considered in the transition process under the Disability Services Act.

3.3 Funding for Transition

Under the CSDA $22.8m was transferred from the Commonwealth to the State to facilitate the transition of disability services and to assist the upgrade of facilities.[23] The purpose of these funds was to:

- reconfigure services so as to conform with the Disability Services Act
- provide additional funding for services that were not financially viable on transfer to the State
- provide individual funding packages
- achieve quality improvements across all service models.

The Cost of Transition

The assessment of transition costs for reconfiguring large government and non-government centres alone (as indicated by their transition plans) is $88.1m to fully implement the plans ($63.5m for government services) and $77.9m recurrent funding to support the new service configurations ($54.6m for government services).[24] These amounts far exceed the Commonwealth contribution of $22.8m.

Government institutions have always been a State responsibility and therefore, it is expected that the cost of transition for these services would be met by the State.

Since July 1996, transition funds have been committed to reconfigure one of 17 large government services. However, the Minister for Community Services, in response to the draft audit report, advised that the devolution of an additional four government residential centres had been approved. The Minister reports that 161 people in total will move to the community.[25]

[23] NSW Budget Paper No.2 1995/96 p 49. The Ageing and Disability Department advise that the amount quoted in the Budget Paper is incorrect. Correct amount transferred from Commonwealth should be $18.391m.
[24] Ageing and Disability Department Briefing Paper to the Cabinet Office on Transition funding for Large Congregate Services 24.2.97
[25] Memorandum from the Minister for Community Services to The Audit Office dated 29.5.97.

Only 1 of 30 large non-government service has received funds to reconfigure. An additional 7 non-government services have received transition funding ($4.4m) to implement their plans, however, these services had Commonwealth approved transition plans and were about to commence transition (or were caught part way through transition) when transferred to the State.[26]

The Minister for Community Services, in his letter of 29 May 1997 has advised that transition funding to non-government centres (including the allocation of funds to devolve the Hall for Children) will result in 318 people with disabilities moving to the community from these centres. It is understood these movements should occur in line with the timeframes provided in the service transition plans.

Institutions that do not receive funds to reconfigure are required to provide services that *conform as closely as possible* with the Objects, Principles and Applications of the Principles of the Disability Services Act. Because no time limits are imposed by the Act, large residential centres can continue to operate indefinitely if they are judged to *conform as closely as possible*.

3.4 Effects of the Uncertainty of Transition

The transition process has created special problems for large residential centres. For these centres, transition means reconfiguring to community based services and the result has been that centres have been in a "holding pattern" while awaiting funds to devolve.

The response from staff in some centres has been "*close us down don't run us down*".

The standard of accommodation in residential centres has been allowed to deteriorate. Buildings have not been refurbished because they are due to be vacated. Whereas before, small groups of residents were moving into the community, no one is moving into the community now because any future relocation depends on the implementation of the transition plan.

> *I wonder if it will ever happen - going out and living in the community and having a happy life and future, like I dream about.*
>
> Resident

[26] Submission to the Minister from the Ageing and Disability Department 15.8.95

The transition process has meant centres have difficulty retaining and attracting staff to fill vacant positions and all parties face an uncertain future.

In every centre, parents raised concerns about transition, were anxious about their family member moving into the community and were unsure of when transition would occur. On some sites, centres have advised parents of target dates for transition to commence but these deadlines have long since passed with no change in sight.

4. Operational Policy

4.1 Policy Requirements

The Disability Service Standards require that all centres have documented policies which are reflected in their practices.

The progress of institutions towards the documentation of policies varies from a complete set of comprehensive policies which are consistent with the Standards to a total absence of policies. The development of local policies and procedures in consultation with residents, their families or representatives, has not progressed.

In particular, audit has focussed on assessing centre policies which address the ten critical practice areas (see Table 6). Audit examined whether policies clearly set out expectations to adequately guide practices and management's approach to implementation of policies to ensure staff apply policies in practice.

Table 6: Existence of Policies

	Government Centres	Non-government Centres		
CENTRE	Department of Community Services Policies	Centre 1	Centre 2	Centre 3
Behaviour Management	✓	✓	✗	✗
Management of Incidents Including Injuries and Assaults	✗	✗	✗	✗
Medication Controls and Consents	✓	✓	✓	✗
Nutrition, Hygiene and Health Care	✓	✓ health care	✓ health care	✗
Community Access	✓	✗	✓	✗
Promoting Access to Family and Friends	✓	✗	✓	✗
Privacy and Dignity	✓	✓	✓	✓
Individual Service Planning and Skill Development	✓	✗	✗	draft in progress
Safety	✗	✓	✓	✓
Dealing with Complaints and Concerns	✓	✓	✓	✓

4.2 Policies for Government Centres

Findings

- **Policies used by government centres cover the ten critical practice areas except fire safety and the reporting and management of critical incidents including resident accidents and injuries.**
- **Even where policies had been developed to guide practices, actual practices fail to protect the human and legal rights, safety and dignity of residents. Reasons for this are the nature of institutional care (the environment renders some policies ineffective), inadequate implementation and practices that do not comply with policy.**

The Department of Community Services distributed its *Policies for Working with People with Disabilities* in January 1996, in line with the requirements of the Disability Services Act 1993. The manual continued to be developed with the second version released in November 1996 along with a Plain English version and a number of detailed papers to guide practices.

These policies represent an important development in establishing a coordinated policy framework and standards for the provision of services in government accommodation centres. It also represents a significant advance since the release of The Lachlan Report which found:

> *Policies and guidelines...are either non existent or unclear, inadequate or dramatically out of alignment with the law on assault and false imprisonment, international human rights instruments, NSW Disability Service Standards and the Principles of the Disability Services Act 1993.....*[27]

Policies for Working with People with Disabilities are a generic set of policies and guidelines to be implemented in all government centres regardless of service type ie. they apply equally to institutions as well as group homes and even non accommodation services. However, the nature of institutions make some policies, such as privacy and dignity, difficult to implement in that setting.

Prior to the distribution of *Policies for Working with People with Disabilities*, residential centres relied on policies inherited from the NSW Department of Health, Department of Community Services corporate policies and local standards to guide practices.

[27] Community Services Commission, *The Lachlan Report,* 1995 page 10

The review of the Department of Community Services policy documents by audit indicated that policies cover most of the ten critical practice areas. However, policies had not been developed for safety (particularly fire safety) and the management of critical incidents (resident injuries and accidents).[28]

Local Policies

There were significant differences in how individual centres had progressed the introduction of policies and the degree of practice compliance with Department of Community Services policy directions. None of the government centres had developed local policies in consultation with consumers.

Some centres had developed approaches to support staff to implement policies (discussion at regular meetings with a supervisor) whereas other centres had merely distributed policies to staff without appropriate discussion, training or support.

Centres reported difficulties in implementing some of the generic policies in the institutional setting. Centres may be able to undergo the process described in the policy, but are unable to achieve the intended outcome of the policy. Some examples are the policies on individual planning and behaviour management.

The policy on behaviour management, for example, requires that aspects of a person's lifestyle and environment which may cause frustration (and lead to an incident or outburst) be reviewed and changed. However, there is minimal capacity within institutions to alter either a person's lifestyle or their environment.

Findings across the government centres indicate that Department of Community Services policies had not standardised practices across all sites. Compliance with policies varied both within centres (from one residential unit or site to another) and between centres.

[28] The Building Code of Australia is the only set of fire safety standards applicable to institutions. However, the Code does not apply to buildings constructed early in the century. This has led to differences in fire safety precautions that were observed across sites. For example, some services have a direct line to the Fire Brigade while others have a manually operated alarm system.

4.3 Policies in Non-government Residential Centres

Findings

- **Without adequate policies to guide service delivery and establish standards, practices in non-government centres were not of a consistent quality or an appropriate standard, especially in the ten critical practice areas. The human and legal rights, safety and dignity of residents could not be adequately protected.**
- **Policies were deficient :**
  - ◊ **in the extent of policy coverage (they did not cover the ten critical practice areas)**
  - ◊ **because the content of policies did not provide adequate guidance to staff**
  - ◊ **because policies did not reflect the Disability Service Standards.**
- **Staff were unaware of the existence and content of policies and had not received training to support the implementation of policy.**

None of the non-government services reviewed by audit had developed a set of policies or procedures which were adequate to protect or promote the human and legal rights, safety and dignity of residents.

One centre had simply adopted Department of Community Services policies without amending them to meet the organisational needs or characteristics of their residents. Another centre had no policies or procedures to guide direct care staff in critical practice areas.

Non-government centres visited by audit have failed to establish adequate policies to direct service provision for these reasons:

- a lack of recognition on the part of service providers of the factors which constitute risk to residents, and the need to reduce risk by issuing policies which set standards for practices
- lack of skills in some centres to develop policies
- the Disability Service Standards do not clearly articulate practice requirements, especially in areas critical to protecting residents' human and legal rights, safety and dignity

- to date, minimal assistance has been provided by the Ageing and Disability Department to guide services in the development of policies in critical areas and the Ageing and Disability Department has not indicated the standard of service required in order to *conform as closely as possible* with the Disability Services Act 1993
- the absence of any independent assessment of centre policies, where they exist, to determine conformity with the Disability Service Standards and to ensure policy reflects Standards
- the failure of service providers to use networks such as ACROD (a peak organisation for disability service providers) that could facilitate the exchange of information and sharing of innovations. [29]

4.4 The Role of the Ageing and Disability Department in Policy Development

Findings

- **Audit found a substantial policy vacuum in the non-government sector in respect of policies to protect people in large residential centres.**
- **There is a need for the Ageing and Disability Department to provide assistance to all centres in the development of policies.**

The Ageing and Disability Department has a role in the development of whole of government policy and a responsibility to provide policy guidance to both government and non-government service providers to assist them to develop their own operational policies.

The Ageing and Disability Department determined the policy needs through a forum of 25 service providers held in early 1996. The forum identified a number of areas where policy assistance would be useful (such as duty of care, dealing with challenging behaviour, sexuality, assault and abuse).

[29] Australian Council for the Rehabilitation of the Disabled.

However, the Ageing and Disability Department have drafted only one set of guidelines to assist service providers. In response to a recommendation in The Lachlan Report, guidelines for managing challenging behaviours *(The Positive Approach to Challenging Behaviour)* were developed and audit has been advised that these will be distributed to centres in June 1997.

In the absence of guidance from the Ageing and Disability Department, some non-government services have purchased copies of the Department of Community Services *Policies for Working with People with Disabilities* and have adopted these policies as their own.

There is no definition of *conforming as closely as possible* or minimum standards for service delivery in large residential centres. Such a definition is essential to assist non conforming services in their efforts to *conform as closely as possible* and should have been defined when transition plans were approved in April 1996. The Ageing and Disability Department is yet to define these standards.

5. Practices in Institutions

5.1 Examining Practice Compliance with Policy

The protection of people with an intellectual disability residing in institutions can be improved by the development and implementation of policy and government directions on how services must be delivered.

In comparing service practices to policies, Disability Service Standards and legal requirements, audit focused on the ten areas considered critical to protecting residents from abuse. These ten key areas are:

- behaviour management
- management of incidents including injuries and assaults
- medication controls and consents
- nutrition, hygiene and health care
- community access
- promoting access to family and friends
- privacy and dignity
- individual service planning and skill development
- safety
- dealing with complaints and concerns.

Overall, and across both government and non-government centres, audit found services without adequate policies and procedures. Even where policies had been developed, practices deviated from policy and resulted in a failure to protect the human and legal rights, safety and dignity of residents.

5.2 Behaviour Management

Findings

- **There is continued use of restricted practices in response to challenging behaviour. In some cases these practices are used in breach of legal and policy requirements, and human rights.**
- **The effectiveness of behaviour management in institutions is limited. Centres achieve behavioural control of residents rather than long term behavioural change.**
- **The inability of centres to address the challenging behaviour of residents leaves residents themselves and others at risk of injury and assault.**
- **Residents with challenging behaviour may experience chemical or physical restraint, restriction on their day to day activities and problematic relationships with staff and**

other residents.

Audit identified residents in every centre who displayed behaviour which could be dangerous to themselves or others and that required special support. Examples of the behaviours are aggressive outbursts such as screaming, biting or hitting self or others, head banging or other self-injurious behaviour, causing damage to property and possessions, and inappropriate sexual behaviours.

The core features of good practice in behaviour intervention include:

- identification and analysis of the purpose, frequency and triggers of the challenging behaviour
- an emphasis on examining lifestyle and environmental factors that might provoke or reduce such behaviours
- the use of behaviour management plans, developed by multi-disciplinary teams (including specialists where required) that list strategies to reduce the need for reactive (incident driven) strategies, including teaching the person more adaptive behaviours and how to cope with undesired events
- review and monitoring of the planned strategies.[30]

There are significant differences between the government and non-government centres in responding to residents with challenging behaviour and their capacity to support residents with these behaviours.

Planned Responses

The Department of Community Services has developed a policy for dealing with residents with challenging behaviours and centres employ specialist staff to develop programs to support residents with challenging behaviours.

Although government centres have a high level of awareness of the need for documenting strategies for dealing with residents with these behaviours, the quality of behaviour intervention plans varied. Some plans were developed in line with good practice. In other centres, plans consisted only of redirection strategies for staff to follow in responding to a behavioural incident.

Non-government centres are characterised by a lack of recognition and response to the special needs of these residents. In non-government centres, there was substantial evidence that staff have difficulty dealing with residents with challenging behaviours and are unsure how to respond.

[30] These features are identified in Department of Community Services policy, and reflect good practice standards in behavioural literature.

Table 7: Behaviour Management

Government Centres

CENTRE	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Policy	✓	✓	✓	✓	✓	✓	✓
Written strategies/ or Formal Plans	✓	✓	✓	✓	✓	✓	✓
Plans match needs (residents and target behaviours)	✘	✘	✓	✘	✘	✓	✓
Specialist support involved	✓ psychologist	✓ psychologist	✓ psychologist	✓ psychologist	✓ CNS[31]	✓ psychologist	✓ CNS
Plans/strategies reviewed	✓	✓	✓ as part of Individual planning	✓ as part of Individual planning	✘	✓	✓

Non-government Centres

CENTRE	Centre 1	Centre 2	Centre 3
Policy	✓	✘	✘
Written strategies or formal plans	✘	✘	✓
Plans match needs (residents and target behaviours)	✘	✘	✘
Specialist support involved	✘	✓ a psychiatrist[32]	✓ a psychiatrist
Plans/strategies reviewed	✘	✘	✘

[31] Denotes Clinical Nurse Specialist.

[32] Visiting psychiatrist arranged by the centre. Psychiatrist would only be involved with those residents who are prescribed psychotropic medications. Residents who are not on psychotropic medications would be reviewed by staff responsible for behaviour intervention.

In two non-government centres (McCall Gardens and Hall for Children) there were no formal behaviour management plans which outlined how staff should respond to incidents of challenging behaviour and strategies for reducing the occurrence of the challenging behaviour. None of the non-government centres used specialists, such as psychologists to assist in developing individual management plans.

Restricted Practices

Practices such as physical restraint (holding a resident down), seclusion and containment (imprisonment by locking people in rooms) and chemical restraint (use of psychotropic medication[33] or sedation as PRN[34]) are sometimes used in an attempt to decrease challenging behaviour, or as a response to a behavioural incident.

Such practices are commonly referred to as "restricted practices" because they are unlawful, except in certain conditions, such as where the action is necessary to prevent imminent harm to the person or others, or where appropriate consent has been given for the practice as part of a behavioural strategy.

Government centres have guidelines outlining the conditions under which restricted practices can be used, and staff demonstrated a high level of awareness of consent and other requirements for the use of restricted practices.

However, despite these guidelines, and staff awareness of the requirements, such practices are still used. These practices are not always identified or monitored by management and do not lead to appropriate follow-up or review. Examples include the seclusion of residents in courtyards or bedrooms not being reported and the repeated use of restraint or seclusion in response to a crisis.

Behaviour Intervention Practices
A resident with severe self-injurious behaviour had injured himself 17 times in a six month period. On 6 of these occasions, his behaviour required staff to restrain him to prevent further injury. Although these injuries and staff actions were recorded on forms, which were reviewed by management, this resident did not have a behaviour management plan.

[33] Psychotropic medication includes all drugs that influence cognitive ability ie thinking, feeling, perception and behaviour.
[34] PRN (pro re nata) refers to medications prescribed for use 'as required', rather than according to a medication schedule.

The level of awareness of consent and other requirements for restricted practices was poorer in the non-government sector. Audit found evidence of unlawful practices such as the use of psychotropic medication without appropriate consent[35] and the containment of residents without either consent or meeting the requirements of imminent risk (or self-defence).

In one centre (Hall for Children) children were being locked in bedrooms, the courtyard and the bathroom, despite policies which indicated that seclusion and restraint were not appropriate responses to behaviour.

Management of centres claimed that either they were not aware that these practices were occurring or not aware that they were unlawful. Some staff reported that such practices were unavoidable given staffing levels.

> *I feel (that) to commit duty of care, I need to lock people in. I feel I am required to break the law.*
>
> Staff member.

Use of Psychotropic Medication

There are residents in all centres who are prescribed psychotropic medication for behavioural control (including on a PRN basis). Some of these residents did not have a corresponding behaviour management plan, and in some cases, psychotropic medication was prescribed without the involvement of a psychiatrist. It appears that these centres rely on chemical restraint as the primary response to challenging behaviour, rather than more positive approaches to behaviour management, contrary to good practice.

Restricted Freedom of Movement

In most large residential centres (both government and non-government), residents with challenging behaviours have their freedom of movement restricted, most commonly through the practice of locking access doors in units where these people live. In some cases, this was in the absence of other strategies for dealing with the challenging behaviour. Residents are not able to leave the unit without staff permission or supervision and there are no mechanisms to regularly review this situation.

[35] Guardianship Board Guidelines require that where a person is unable to consent for themselves to major medical treatment, then an identified 'person responsible' must consent in writing for the treatment proposed. Psychotropic medication is a major medical treatment under these Guidelines.

> *The building is like a gaol ... I have to ask to get out. I don't feel safe. They don't give me attention when I need it ... When I get agitated I would like them to sit and talk with me. Only three of us (in the residential unit) can speak, most were born not to talk. The NUM* (Nursing Unit Manager) *he's too busy to tell him what I want.*
>
> Resident living in a locked unit for people with challenging behaviour.

Effectiveness of Behaviour Intervention

Across all centres reviewed, formal intervention (the use of behaviour management plans) in institutions was rarely successful in changing or controlling the behaviour. It is not always possible to develop skills in residents or address lifestyle issues which might result in a reduction of the challenging behaviour.

In institutions, the size of the population, the configuration of the accommodation and the mix of residents increases the need for behaviour intervention while simultaneously limiting the effectiveness of any programs.

Services also acknowledged this as an issue.

> *For our client population, behaviour may be modified, but it will never really go away. We achieve behaviour control rather than behaviour change.*
>
> Staff member.

> *... they don't need more behaviour intervention plans, they need a major lifestyle change.*
>
> Centre Manager.

The limited response to challenging behaviour results in residents repeatedly hurting each other, staff or themselves. Many staff talked about the difficulties of working in an environment where physical aggression is a regular occurrence. Residents and family members also described the impact of other resident's behaviour.

> *People in the unit go crazy - there's biting, kicking, punching. (*Name of another resident*) got bitten, he can't get out of the way quick enough and I have to help. If there is any danger, I step in.*
>
> When asked what he does when 'people go crazy', the resident answered:
>
> *I feel tense (*indicates his chest*) - the bedroom door doesn't close, I have to barricade myself in with the bed.*
>
> Resident living in a locked unit with people with challenging behaviour.

> *I am scared to go in (*to the unit*)...I don't know how my child can stay there all day. There is an old woman who screams all the time.*
>
> Parent of a resident.

5.3 Management of Incidents Including Injuries and Assaults

Findings

- **The response by centres to incidents involving residents is inadequate. The failure consistently to define, report, monitor and analyse information about resident injuries and incidents leaves residents at risk of injury and assault.**

- **The largest category of injury to residents is reported to result from resident to resident aggression.**

- **Serious or repeated injuries listed as having an unknown cause are not always appropriately investigated. Centre management also do not consistently respond in an appropriate or timely manner to repeated injuries and incidents.**

- **The risk of injury to residents is increased by some of the features of institutional living such as poor staff to resident ratios, the mix of residents, the number of residents in the service, and the configuration of accommodation.**

Sample of Resident Injuries Reported in one Institution 1.1.96 to 31.12.96 *	
Total number of injuries reported	**3710**
Average number of injuries per client	**7.23**
Percentage of serious injuries (burns/scalds fracture choking dislocation)	38%
Type of injury	
• Abrasion	35%
• Cut	28%
• Bruising	10%
• Other	27%
Reported cause of injury	
• Resident to Resident Assault or Aggression	44%
• Self Injury	17%
• Fall	13%
• Unknown	26%

** Service accommodates more than 500 residents.*

Across all government and non-government centres, the largest reported category of injury to residents results from resident to resident aggression and self injurious behaviour. Other reported causes of injury included falls, and injuries of unknown cause. The injuries reported ranged from minor, through to serious such as broken bones and loss of limbs and extremities.

A review of incident reports for a 12 month period indicated the following serious injuries to residents*

- fractured wrist, cause unknown
- fractured leg, fell from veranda
- fractured leg, fell in bathroom
- fractured leg, alleged altercation with another resident
- fractured shoulder, fell during seizure
- undescribed injuries, hit by car
- fractured wrist, unknown cause
- fractured jaw, fell during seizure
- fractured jaw, suspected assault by another resident
- fractured hip, pushed by another resident
- leg amputated, hit by car
- finger bitten off
- injured finger, altercation with another resident
- finger amputated, infection

* Data from incident reports in a large residential centre accommodating over 500 people. This list does not include minor injuries.

Data on injuries and incidents is valuable management information which can be used (and is used by some centres) to develop strategies to reduce the frequency of incidents. However, the approach to recording, reporting and responding to incidents by centres varied, along with the definition of what constituted a critical incident.

As a result, no sector wide comparisons of the risk of injury to residents can be made and it is not possible to identify centres that have higher levels of injuries or incidents.

Centres which do not have an effective system for assessing incidents and injuries are less likely to be able to develop strategies to address causes, and reduce the level and seriousness of injuries and incidents.

In the non-government sector, two centres had introduced a reporting system for critical incidents involving residents. However, none of the non-government centres collated or systematically analysed data on incidents to identify cause, patterns (location, time, severity) and to develop resident specific interventions. As a result, there are a high number of unexplained injuries, and a failure to develop prevention strategies.

Table 8: Management of Incidents Involving Residents

Government Centres

CENTRE	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Guidelines on reporting incidents	✘	✘	✓	✓	✓	✓	✘
Reporting Form/systems	✓	✓	✓	✓	✘	✓	✓
Management review of incidents	✓	✓	✓	✓	✘	✓	✓
Centralised data	**Injuries only - not other types of incidents**	**Injuries only - not other types of incidents**	✓	✓	✘	✓	✓
Data provided to units for review	✘	✘	✓	✓	✘	✘	✘

Non-government Centres

CENTRE	Centre 1	Centre 2	Centre 3
Guidelines on reporting incidents	✘	✘	✘
Reporting Form/systems	✘	✓	✓
Management review of incidents	✘	✓	✘
Centralised data	✘	✓	✘
Data provided to units for review	✘	✓	✘

All government centres had some form of guidelines or reporting system for critical incidents and injuries, but only some centres used the information to identify cause, patterns and develop resident specific interventions.

Factors that affect the risk of injury are poor staff to resident ratios, the different behaviour and physical abilities of residents, the large size of resident groupings, dormitory style layout of the accommodation, the effectiveness (or existence of) behaviour management plans and the success of prevention strategies (where these have been developed).

Resident injuries that are recorded as "cause unknown" raises concern. Centres do not always investigate injuries to determine cause, even where the injuries are very serious or repeated. Where the cause of injury can not be identified, centres are unable to take appropriate remedial action.

Even the reporting of incidents (where cause was known) to management did not always result in an appropriate response to reduce recurrence. Examples were incident records showing patterns of repeated injuries, assaults or victimisation without any attempt by management to implement preventative strategies.

Case Study : Resident Injuries

A resident living in a locked unit of a large residential centre sustained 61 injuries in an 18 month period. Audit analysed 28 injury reports for a 6 month period and found that:

- 10 injuries resulted from resident to resident aggression
- 14 injuries were listed as being of unknown cause
- 4 injuries were sustained during seizures.

In 16 of these 28 cases, staff sought medical attention for the resident. Injuries included scratches, bruises, lacerations and abrasions.

Only after the parent of the resident complained to the centre (following an incident where the resident sustained severe facial injuries), was there any evidence on file to indicate that the centre considered protective mechanisms for the resident.

5.4 Medication Controls and Consents

Findings

- **Controls over the administration of medication in government centres often failed, and the legal requirements for gaining consent for medication are often breached.**
- **In non-government centres, medication controls are either non-existent or ineffective. The legal requirements for gaining consent for medication are poorly understood and often breached.**
- **The failure to gain appropriate consent for medication is a problem across all centres, particularly for the use of psychotropic medication.**
- **Some residents are being prescribed psychotropic medication in the absence of other strategies such as (non-chemical) behaviour intervention or in the absence of appropriate consent or expert scrutiny.**

Administering Medication

The Department of Community Services policy on medication requires large residential centres to comply with the requirements of the Poisons Regulation 1994 and NSW Health Department *Guidelines for the Handling of Medication in NSW Public Hospitals*. Two of the non-government centres did not have any policies or procedures to control the provision of medication to residents.

Controls over medication including administration, recording, monitoring and review, failed in the majority of centres. Some of the problems identified were:

- medication charts not being accurately signed off to show medication administered, including PRN medications:

> *M (resident) has been given at least 9 doses of PRN Vallergen and I have only noticed 1 notation of this.*
>
> Staff communication book.

- psychotropic medication as PRN being administered beyond the review date or administered without a doctor's authorisation
- putting medication in food rather than administering directly to the person. In large group living situations this presents a risk of the wrong person ingesting the medication, and makes it difficult to ensure that the medication is actually taken

- administering prescription medication to the wrong person

> *I overhead mention of T* (resident) *helping to give out pills...he took it upon himself to dispense K's medication (wrong day in this case)*
>
> Staff communication book.

- medication charts were incomplete (eg no details about reason for prescribing particular medications) or incorrect (eg details of medication and dosages were not accurate).

Parents also commented on problems with the administration of medication.

> *We* (parents) *are eternally vigilant about checking his medication. Those people who don't* (have family members to) *do this are at risk.*
>
> Parent of resident.
>
> *There are problems with the distribution of medication - I always check it.*
>
> Parent of resident.

Use of Psychotropic Medication

The Department of Community Services policy requires that only a psychiatrist prescribe psychotropic medication and that residents prescribed psychotropic medications be regularly reviewed. However, resident access to a psychiatrist is dependent on which institution the resident lives. Access to a psychiatric services ranges from regular 6-8 weekly visits at some centres through to no access at others.

In cases where no psychiatrist had been arranged, centres rely on a general practitioner to prescribe and review psychotropic medication.

Audit also identified residents in most centres who are prescribed psychotropic medication as a response to challenging behaviour. This did not always result in the development of a behaviour intervention or support plan for the resident concerned.

This presents the risk that psychotropic medication (particularly on a PRN basis) may be used excessively or inappropriately by staff to control behaviour as there are no alternatives available.

Extract from Unit Report

... Susan[36] returned after holiday. On return, she was overexcited, invading personal space ++, inappropriate behaviour in Susan's approach to staff and fellow residents, redirection to no avail, becoming more agitated. PRN Melleril (given). This had a settling effect in 1 ½ hours.

Consent for Medication

Consent to medical treatment (including medication) for people who are unable to provide informed consent is governed by the NSW Guardianship Act 1987. The Act requires consent to medical and dental treatment to include:

- the particular condition requiring treatment
- alternative courses of treatment available
- general nature and effect of those courses of treatment
- nature and degree of any risks of the courses of treatment
- reasons why a particular course of treatment is proposed.

The legal requirement that consent be obtained for medication and medical/dental treatment was well understood by staff in government centres, although not complied with in all instances. Examples of breaches of consent requirements in government centres include:

- medication being administered without consent (Tomaree)
- consents for medication sought without indicating the prescribed dosage or providing information about possible side effects of the drugs.

Non-government centres placed varying interpretations on the legal requirements of consent, such as:

- not seeking consent in the belief that consent by centre management and a doctor was adequate (McCall Gardens)
- obtaining a signed general consent for unspecified medical treatment from parents on admission of the resident (Hall for Children)
- obtaining consent for some treatments such as flu vaccinations, but not for administering psychotropic medication (Sunshine Home).

[36] Real name of resident withheld to protect identity.

The most consistent failure across all centres (both government and non-government) related to the administration of psychotropic medication without appropriate consent.

Families were not provided with adequate information about the purpose and side effects of medication. Audit also noted that families often lacked the confidence to question service providers and doctors about proposed medical treatment.

Many families were unaware of their rights and responsibilities in regard to consenting to medical treatment on behalf of a resident who is a family member.

5.5 Nutrition, Health and Hygiene

Findings

- **Two non-government centres use donated food on a regular basis. This practice impacts on menu planning, and presents a risk in regard to the quality of meals provided.**
- **Meal arrangements in centres provide residents with little choice or flexibility.**
- **Few centres have standard arrangements for accessing support to meet important needs of residents such as dietary and nutritional advice, physiotherapy and speech therapy.**
- **While resident health indicators are recorded in all centres, the recording and monitoring of this information is unreliable and does not assure timely and appropriate intervention.**

Food and Nutrition

Some centres prepare food in a central kitchen and serve meals in the residential units or central dining room which seats between 20 and 70 people at a time. The majority of centres prepared or purchased 'cook-chill' meals which are heated and served in the unit.[37] Food is rarely prepared in the kitchens of residential units.

Meals are provided on a fixed schedule with limited time to eat. Generally residents eat in groups. There is limited choice of foods.

[37] 'Cook-chill' is a mass meal production system where food is cooked then immediately chilled for storage, transported to where it is to be consumed and reheated for serving.

> *Food comes in a truck and everyone eats at the same time - you miss out if you don't get there in time.*
>
> Resident

> *60 people eat most of their meals each day together and a hooter is used for meal times.*
>
> Staff member

Menus rotate for variety except in one centre (Hall for Children) where a static 7 day menu was followed.

Two non-government centres (McCall Gardens and Hall for Children) receive donated food to reduce service costs. Menu plans are adapted to utilise the donations, which impacts on nutritional planning and resident choice. The quality of donated food is questionable. One centre reported that the donations received were generally foods which had reached their expiry date, or deemed not to meet commercial standards for some reason.

While all centres accommodate people who are physically or medically frail (and therefore vulnerable to being underweight), access to specialist dietary advice for individual residents or to assist with menu planning is limited. While one government centre employs its own dietitian (Hunter Region Developmental Disability Service), others rely on public hospital services if a nutritional assessment is required. Centres report varying levels of accessibility to generic services.

None of the non-government centres arranged for specialist dietary advice for individual residents or for menu planning in general.

Monitoring Resident Well Being

All centres had established systems for monitoring the health of residents such as weight, seizures, bowel movements and menstruation. However, audit found that recording and monitoring of this information did not always lead to timely intervention. For example, weight losses of up to 6 kgs in a month were not investigated by one centre.

In all cases, the centre selects and makes arrangements for visiting medical officers and other specialists (such as psychiatrists and therapists) on behalf of the residents. While centres agreed that residents could see a doctor of their choice, in practice this was generally by exception and only at the insistence of families.

Audit found that both government and non-government centres had limited access to services which would enhance resident well-being and independence such as physiotherapy or speech therapy. In some cases this means that individual needs of residents for assistance in independent movement and mobility, eating and communication were not being met.

5.6 Community Access

Findings

- **Many residents have limited opportunities to participate in activities in the community, spending most of their time on the grounds of the large residential centre.**
- **Community access is dominated by diversional activities (such as group bus rides and group outings) with no focus on community integration.**

The primary purpose of community access is to encourage and support the participation and integration of people with a disability in the wider community.

In most cases, community access for residents in large residential centres does not achieve this purpose. Most activities occur in groups with a focus on diversion (to get residents off the site) rather than participation and interaction with the community.

Examples of Community Access

One centre recorded the following as community access activities:

- 17 residents going for morning tea together
- 16 residents going for a picnic together
- 14 residents going for a haircut together

The decisions about these outings were made by management. A list of residents to go on the outing was issued to staff on the morning the outing was scheduled.

The more participatory and individualised activities achieved by some centres included assisting residents to attend TAFE or evening college courses, going to local clubs, using the library or shopping trips.

Even in those centres where an effort is made to provide individualised access (ie. on a one to one basis), opportunities are still limited and can only meet the needs of a small number of residents.

Factors which limit community access opportunities are the availability of staff, the availability of vehicles, the number of residents and their support needs, distance from community facilities and the availability of community activities that people from residential services can be involved in.

> *The major issue for all these centres is their isolation perpetuating problems of social deprivation and lack of community access particularly day activities ... residents continue to suffer from lack of meaningful activity ... and in some cases exclusion from community activities.*
>
> Correspondence from guardian.

> *We don't get enough things to do in the daytime. We get out of here once a week and that's not enough. We don't get to use the bus very often. We can't choose things we would like to do in our spare time.*
>
> Resident.

In two non-government centres (McCall Gardens and Hall for Children) all community access (including holidays) was arranged in groups. For some residents, this meant that they never have an opportunity to spend time with people other than fellow residents of the centre.

Across all centres, those residents with involved families had higher levels of community access than those without involved families.

5.7 Promoting Access to Family and Friends

Findings

- **In most centres there are no formal restrictions on visiting hours or formal practices that would prevent family contact and in most cases family contact is supported and promoted by the centre. However, the nature of institutional services mitigates against visits and extended contact.**
- **Few centres have attempted to promote relationships between residents and community members.**

The Disability Services Standards recognise the importance of preserving family relationships and to support consumers to maintain contact with family and friends.

In the majority of centres there are no formal practices that restrict the access of residents to family and friends, such as set visiting times, and centres promote family visits and contact through regular telephone calls, providing on site accommodation and hosting regular family events.

However, two non-government centres have policies and practices which could be interpreted as placing limits on access:

- a policy allowing management the right to deny visits to residents within the first six weeks following admission (Hall for Children)
- the allocation of alternate Sundays as a visiting day for families (McCall Gardens).

In all large residential centres, there are environmental factors that impede family contact such as lack of private areas for visiting and spending time together, service routines and the distance between institutions and the family home. There is also a lack of privacy for residents to make telephone calls. Residents who require staff assistance to access or use a telephone also experience less privacy for communication.

> *I can't spend time here with my brother as the other residents invade us. We always take him out for a picnic.*
>
> Family member of a resident.

> *I can't call my parents without the staff listening.*
>
> Resident.

There are also few opportunities for residents to form relationships outside of the centre, given the limited opportunity for community access. Only residents in two services (Western Sydney Developmental Disability Service and Hunter Region Developmental Disability Service) had access to schemes which facilitated contact with members of the community (who would visit the centre).[38] In most cases, residents are reliant on family contact to develop or foster outside relationships.

[38] The Community Friends scheme is run by the Western Sydney Intellectual Disability Support Group (based at Western Sydney Disability Developmental Service) and aims to foster friendships between people of Western Sydney and children and adults with intellectual disabilities living in residential centres. The Foster Grandparents scheme at Hunter Region Developmental Disability Service aims to provide friendship and caring support from mature members of the community, particularly for those residents who have no family contact.

5.8 Resident Privacy and Dignity

Findings

- **Dormitories, open plan bathrooms, common dining and sitting rooms deny residents an acceptable level of privacy.**
- **Institutions are largely unable to maintain an acceptable level of resident dignity, or assist residents to maintain personal possessions.**
- **Features of institutional living and some specific service practices impinge on the ability of people to express their sexuality.**

Personal Privacy

Large residential centres generally have dormitories for sleeping (or shared rooms), large common dining and sitting rooms and courtyards or other enclosed areas for recreation.

There are no areas for residents to use as private space, except for the small minority who have their own bedroom.

The design and layout of bathroom and toilet facilities is typical of institutional settings and deny residents adequate privacy. Examples of this include showers and baths located in the same room, baths in an open area; access to toilets being through shower or bath areas; and no areas for dressing and undressing without being in full view of others.

Such an environment makes it difficult for both staff and residents to protect and respect physical privacy, sometimes requiring directives from management regarding basic privacy issues.

Extract from Minutes of a Staff Meeting
(Resident) is to be prepared for bathing in her room - not stripped in the hallway near the bathroom, then afterwards taken to her room for dressing.

Some centres had refurbished residential units to achieve improvements in privacy such as single bedrooms or partitions between beds. In others, low or no cost improvements were used to gain some privacy (such as the placement of cupboards between beds).

Personal Possessions

Residents are rarely able to have personal possessions due to the risk of theft or damage. Residents, staff and families all reported that large residential centres have little success in protecting personal possessions (including clothing).

To overcome this problem, services lock personal possessions away from residents (including toys and clothes) or provide residents with lockable cupboards and chests. Most residents simply choose to leave their personal possessions in the family home or do not have any personal possessions in the institution.

> *He* (my son) *doesn't bring things here because he is worried that they will be stolen.*
>
> Parent of a resident.

> *Personal possessions are very prone to loss and destruction. It has become necessary to screw my son's family photographs to the wall of his room because they had disappeared or been destroyed several times. We now keep the wrist watch for my son to wear only at home, because several have been broken at the service. Similarly we now buy cheaper quality clothing because some new garments were never seen again.*
>
> Parent of a resident.

Dignity

Common features of institutional care which impact on residents' dignity include:

- lack of choice and control over their day to day life (such as what and when to eat, what to do during the day, what to watch on TV) as well as no involvement in significant decisions (such as who to live with, what jobs, training or education to undertake)
- poor accommodation standards for residents, ranging from stark and impoverished, through to living and sleeping areas with some personal effects

- limited freedom of movement, through use of locked units, or by locking particular parts of the units eg kitchens, fridges, dining rooms, courtyards
- lack of control over physical environment and comfort (eg. not being able to control shower taps, or TV controls)
- language/terminology used by staff to refer to residents which demeans their status (eg 'boys' or 'kids' when referring to adults; 'matties' when referring to people who are immobile and spend most of their time on floor mats; 'inmates' when referring to residents).

Sexuality

All centres seem to face some difficulty in dealing with issues of resident sexuality. The nature of institutional living restricts opportunities for residents to express their sexuality in private and in a dignified way.

However, there are also inappropriate practices amongst non-government centres such as:

- putting most female residents on the contraceptive pill (Hall for Children)
- refusing to acknowledge the sexual needs of residents (McCall Gardens)
- the manner in which allegations of sexual assault are investigated (Hall for Children, Sunshine Home).

Although a policy on sexuality is in place in government centres, there is still wide variability in how centres respond to this issue. For example one centre counsels and supports residents regarding their sexuality (Hunter Region Developmental Disability Service) while another reported that sexual activity is prohibited (Riverside).

Few centres adequately deal with sexual health issues, particularly in relation to health checks such as pap smears and breast examinations, education and support regarding sexually transmitted diseases and contraception.

5.9 Individual Service Planning and Skill Development

Findings

- **Even when individual plans are prepared, the plans are not always used to provide the support needed or wanted by the residents. Accordingly, most centres are structured to meet management and organisational requirements not the needs of residents.**
- **Opportunities for skill development are limited in institutional settings even where day programs are available.**

Individual Planning

Planning services to meet the individual needs of residents is an important way for centres to be accountable to their consumers and to ensure that service delivery is not driven by the needs of the group at the expense of individuals. The importance of planning around individuals is also reflected in the Objects, Principles and Applications of Principles of the Disability Services Act and the Disability Services Standards.

The aim of individual planning is to ensure that personal goals, preferences and needs of each person is taken into account in determining centre activities and support, and that appropriate assistance is provided to help each individual develop more positive lifestyles.

The concept of individual planning is critical to changing the focus of service delivery from group requirements, to that of the needs and preference of each person. Many of the other critical practice areas covered by this audit could be dealt with through a comprehensive individual planning system.

All government centres were conscious of the need to develop plans to identify and meet the needs of individual residents and had implemented an individual planning model in some form.

The findings in regard to the development of individual service plans are summarised in the following table.

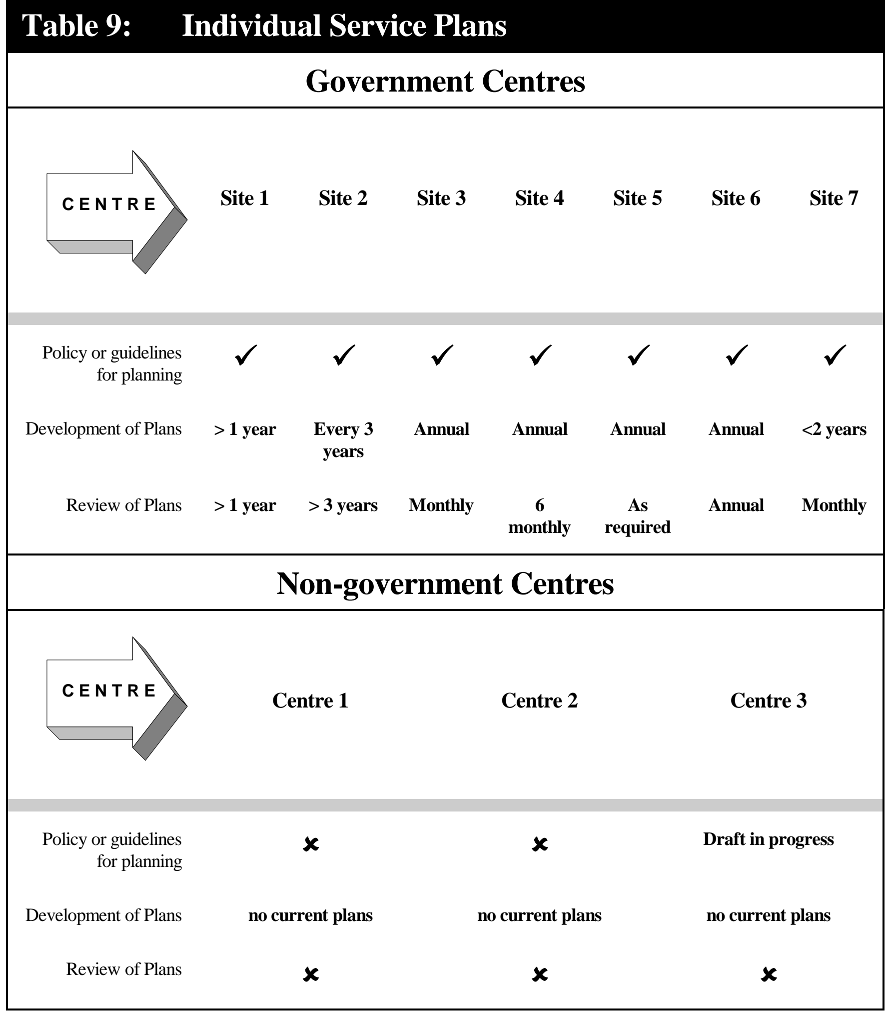


Table 9: Individual Service Plans

Government Centres

CENTRE	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Policy or guidelines for planning	✓	✓	✓	✓	✓	✓	✓
Development of Plans	> 1 year	Every 3 years	Annual	Annual	Annual	Annual	<2 years
Review of Plans	> 1 year	> 3 years	Monthly	6 monthly	As required	Annual	Monthly

Non-government Centres

CENTRE	Centre 1	Centre 2	Centre 3
Policy or guidelines for planning	✘	✘	Draft in progress
Development of Plans	no current plans	no current plans	no current plans
Review of Plans	✘	✘	✘

Across government centres there were varying results in the quality of the overall plan, the timing of reviews and the achievement of individual goals.

Where plans were developed, they were not effective in shaping service delivery. Rather, the type of activities and services already available determined the goals that were identified for residents.

> *I always hear about goals that are set for him, never any achievements. I don't know what his potential is.*
>
> Parent of a resident.

All centres faced difficulty in obtaining an advocate (in the absence of a family member) to assist or represent a resident in planning discussions and the individual planning meeting.

> *ISPs* (Individual Service Plans) *are about goal setting. There are very few outside people attending. A true client centred focus needs outside comment. 'Increase community access'* (as a goal*) is very nebulous, although it does mean that a resident does get to be taken out.*
>
> Staff member.

None of the non-government centres had prepared individual plans for residents.

Skill Development

Opportunities for skill development in areas such as social skills, domestic and community access skills (such as travel training and money skills) are extremely limited in institutions. Some of the barriers are resources (insufficient staff to run programs), the number of residents, the nature of the accommodation (eg absence of domestic appliances) and daily routines. The result is that residents are rarely able to develop or maintain skills, even for basic needs such as communication.

There is common over use of the term 'program' to describe daily routines where residents are actually practising previously acquired skills, or participating in a routine activity but are not gaining new skills. Examples are showering programs, lunch programs, and teeth cleaning programs. This creates the impression that more formal training is conducted in institutions than is actually the case.

> *The effectiveness of day programs is questionable - often residents go to* (program area) *and lie on the floor - they might as well stay in the unit. It makes it look good in data though. Looks like lots of activities are being undertaken, but there is no quality review of activity programs.*
>
> Parent of resident.

In most centres, residents remained on-site for the day, and participated in whatever day programs or activities were provided.

The approach to providing day programs differed (even across the government centres) in the following ways:

- the type of program offered, ie. unstructured programs (video viewing) or structured training (cooking programs)
- attendance patterns (optional or mandatory)

- duration of programs (half-days, full days)
- availability of programs (sessional, 5 days a week, 7 days a week)
- the quality and usefulness of activities offered in day programs
- whether staffing is separate to that of the residential unit, or shared.

The purposes of day programs are skill development, leisure and recreation. Few day programs are effective in fulfilling these requirements. Where day programs do offer skill enhancement, there is limited opportunity for these skills to be practiced in residential units. Some day programs provide activities that involved skills that may be useful in employment, others did not. In one centre, the employment program was sorting glass and bottle smashing.

Other limitations on the effectiveness of day programs are:

- that they are not developed in response to residents needs
- that they are conducted to suit staff work practices, ie. shift arrangements
- activities offered are determined by staff interest and skill
- the availability of facilities.

Staff acknowledged that in many cases, the main purpose of day programs is to distract the resident, break up the resident groupings for part of the day and relieve the boredom of life in an institution.

> *What you are doing is creating a job for a staff member, and the residents just hang around* (the staff member*).*
>
> Manager of a large residential centre.

> (Day programs) *represent a massive movement of the same group of people moving to another area.*
>
> Staff member.

5.10 Safety

Findings

- **Residents are at risk of injury living in large residential centres. These risks are not managed adequately by centres.**
- **The failure of centres to address risk of injury and other incidents leaves residents (and staff) in fear for their personal safety.**
- **There are no policy standards or procedures in response to fire risks, resulting in varied approaches to risk reduction.**
- **The general response to environmental safety risk is resident containment.**

Personal Safety

Centre reports indicate that a major safety risk for people living in institutions is from aggression and assault (including sexual assault) from other residents. As discussed in *Management of Critical Incidents*, injuries can range from severe injuries (limbs broken or lost) through to minor injuries (scratches, abrasions and bruising).

While the features of institutional living (such as large groups of people with different needs being accommodated together) contribute to this safety risk, it is exacerbated by the failure of management to develop strategies to minimise risks, including behaviour intervention or appropriate investigation into injuries with unknown causes. In some cases, poor staff to resident ratios make it difficult to prevent incidents leading to injuries or which pose a danger to residents (such as being able to prevent residents from ingesting items such as rubber gloves, paint chips and electrical cords).

The number and severity of injuries experienced by residents (and staff) is only one indicator of personal safety within institutions. Incidents of resident aggression or agitation which may not result in injuries contribute to an environment where residents (and staff) express fears for their safety.

> *I'm scared I might die in here.*
>
> Resident living in locked unit with people with challenging behaviours.

> *I'm scared of the boy next door. I get the night nurse to lock me in my room for the night, but one morning he got into my room and whacked me in the neck. I want to get out of here.*
>
> Resident living in a locked unit with people with challenging behaviour.

Fire Risk

Government residential facilities are required to comply with the safety standards outlined in the Building Code of Australia. However, there is no policy for government residential facilities regarding procedures for identifying and minimising fire risk (such as the need to have evacuation procedures or conduct regular fire drills). The result has been varied approaches to reduce fire risk which include:

- annual fire safety audits
- fire alarm systems linked to the local fire stations
- use of smoke detectors
- training of staff in the use of fire fighting equipment
- fire evacuation procedures and regular fire drills.

Some sites had all these features; other sites did not regularly conduct fire drills. Few services involved residents in fire drills.

The Department of Community Services recently reviewed its large residential centres against the requirements of the Building Code of Australia. The report indicates that the conditions of the centres (in respect to fire safety) ranged from poor through to complying with the Code. Findings included an absence of appropriate fire detection or alarm systems and little fire compartmentation in accommodation areas.[39]

Fire safety standards for non-government residential facilities are outlined in the Building Code and local government requirements. However, two of the centres did not have fire evacuation procedures or conduct evacuation drills.

[39] Report to Department of Community Services from consultant fire and safety engineers dated 22.4.97

Many parents and staff referred to their fears of the impact of a fire in large residential centres:

> *If there was an emergency here, it would be a disaster. You know when you put you son or daughter in a place like* (this centre*), and there is a fire, you know they will burn - you just accept it.*
>
> Parent of resident.

> *With 60 residents and 3 staff at night, I don't think we'd get people out in an emergency. Haven't had a fire drill on my shift for two years.*
>
> Staff member.

Environmental Risk

All centres (both government and non-government) identified environmental safety risks such as roads or rivers for residents who lacked road sense or who are prone to wander off.[40] However, the common response to these risks is to restrict the movement of residents (and others who may not be at risk) through keeping residents in locked residential units rather than assist residents to acquire the skills necessary to deal with these risks.

In most centres there is no mechanism to review the continued need for residents to be restricted (locked in a residential unit).

[40] Centres commonly used the term 'absconders' to refer to people who attempt to leave a restricted area without staff supervision or knowledge

5.11 Dealing with Complaints and Concerns

Findings

- **Not all centres had established effective procedures for investigating and managing complaints and families (and residents) were unsure of their rights.**
- **There are particular problems in handling issues raised by residents, especially when they relate to the alleged improper conduct of a staff member. The lack of appropriate procedures to deal with such allegations leaves residents at risk of abuse or poor treatment.**
- **Families and staff indicated a fear of retribution if they raised concerns or made complaints to service providers.**
- **Few centres have established mechanisms to capture or obtain information from families and advocates about concerns and issues, other than through formal complaint systems.**

All government centres are covered by the Department of Community Services complaints procedures. All but one government centre had established local complaints procedures based on the Department's model. Only one service (Hunter Region Developmental Disability Service) had taken the additional step to inform family members of how to lodge a complaint.

Two non-government centres had only recently introduced complaints procedures for residents and their families.

Complaints procedures seemed to have done little to reduce the fear (of families and members of staff) of retribution if they raised concerns or made complaints to service providers. Families told of concerns or allegations which they had chosen not to raise with the centre for fear of being seen as troublemakers or of the potential consequences for their relative if a complaint was lodged.

The most commonly expressed fear of families of residents in non-government centres was that the centre could evict or discriminate against their relative if they complained. This fear is heightened by the wide discretion non-government service providers can exercise about such decisions, and the limited protection against such action.

Table 10: Complaints Procedures

Government Centres

CENTRE	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Procedures for handling local complaints	✓	✓	✓	✓	✓	✓	✗
Complaint Records	✓	✓	✓	✓	✓	✓	✗
Data reported and reviewed	✗	✗	✓	✓	✓	✗	✗
Feedback on complaints to consumers and families	✗	✗	✓	✓	✓	✗	✗
Consumer support mechanism provided by service	✗	✗	✓	✓	✓	✗	✗

Non-government Centres

CENTRE	Centre 1	Centre 2	Centre 3
Procedures for handling local complaints	✗	✓	✓
Complaint Records	✗	✗	✗
Data reported and reviewed	✗	✗	✗
Feedback on complaints to consumers and families	✗	✗	✓ **consumers only**
Consumer support mechanism provided by service	✗	✗	✓

> *I'm always concerned for his personal safety. I once found him with blood blisters right around his tummy where clothing had been tied too tightly. He has bite marks all over his back from being bitten by another resident. I don't feel comfortable complaining. I'm really frightened about leaving him here.*
>
> Parent of a resident.

> *I don't complain to the NUM* (Nursing Unit Manager) *if there are problems ... it just creates problems for me if I complain. There are some vicious staff attitudes and cultures here.*
>
> Staff member.

Many families also expressed a view that they were not provided with adequate information about what they should expect from a centre (ie. about policies and service standards), or were unclear of their rights and those of residents. This lack of information restricted families' ability and confidence to raise issues or make complaints.

Issues raised by residents are generally poorly dealt with. Only two services (Hunter Region Developmental Disability Service and Sunshine Home) had introduced complaints procedures which were accessible to and used by residents. In other centres, complaints raised by residents (particularly in relation to improper conduct by staff) are poorly dealt with. In some cases, complaints were not recorded, or were noted in resident files, but not registered as a formal complaint.

It is recognised that centres face difficulty investigating complaints against staff, particularly in the absence of a witness. Audit found evidence of inappropriate and inadequate responses by centres to complaints and issues raised by residents. A contributing factor is the absence of procedures for dealing with complaints and allegations by residents.

Few centres had established informal mechanisms to facilitate raising of concerns and issues such as parent meetings, unit based social functions etc. This limits the feedback the centre receives, and the opportunities for families or advocates to raise issues (given their reluctance to make formal complaints).

6. Contributing Factors

6.1 Contributing Factors

In the main, large residential centres are unable to protect the human and legal rights, safety and dignity of people living there. Centres face numerous difficulties in meeting individual needs for skill enhancement, positive lifestyles, personal preferences and the physical, social or emotional needs of residents. Residents are therefore vulnerable, at risk, not able to lead a quality life and develop their full potential.

This chapter examines the factors, other than policies and practices, that contribute to the standard of service in institutions and impact upon resident safety. The factors raised by participants in the audit as barriers to improvement were:

- recruitment and staffing issues
- resources
- the physical condition of institutions
- other factors - the lack of advocacy services, the need for some people to have a guardian, respite care, payment for services and conflict between the needs of residents and staff.

6.2 Recruitment and Staff Development

Findings

- **Under current work arrangements government centres cannot match staffing mix, allocation and shift patterns to resident need.**

- **Limited staff induction and training occurs in large residential centres.**

- **Non-government service providers face significant problems in recruiting staff to provide services to people with an intellectual disability.**

Staffing arrangements for all large residential centres are designed to take into account the basic supervision needs of large groups, rather than the individual.

There are significant differences in staffing issues facing government and non-government institutions. Common to both is the need to support and train staff. There is a wide variation in staffing ratios across centres and the type of staff each may employ.

Employment Practices in Government Centres

Large government residential centres employ staff with nursing qualifications to provide direct care services. The reason for this is historic. When responsibility for disability services was transferred from the Department of Health to the former Department of Family and Community Services in 1989, nurses working in institutions retained conditions that existed under the Health system.

Competencies

The Department of Community Services has identified competencies required for residential care staff. These competencies are the skills and abilities essential for staff who provide residential support to people living in group homes.[41] For example, competencies have been identified in the areas of establishing a healthy and safe environment, the well being of people with disabilities, encouraging learning, managing crisis, individual planning, community integration, independence and interdependance. There are no plans to apply these competencies to nursing staff in institutions, even though they also provide residential support. The skills of nurses have been mapped against these essential competencies to identify future training needs. This preliminary exercise indicated that nursing skills did not match these competencies in several areas such as encouraging learning, principles of duty of care and dignity of risk and philosophy and attitudes towards community integration.

Some people living in institutions are physically frail and require medical and health support and care. Many others are physically robust and do not require nursing care. However, all people living in institutions require the type of residential support provided in group homes in order to lead a quality life and develop to their full potential. It is in providing this type of support that there are gaps in the skills and competencies of nursing staff.[42]

The Department of Community Services is only able to employ residential care workers in institutions when the institution undergoes transition, and union agreement needs to be obtained to fill such a vacancy.

[41] It is not planned to extend residential support competencies to staff working in large residential centres. The reason is that transition will result in the transfer of large residential centres to community based accommodation.

[42] However, some nurses have completed specialist training in Mental Retardation. General-trained nurses have no training in developmental disability.

In order to design a service more closely around the needs of the individual, a greater degree of flexibility is required to determine the mix of staff skills and backgrounds that can best meet the individual needs of people living in institutions.

Work Patterns

Patterns of work and industrial arrangements in government institutions have impacted negatively on service delivery and client outcomes. Service delivery should be driven by the needs of the resident. This is currently not happening.

Staff in large government residential centres work shifts. The morning peak may last for three or four hours but staff are on duty for 8, 10 or 12 hours, as split shift arrangements are not utilised. Day program times are aligned to shift changes and meal breaks. Up to two hours a day can be spent on meal breaks, with resident activities structured accordingly.

Government centres have not progressed short or split shift arrangements, although they have been used in non-government centres.[43] There is little capacity under current arrangements to engage more staff for peak times (morning and evening) and less throughout the day. The cost of direct care staff is inflated by overtime, penalties and allowances.[44] Below is a summary of the key differences in working conditions for direct care staff in institutions and group homes.

Table 11: Comparison of working conditions

Government Institutions	Government Group Homes
6 weeks annual leave	4 weeks annual leave
Night shift - full payment, plus penalty	Sleep overs[45] - payment for three hours
High costs in overtime, penalties and allowances	Minimal cost in overtime, penalties and allowances
Significant opportunity to pick up other types of allowances, such as ‘in-charge’ of shift	‘In charge’ allowance does not apply

Source: Department of Community Services.

[43] For example, an existing eight hour shift might be split into two four hour shifts, one to cover the morning peak and the other the evening peak.
[44] For example at Strathallen, around 25% of salary costs are paid in overtime, penalties and allowances.
[45] A staff member sleeps overnight in the group home. Residents do not need active support overnight but there is a need to have someone available in case of emergency. Sleep overs result in significant cost savings.

Non-government Centres

Non-government service providers appear to face significant problems in recruiting staff to provide services to people with an intellectual disability.

Audit noted that in two centres, Hall for Children and McCall Gardens, the practice of employing staff with no skills or experience in developmental disability was commonplace. Some examples of employment backgrounds included truck driver, beauty therapist, security guard, school leaver, student, labourer.

Centres report that it is difficult to attract and retain staff because of the low award rates (about $10 per hour).

Training and Induction Government Centres

The approach to staff training varied from the provision of an ongoing, internal training program in some centres, to ad hoc training provided by external suppliers in other centres (with limited training being undertaken).

The amount of training a staff member receives is a function of the centre in which they are employed. In centres where a formal training program was available, staff indicated a greater awareness of practice issues and improvements.

Annual expenditure in 1995\96 on staff development for direct care staff in government centres ranged from $50 at Riverside (or 62c per staff member employed in direct care) to $40,188 at Western Sydney Developmental Disability Service (or $80 per staff member employed in direct care).[46]

Induction practices varied from a brief two hour rundown to a comprehensive two day induction.

Training and Induction Non-Government Centres

Given the skill and experience of staff employed, it is the responsibility of each centre to provide proper induction and training to ensure staff are capable of providing an adequate standard of care.

[46] Department of Community Services 1995\96 Expenditure in Large Institutions.

Two non-government centres failed to support staff with proper service induction and formal training to improve skill levels. Supervision was also inadequate which further impacted on the ability of these centres to provide an acceptable standard of care.

These centres also had high staff turnover rates with a continual influx of inexperienced workers who do not know the needs of residents.

The result was practices which were poor and an increased risk to resident safety.

Very limited training was offered by non-government service providers. Untrained (and inexperienced) staff pose a risk for services in being able to protect residents and provide an appropriate standard of care.

6.3 Resources

Finding

- **Residential centres are funded on historic grant levels without regard to equity or the results of service provision.**

Funding to large residential centres is based on historical factors. Therefore the needs of the resident population do not determine the resources an institution receives. Funding on this basis does not take into account factors such as equity, the needs of residents, efficiency or the quality of services provided.

Resourcing impacts upon the type of services an institution can provide, and differences were observed in a centre's ability to provide day activities and obtain specialist support such as psychologists, social educators and therapists.

The quality of life for residents is often a function of the service in which he or she lives.

Government Centres

Block funding is transferred from the Ageing and Disability Department to the Department of Community Services for distribution to its centres. Allocations to large residential centres are also based on historical budget figures. A resource allocation model has been introduced for group homes.[47] The Department of Community Services does not apply the model in government institutions or adjust the historical budgets of institutions in line with the resource allocation model.

[47]Department of Community Services Resource Allocation Model Revision 1996-97.

Productivity Savings

Large government residential centres have been required to achieve productivity savings without cuts to direct care. However, few have achieved the targeted amount of savings:

Table 12: Imposed Productivity Savings In Government Centres

	Savings Target 1995-96 $	Savings Achieved $	Savings Targets 1996-97 $	Likely to be Achieved $
WSDDS*	.5m	.43m	.5m	unlikely
HRDDS*	1.2m	.89m	1.2m	unlikely
Riverside	.5m	nil	.01m	unlikely
Strathallen	.5m	nil	.03m	unlikely

Source: Department of Community Services.

* Western Sydney Developmental Disability Service

* Hunter Region Developmental Disability Service

Efficiency Gains

Government centres are constrained in their ability to extract savings from a budget in which there are sizeable salary costs including overtime, penalties and allowances.

Potential savings lie in a review of employment and work practices (such as shift patterns, staff type, overtime, penalties and allowances) and introducing service competition (such as the contracting out of domestic, outdoor and trades services). Larger residential centres employ tradespeople. For example, the Hunter Region Developmental Disability Service employs 39 tradespeople and 17 outdoor staff. Industrial barriers have prevented some of these savings being realised.

Inequities for Residents

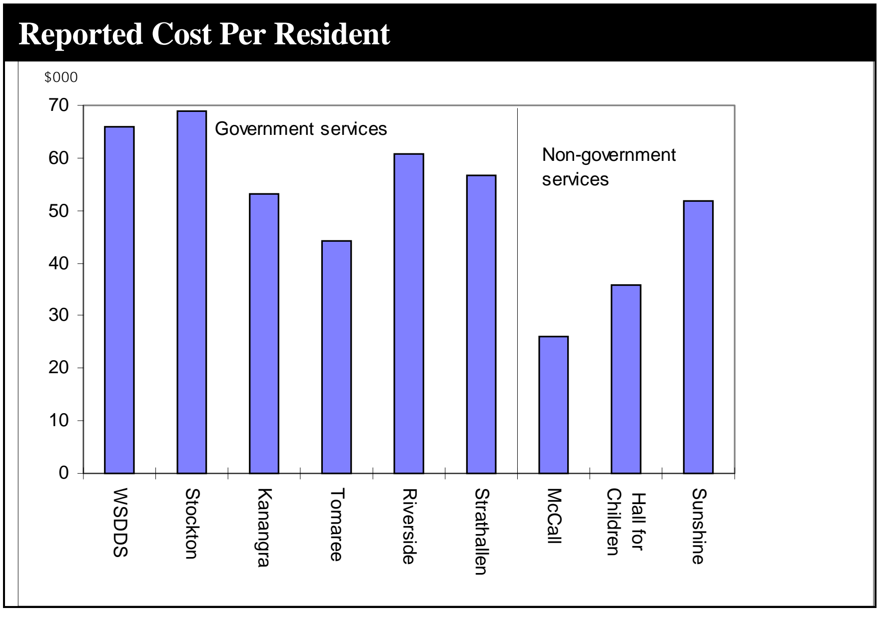
The allocation of resources to institutions results in inequities for residents because of the differing levels and variety of services an institution is able to provide as a result.

Cost per resident in non-government centres ranged from $26,000 (McCall Gardens) to $51,000 (Sunshine Home). The range in government centres was from $44,000 (Tomaree) to $71,000 (Stockton). However, government centres report they have more people with high support needs, which is more costly.

> *... While there is a perception among service providers .... and peak organisations that the Department's disability accommodation services cost more to run than those in the non-government sector, the Department has not been in a position to prove or disprove this ... because of poor information.*[48]

Apart from wide discrepancies between reported cost per resident in different centres, there were also wide discrepancies within the same service (Stockton and Tomaree are both part of the Hunter Region Developmental Disability Service).

Reported Cost Per Resident



Source: Information from centres.[49] Note that the figure for Stockton includes the cost of providing services to the other two sites. These are services such as laundry, catering, trades, outdoor and some administration costs which are not apportioned across sites.

[48] Council on the Cost of Government, February 1997, Review of Aspects of Management of the NSW Department of Community Services, page 39.
[49] The figures are based on total income (for non-government services) and total budget (government services). Note WSDDS includes Rydalmere and Marsden campuses.

Funding to Non-government Centres

The government contributes towards the cost of providing services in the non-government sector through the provision of block grants through the Ageing and Disability Department. The result of this approach is that financial assistance is unrelated to people's needs and does not buy specific inputs, outputs or outcomes for residents.

Funding models in which the needs of the individual determine allocations are not currently used to make funding decisions for large residential centres. However, a scoping study has been commissioned by the Ageing and Disability Department to review and provide advice on the possible introduction of unit costing and output based funding.[50]

Table 13: Percentage Of Total Revenue From Government Assistance
• Hall for Children - 81%
• Sunshine Home - 65%
• McCall Gardens - 50%

Source: Centres Annual Reports.

For the centres reviewed by audit the government contribution was the major source of funds. However, there is no mechanism to assess what the government is receiving for its contribution. The possible move to unit costing and output based funding is an attempt to address this.

Government contributions do not cover the total cost of services provided and these centres (usually registered charities) raise most of the remainder of funds through resident pensions and fees.

6.4 The Physical Condition of Institutions

Finding

- **Centres targeted to move to community based accommodation have become rundown with a consequent impact on resident safety, the basic condition of accommodation and the quality of life for the people living there.**
- **A property condition audit conducted in 1996-97 identified the poor condition of government institutions.**

[50] Output based funding is a funding system under which payments to providers are related to the products or outputs achieved. NSW Ageing and Disability Department, 1996, *Scoping Study on Unit Costing and Output Based Funding.*

Building design and layout, condition and age of the buildings all contribute to residents' quality of life.

Government Centres

The nature and standard of accommodation differed across centres and varied from high quality (such as a cottage with own room and possessions and attempts to make a homely environment) to barely acceptable (people living in large, depersonalised dormitories with old, shabby bed coverings, bare walls and no floor coverings). Some government centres had sufficient funds to reorganise large dormitories into smaller units which decreased the size of groupings. Other centres struggled to maintain existing buildings.

Many buildings are run down and do not meet the standard of accommodation expected by the community and envisaged by the Disability Services Act, 1993. Expenditure on new capital works and refurbishment for each of the large government residential centres over the last five years demonstrates a wide variation. In the older institutions, such as Riverside and Strathallen, there has been no new works expenditure in the last five years.

Table 14: New Works 5 Year Total 1992-93 To 1996-97

	$
Western Sydney Developmental Disability Service	310,252
Hunter Region Developmental Disability Service	1,043,141
Riverside	nil
Strathallen	nil

Source: Department of Community Services, 1995\96 Expenditure in Large Institutions.

Refurbishment has not been a high priority in part due to the expectation that transition to community based accommodation is imminent.

Department of Community Services Property Condition Audit

The Department of Community Services identified in its forward capital estimates submitted to Treasury (October 1996) that its buildings were in poor condition and not of an acceptable standard. A nominal amount of $5m was sought to undertake repairs to its large residential centres.

The property condition audit conducted in 1996-97 by the Department identified that $22m was needed to bring institutions to an acceptable standard (nearly $15m was identified for corrective and maintenance work for the institutions reviewed in this audit).[51]

A large number of the problems related directly to issues of client safety (including fire safety) and the basic condition of accommodation for residents. To date, no further funds have been made available to address these issues.

6.5 Additional Factors which Impact on a Residents' Life

Respite Care

People with an intellectual disability can be placed in large, government and non-government centres on respite on a crisis basis. Often these are people with disabilities who have challenging behaviours who have not been supported adequately in the community.

Respite beds are generally in residential units where permanent residents live. Respite placements, often because of their behavioural problems and special needs, can consume centre resources at a rate greater than permanent residents (often to the detriment of permanent residents) and can have a negative impact on the client mix in a residential unit (incident levels can rise). Often these placements become long term due to lack of appropriate community based accommodation.

Access to Advocacy Services

Residents generally need support or representation to bring forward their views. Representation means increased ability to demand changes in services or to complain about aspects of service as well as participate in decisions about their life.

[51] Department of Community Services Property Condition Audit, 1996.

There is a large proportion of residents in all centres without any representation and who are therefore vulnerable to having their views and needs ignored. Centres attempt to match residents with people that can represent them such as the parents of other residents or visitors. However, these representatives do not always assume the true role of an advocate.

The lack of sufficient advocacy services to meet the needs of all residents in institutions was noted as a critical weakness in the protection of individual rights and the establishment of safeguards.

Guardianship

Audit found that there are people living in institutions who may require, but do not have, an appointed guardian to protect their interests, either because their behaviour or medical needs require significant treatment or where they have no close family.

Children who are placed in residential care may also be in need of guardianship, where substantial contact with parents is not maintained. Even where parental contact is maintained, parents are not always aware of their legal rights and responsibilities as guardians when their child is in care.

It is the responsibility of service providers to identify and refer residents who may be in need of guardianship to the Guardianship Board, in the case of adults, or the Department of Community Services, in the case of children.

User Pays

The option for residents to pay for additional services (such as massages, regular attendance at a gym, swimming classes, companions) or goods (such as electronic equipment, beds, wardrobes etc) that would improve a resident's quality of life is at the discretion of the service and relies on the staff in each centre to pursue purchases. This is particularly the case where a resident does not have any family or an advocate.

Case Study: User Pays

The Office of the Protective Commissioner wrote to a government centre advising that a resident had significant funds in trust and asked if there was anything that the resident needed to buy. The resident was living in a bare dormitory unit.

The centre replied that all the resident's needs were being met and that no money was needed at that time. This decision was made without consulting the resident or considering how the resident's life could have been improved by expenditure for specific purposes.

It was noted that the Government amended the NSW Disability Services Act in 1995 to allow money frozen in Residents' Amenities Accounts (established under the mental health system) to be released for projects to improve the quality of life for all residents of government facilities. However, there is no policy guidance to clarify the goods and services to be provided by the centre within the fee structure and what improvements should be purchased with the additional funds.

Some government centres (and some staff) seem reluctant to use individual consumer funds to improve the quality of a resident's life. There appears to be some confusion about which services and goods should be provided (funded) by centres and which should be purchased by residents.

Conflict Between the Needs of Residents and the Needs of Staff

Government centres in particular, find it difficult to resolve situations where the rights and needs of residents are in conflict with the rights and needs of staff. Examples of this are:

- shift length and meal breaks reflect the needs of staff rather than the needs of residents. Day programs are discontinued during school holiday periods or activities come to a standstill on the weekends
- occupational health and safety strategies deal with risk of injury to staff but do not deal with the needs of residents (especially where residents have challenging behaviour)
- changes in the financial arrangements for holidays for residents of government centres has meant that centres cannot afford to pay the additional costs of staff to accompany residents. This has resulted in residents taking fewer holidays.

7. Monitoring Service Delivery

7.1 The Need for Effective Monitoring

Effective monitoring of residential centres is essential for external accountability and internal management control. This need for effective monitoring is demonstrated by the results of the audit of the Hall for Children (a large non-government residential centre) and the subsequent Community Services Commission Inquiry which found that services were blatantly unacceptable and presented a risk to resident safety.

To determine the effectiveness of monitoring in institutions, audit assessed responsibility for the development, implementation and review of centre policies and examined systems used to monitor practices.

In order to do this, accountability, control and monitoring of service delivery has been examined at two levels. Firstly, the effectiveness of control systems and performance monitoring by managers of residential centres (and Head Office of the Department of Community Services in regard to government centres) was reviewed.

Secondly, the role of the Ageing and Disability Department as the purchaser of services on behalf of consumers, in monitoring service delivery in all large residential centres.

7.2 Government Centres

Findings

- **There are no formal arrangements between the Ageing and Disability Department and the Department of Community Services for the delivery of government services and the monitoring of service delivery**

- **The approach by the Department of Community Services to monitor service delivery is not adequate and does not provide assurance that deficiencies in services would be identified at either the executive, area or local level.**

Although the Ageing and Disability Department provides funding to the Department of Community Services for the provision of services, there is currently no contract or funding agreement which formalises this arrangement.

At the time of audit, the Ageing and Disability Department had not commenced monitoring government services and contractual arrangements between the Departments for the delivery of services were being negotiated.

Accountability Between Services and Area Management

Within the Department of Community Services, large residential centres report to an executive (either to an Assistant Director General or an Area Manager in the regional structure).

Residential centres report regularly on financial and human resource issues (such as disciplinary inquiries) to area management. Allegations of serious physical assault, sexual assault or abuse of a resident are required by policy to be reported to area management and the police.

However, there is no formal requirement for centres to report on other key aspects of service delivery such as the number of critical incidents involving residents, results of investigations of allegations or complaints, complaints received or outcomes for residents.

In general, audit found that:

- there is minimal routine monitoring by Area Managers/Assistant Director Generals of day to day operations. These executives rely on centres to keep them advised of important events
- centre management can (and does) practice discretion in deciding what is an important event that should be reported to area management
- in the absence of standard reporting for centres, Area Managers/Assistant Director Generals are unsure of what information is needed to effectively monitor services (areas of greatest risk)
- performance requirements are provided in the *Policies for Working with People with a Disability* however these are not used by Area Managers/Assistant Director Generals to assist monitoring of service delivery
- issues raised by Community Visitors (refer also 7.6) are not automatically referred to area management by the centre
- information from residential centres (such as complaints, data on critical incidents and injuries) does not converge at any point in the Head Office of the Department of Community Services and often remains with Area Managers/Assistant Director Generals
- responsibility and accountability for service delivery is unclear.

Examples of comments made by managers responsible for monitoring institutions
It is very hard to get a picture of what happens inside the institution. The culture is closed and self protective.
It's very hard to get a picture...The larger they get (institutions*) the more institutional they get and the more institutional the staff get. Staff lose their connection with the world.*

The Department of Community Services' approach to monitoring service delivery is not adequate and does not provide assurance that deficiencies in service would be identified at the executive level.

Audit findings indicated that information was rarely exchanged between centres so that such things as service improvement initiatives were not repeated on other sites.

Case Study : Back to Base Communication
At one large residential centre a resident died as the result of an epileptic fit while on an outing with staff.
The Coroner's report into the circumstances surrounding the death recommended, that as a safety precaution, back to base communication (such as a mobile phone) be made available to staff taking residents on outings. This would allow staff to maintain contact with the centre and call for assistance when required.
Although all government centres take residents on outings, audit found that this recommendation had not been universally applied in other residential centres.

Accountability and Control in the Centre

As discussed in *Operational Policies*, the Department of Community Services had developed a policy framework which establishes standards for the provision of services.

However, audit found across the seven sites, significant differences in the degree of compliance with policy directions. The quality of service and practice varied from the policy directions both within centres (from one residential unit to another) and between centres.

Some of this variability can be explained by the lack of effectiveness of accountability, monitoring and reporting systems in the centre. Again, the approach to monitoring service delivery differed across sites and in general, the systems could neither assure standardisation of practices (policy compliance) nor the protection of residents.

Some examples of the different approaches to internal control were evident in:

- the use of management information systems. Most centres monitor resources such as the budget but only a few centres had established reporting systems that monitor practices and residents' outcomes and well being such as injuries, critical incidents, outings etc
- the way in which unit reports are used to monitor daily activities. Management in some centres regularly review these reports and investigate practices that are inconsistent with policy directions or unsafe. This does not always happen in other centres
- the type of complaints and allegations that are investigated and differences in the approach to conducting investigations
- the role of Nursing Unit Manager (NUM). The NUM on most sites is involved in the provision of direct care services (leaving minimal time for management duties) where on other sites, assumed the role of full time manager, responsible for service delivery in the residential unit.

Performance indicators are not used by any centre to monitor direct care services and very few centres had been subject to any form of comprehensive external review. For some centres, the audit conducted by The Audit Office in conjunction with the Community Services Commission was the first independent assessment of service delivery conducted.

7.3 Non-government Centres

Finding

- **In all centres reviewed, monitoring systems were not adequate to control the quality of services provided to residents and could not provide assurance that residents were protected from abuse, neglect and exploitation.**

Large non-government residential centres are generally under the auspice of a charitable organisation and managed by a Board of Directors. The Boards employ an administrator who is responsible for the day to day operation of the centre.

In all centres, it was found that monitoring and accountability functions were either absent, ad hoc, ineffective or inadequate to ensure that practices complied with policy (where it existed) and that the rights and safety of residents were protected.

System weaknesses included:

- a failure to control, monitor and regularly report key aspects of service delivery (direct care practices)
- responsibilities and accountabilities for direct care staff are not clear
- practices are not standardised through policy statements.

Accountability Between Administrators and the Board

Ultimately, the Board is accountable to the Ageing and Disability Department for the provision of services. However, Boards rely on administrators to monitor and report on key aspects of service delivery in terms of effectiveness, efficiency and quality.

All Board's receive regular reports from administrators, however, these reports concentrate on financial performance rather than comment on service quality or consumer outcomes. Rarely did Boards' request information in addition to that provided by the administrator and rarely did Boards seek independent advice.

There is no performance indicators of key result areas in any of the centres subject to review that would assist the Board to monitor service delivery. The Disability Service Standards could be used as a tool to assist Board's to monitor service quality, however, none of the Boards used this approach.

None of the centres consult directly with residents regarding decisions that impact on their lives or provide a mechanism that allows resident views to be presented to the Board even though the Disability Service Standards require services to provide for consumer consultation. However, these centres do not *conform* and are in transition towards establishing these consultation mechanisms.

Annual reports produced by each organisation do not comment on key aspects of consumer or service outcomes. The focus of the reports is on items of interest such as major fundraising events and activities like resident holidays.

Accountability Between Administrators and Staff

As discussed in *Operational Policies*, none of the centres had developed a set of policies which was adequate to protect the rights, safety and dignity of residents.

Accountability for the protection of residents in two of the centres visited (McCall Gardens, Hall for Children) was frustrated by position descriptions for direct care staff that failed to:

- identify areas of responsibility and accountability but rather listed tasks to be completed by the end of a shift
- require staff to have a knowledge of policies and procedures
- require staff to ensure that practices complied with stated policy, standards or directions
- list competencies or skills required for the job.

Most centres relied on a system of unit reports (used to record the daily events of a resident) to monitor behaviour incidents and staff practices to ensure compliance. The effectiveness of this approach was often impeded by the quality of the recording. For example:

- the majority of staff in two centres (Hall for Children, McCall Gardens) were Residential Care Workers (rather than Registered Nurses) who, on that basis, were refused access to the unit report to record incidents
- none of the centres had guidelines for staff on the purpose of these records. The result was poor or inappropriate records and inconsistency in the type of information recorded
- the nature of the information recorded made it extremely difficult to assess resident risk or identify when management should intervene.

None of the centres are involved in service provider networks in order to exchange information, share innovation, promote training and professional development and develop quality service improvements.

All centres tend to operate in isolation of other providers.

7.4 External Monitoring by the Ageing and Disability Department

Findings

- **The Funding Agreement is the primary means of defining service outcomes and performance standards for monitoring. However, audit considers the 1996/97 Agreement does not clearly articulate minimum service requirements for institutions or outcomes to be achieved for residents.**

- **In the past, there has been a high reliance on the use of financial information to monitor the performance of institutions with little emphasis on service quality. This information has not been adequate to alert the Department of Community Services and the Ageing and Disability Department to deficiencies in service delivery in institutions and trigger timely intervention.**

- **The effectiveness of the Ageing and Disability Department's approach to performance monitoring is limited by the:**
  - **absence of defined minimum standards or benchmarks for service delivery in institutions**
  - **capacity of Service Support and Development Officers to verify and judge the performance of institutions**
  - **absence of independent audit of centre performance.**

Ageing and Disability Department is responsible for monitoring service delivery in both government and non-government institutions.

Purchaser Provider Split

Responsibility for funding and monitoring centres such as those included in the audit previously rested with a major provider of these services, the Department of Community Services. Changes introduced in 1995 led to a type of purchaser/provider split with funding, quality assurance and monitoring transferred to the Ageing and Disability Department (the purchaser of services).

The primary purpose of the purchaser/provider split was to ensure that providers of services (such as the Department of Community Services and non-government agencies) become more responsive to purchaser preferences (consumer wants) and more likely to design services around the needs of individuals.[52] In theory, accountability is enhanced through the separation of service delivery from quality assurance, monitoring and evaluation functions.

Funding Agreements and Accountability

The Deed of Funding Agreement (covered by the Disability Services Act) is the primary means for Ageing and Disability Department to outline to non-government residential centres outcomes for which they will be held accountable.

Funding contracts and agreements are not in place for government services. Arrangements on how government services will account to Ageing and Disability Department were being negotiated at the time of the audit.

[52] The Final Report of the Review of the Commonwealth/State Disability Agreement 1996 p.92

The content of Agreements is covered by Section 12 of the Disability Services Act and is to include:

- the extent to which the service must conform with the Principles and Applications of Principles of the Act
- outcomes to be achieved for people with disabilities
- protection of the rights of people with disabilities
- performance indicators.

To be effective, Agreements need to clearly identify the minimum standards for each institution to *conform as closely as possible* in terms of service standards, service quality and service outcomes to be achieved.

The current Agreements for institutions do not stipulate minimum standards. This leaves centres uncertain regarding the quality of service expected and the Ageing and Disability Department without criteria to judge whether centres meet minimum standards or present a risk to residents.

Performance Monitoring

Until March 1997, service monitoring was undertaken by the Department of Community Services (through Community Program Officers) on behalf of the Ageing and Disability Department. This function has now been transferred to Service Support and Development Officers employed by the Ageing and Disability Department.

1995/96 Funding Cycle

In terms of monitoring the performance of non-government residential centres, Community Program Officers examine audited financial statements and annual reports provided by centres before recommending whether funding should continue.

This is not adequate to monitor service delivery.

1996/97 Funding Cycle

Monitoring was expanded for 1996/97 to include performance of an institution against its transition plan (goals listed in year 1 of the plan).

For non-institutional facilities, the Ageing and Disability Department reported that the transition plans include outcomes for residents and strategies, indicators and time frames for implementation.

The major flaw in this approach to monitoring institutions is that transition plans for institutions contain strategies to reconfigure to community based accommodation services (of not more than 6 people per dwelling). Plans were prepared by centres on the premise that funding to implement transition would be received. In the absence of funding, the plans do not indicate how the institution will move closer to conformity without reconfiguring the accommodation.

A review of goals set by the three non-government centres included in the audit found monitoring achievement of these goals would not produce helpful information. The goals could be easily attained, would not result in significant service improvements or could not be achieved without additional (transition) funding. Nonetheless, centres will report performance against these goals when applying to the Ageing and Disability Department for financial assistance in 1997.

Service delivery (performance) indicators have not been developed for this sector and there are no benchmarks for judging services in institutions or minimum standards for service delivery.

7.5 New Directions : Monitoring Through Self Assessment

1997/98 Funding Cycle

Ageing and Disability Department will introduce for the 1997/98 funding cycle, a self assessment tool for all non conforming services (including institutions) to evaluate their performance against the Disability Service Standards.

The Department's Service Support and Development Officers (who will have direct contact with centres) will verify the results of these self assessments to identify where there are deficiencies in service delivery.[53] Results of assessments will also be used to monitor the achievement of desired outcomes for people with a disability.

[53] Ageing and Disability Department 1997 Continuation of Funding Package page 9

However, as reported previously, the Department has not defined what the service standards are for institutions (ie. *conforming as closely as possible*) or how judgements can be made using the results of the self assessment tool. Service Support and Development Officers can be responsible for up to 50 services. There is a serious risk that much of their time will be taken up with service support leaving little opportunity for performance review and monitoring.

The validity and reliability of the results of self assessments would be enhanced by conducting independent testing. At this stage, services are to be independently assessed every three years against the Disability Service Standards to maintain funding. This means for the type of institutions visited by audit, an independent assessment would be conducted in approximately two years.

In the interim, the Department will rely on the findings of Service Support and Development Officers to make recommendations to the Minister regarding future financial assistance.

7.6 Other Approaches to External Monitoring

Findings

- **The benefits derived from the Community Visitor Scheme could be enhanced by the regular reporting of findings and recommendations to positions in authority**
- **There is an inverse relationship between the decline of most parent associations and the need for other forms of service monitoring.**

Community Services Commission

Information arising from the functions of the Community Services Commission could be important to assist the Ageing and Disability Department in monitoring individual services and systemic issues. This information would also be useful for Service Support and Development Officers in assessing applications for continuation of funding.

Community Visitor Scheme

The Community Visitor Scheme commenced in July 1995 under the Community Services (Complaints, Appeals and Monitoring) Act 1993. Initially, 40 visitors (as at 24 April 1997, 33) were appointed by the Minister for Community Services and commenced visits to residential services in October 1995.

The role of Community Visitors is to monitor the quality of service provision and advocate for residents by raising issues of concern with the service provider. Community Visitors can visit unannounced, interview any person connected with the service, and have access to all documents maintained by the service provider.

The Community Visitor Scheme is coordinated by the Community Services Commission, who determine the frequency for visiting (based on identifiable risk factors) and provide support, training and program development. Community Visitors are independent of the Commission.

There are currently 877 services in NSW providing full time care and accommodation to children and adults with disabilities that are visited by Community Visitors. Institutions included in the audit had at least two visitors assigned to each centre.

Community Visitors report findings of their visits to the service provider and provide reports on visits to the Commission.

Community Visitors do not have the authority to ensure services implement their recommendations on behalf of residents and recommendations are not automatically referred to those in positions of authority (such as the Minister for Community Services or the Ageing and Disability Department). However, reports to the Commission can become the subject of complaints, reviews or inquiries by the Commission which are then reported to the Minister and the Ageing and Disability Department.

Parent Associations

Audit found that on most sites a parent association had been established. Some associations were very active and involved in service planning whilst others suffered declining memberships (in some areas less than 5% of families were members) mainly due to the ageing population of parents of residents living in institutions.

The value of an active parent association is seen in its ability to argue for improvements in services and to act as advocates for residents who are not capable of representing themselves.

Appendices

APPENDIX 1

Audit Objectives and Scope

Audit Objectives

- To identify whether key policies and procedures to protect the human and legal rights, safety and dignity of consumers are in place in residential centres for the developmentally disabled in NSW and accessible to direct service staff and consumers, their families and other advocates.

- To review the implementation of those policies and procedures to ensure they are effective (that is, that they are implemented and consonant with policy objectives of the Government) in protecting the maintenance of consumers' human and legal rights, safety and dignity, and compliance with Government and service policy directions.

- To assess the adequacy of the management and direct care staff responsibility and accountability mechanisms for such policies and procedures, including responsibility. for their initial development, their dissemination, implementation (including, where appropriate, necessary authorities and approvals), monitoring and their regular review.

- To identify gaps in policy, and practice that need to be addressed to ensure that the human and legal rights, safety and dignity of consumers are brought to and maintained at an acceptable level.

In order to complete the review of large residential centres for people with a disability and report in 1997, the following segments were deferred:

- the assessment and adequacy of staffing levels/ratios, skills, competencies, selection processes, induction training, support and supervision
- the review of the management of consumer finances and the financial arrangements concerning service delivery
- the audit of group homes.

The performance audit was undertaken in the period February 1996 to March 1997.

Sample Size

The audit included seven large government residential centres and three non-government accommodation centres that receive financial assistance from the Government. A profile of the services visited is provided in Appendix 2.

Audit Scope

The reviews of residential centres were extensive and included:

- service provider interviews (management, direct care staff, support staff, staff forums and interviews with other professionals)
- consumer, parent, advocate and Community Visitor interviews
- parent forums
- written submissions from family members, guardians and advocates
- document review including service information (policies, procedures, transition plans) and unit information eg. day books, incident and accident reports and investigations, and client files
- interviews with staff from the Ageing and Disability Department and the Office of the Protective Commissioner
- site visits by the audit team.

Interviews conducted as part of the audit and submissions received are listed in Appendix 3.

Consultants were engaged at various stages of the review by The Audit Office. Firstly, to provide advice on the audit methodology (Sue Hurley Consulting Services) and secondly, to review the draft report (Strategic Solutions).

Critical Practice Areas

In assessing policy coverage and service delivery, the audit focussed on ten areas considered critical to protecting residents rights, safety and dignity. These critical practice areas were identified by representatives of each of the agencies involved in the audit as being those which were essential to ensuring that people with disabilities were living in a safe environment. The critical practice areas are:

- behaviour management
- the management of incidents including injuries and assaults
- medication controls and consents
- nutrition, hygiene and health care
- community access
- promoting access to family and friends
- privacy and dignity
- individual service planning and skill development
- safety
- dealing with complaints and concerns.

Audit criteria used to assess service delivery are outlined in Appendix 6.

Consultation

An initial briefing was held with consumer and advocacy groups to discuss the audit scope and objectives. From this meeting a reference group was formed to provide comment on the audit methodology and advice on audit conduct. Four meetings were held with the reference group. This group comprised representatives from peak consumer associations, namely:

- Disability Council of NSW
- NSW Council for Intellectual Disability
- Action for Citizens with Disabilities
- Institute of Family Advocacy and Leadership Development.

Methodology

An important by-product of the audit has been a methodology that can be used (and will be used by the Commission and other agencies) to test service delivery in other residential centres. This methodology was developed by The Audit Office in consultation with the Commission and the Department of Community Services.

Reports on Findings

The performance audit report presents overall findings in relation to service delivery in each of the large residential centres and draws on examples of practices in the centres visited. Individual reports have also been provided to management on each of the centres visited, however, it is not intended to publish these reports.

In response to the individual reports, two non-government services (McCall Gardens, Sunshine Home) have prepared strategic plans for implementing service improvements identified by audit.

> *Your visit and report has encouraged this organisation to improve and change some of its policies and practices which can only lead us to providing an even better quality of care for our residents.*

Comment from an Administrator, non-government centre.

Government institutions have taken a similar approach in response to audit findings.

APPENDIX 2

Profile of Centres

Government Centres

CENTRE	HRDDS [54] Stockton C.1900	HRDDS Tomaree C1939 [55]	HRDDS Kanangra C.1909	WSDDS [56] Rydalmere C.1960	WSDDS [57] Marsden C.1969	Strathallen Centre C. early 1900s	Riverside Centre C.1900s
Total Population	480	69	160	233	268	88	75
Population Details	Adults Female and Male	Adults Female and Male	Adults Female and Male	Adults. Female and Male	Adults and Children Female and Male	Adults Female and Male.	Adults Female and Male
Number of residential units/residents per unit	20 Units 7-40 residents per unit.	10 Units 2-14 residents per unit.	7 Units 7-41 residents per unit.	7 Units 18-30 residents per unit.	9 Units 5-35 residents per unit.	3 Units 19-25 residents per unit.	5 Units 7-24 residents per unit.
Units Audited (number of resident in each unit)	Unit 17 (38) Unit 9 (25)	6 residents	Unit 3 (15) Unit 10 (41)	Unit 3 (17) Unit 8 (25)	Unit 3 (21) Unit 6 (24)	Unit 12 (16)	Peel (13) Namoi (17)
Service Budget 1995/96	$33.14m [58]	$3.06m	$8.53m	WSDDS total $35.75m.	N/A	$4.99m	$4.56m

Non-government Centres

CENTRE	McCall Gardens C.1975	Hall for Children C.1908	Lorna Hodgkinson Sunshine Home C.1923
Total Population	68	60	132
Population Details	Adults. All male.	Adults and Children. Female and Male	Adults and Children. Female and Male
Number of residential units residents per unit	4 dormitories, 17 residents in each dormitory	Two wings South 16 North 44	4 Units 22-38 residents per unit
Units Audited (number of residents in each unit)	11 residents	Brown group (9) Pink group (9) Green group (10)	Morgan House II (28), Women's Unit (38)
Total Revenue 1995/96	$1.76m	$2.15m	$6.84m

APPENDIX 3

[54] Hunter Region Developmental Disability Service.
[55] Constructed 1939-45 to house United States Army personnel.
[56] Western Sydney Developmental Disability Service.
[57] Designed specifically as children's accommodation.
[58] Includes the cost of providing services to Kanangra and Tomaree.

Summary of Interviews Conducted by Audit and Submissions Received

Government Services

CENTRE	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Interviews with parents	9	7	5	12	1	6	6
Parent/Guardian and advocate correspondence	12	8	26	1	1	2	2
Resident interviews	2	4	6	5	1	3	4
Number attending staff forum	13	12	33	5	0	15	25
Number attending Family/advocate forum	30	40	9	2	3	5	6
Staff interviews conducted	11	16	16	6	6	5	10
Community Visitors Interviews conducted	2	1	3	2	2	1	1

Non-government Services

CENTRE	Centre 1	Centre 2	Centre 3
Interviews with parents	5	7	4
Parent/Guardian and advocate correspondence	0	2	3
Resident interviews	7	2	8
Number attending staff forum	18	12	5
Number of attending Family/advocate forum	80	25	70
Staff interviews conducted	19	12	12
Community Visitors Interviews conducted	1	2	2

APPENDIX 4

Schedule 1 Disability Services Act 1993 Principles and Applications of Principles

Principles

1. Persons with disabilities have the same basic human rights as other members of Australian society. They also have the rights needed to ensure that their specific needs are met. Their rights, which apply irrespective of the nature, origin, type or degree of disability, include the following:

   a) persons with disabilities are individuals who have the inherent right to respect for their human worth and dignity

   b) persons with disabilities have the right to live in and be part of the community

   c) persons with disabilities have the right to realise their individual capacities for physical, social, emotional and intellectual development

   d) persons with disabilities have the same rights as other members of Australian society to services which will support their attaining a reasonable quality of life

   e) persons with disabilities have the right to choose their own lifestyle and to have access to information, provided in a manner appropriate to their disability and cultural background, necessary to allow informed choice

   f) persons with disabilities have the same right as other members of Australian society to participate in the decisions which affect their lives

   g) persons with disabilities receiving services have the same right as other members of Australian society to receive those services in a manner which results in the least restriction of their rights and opportunities

   h) person with disabilities have the right to pursue any grievance in relation to services without fear of the services being discontinued or recrimination from service providers

   i) persons with disabilities have the right to protection from neglect, abuse and exploitation.

Applications of Principles

2. Services and programs of services must apply the principles set out in clause 1. In particular, they must be designed and administered so as to achieve the following:

   a) to have as their focus the achievement of positive outcomes for persons with disabilities, such as increased independence, employment opportunities and integration into the community

   b) to contribute to ensuring that the conditions of the everyday life of persons with disabilities are the same as, or as close as possible to, norms and patterns which are valued in the general community

   c) to form part of local co-ordinated service systems and other services generally available to members of the community, wherever possible

   d) to meet the individual needs and goals of the persons with disabilities receiving services

   e) to meet the needs of persons with disabilities who experience an additional disadvantage as a result of their gender, ethnic origin or Aboriginality

   f) to promote recognition of the competence of, and enhance the image of, persons with disabilities

   g) to promote the participation of persons with disabilities in the life of the local community through maximum physical and social integration in that community

   h) to ensure that no single organisation providing services exercises control over all or most aspects of the life of a person with disabilities

   i) to ensure that organisations providing services (whether specifically to persons with disabilities or generally to members of the community) are accountable to persons with disabilities who use them, the advocates of those persons, the State and the community generally for the provision of information from which the quality of those services can be judged

   j) to provide opportunities for persons with disabilities to reach goals and enjoy lifestyles which are valued by the community generally and are appropriate to their chronological age

k) to ensure that persons with disabilities participate in the decisions that affect their lives

l) to ensure that persons with disabilities have access to advocacy support where necessary to ensure adequate participation in decision-making about the services they receive

m) to recognise the importance of preserving the family relationships and the cultural and linguistic environments of persons with disabilities

n) to ensure that appropriate avenues exist for persons with disabilities to raise and have resolved any grievances about services, and to ensure that a person raising any such grievance does not suffer any reprisal

o) to provide persons with disabilities with, and encourage them to make use of, avenues for participating in the planning and operation of services and programs which they receive and to provide opportunities for consultation in relation to the development of major policy and program changes

p) to respect the rights of persons with disabilities to privacy and confidentiality.

APPENDIX 5

Disability Service Standards

Standard One - Service Access

Each consumer seeking a service has access to a service on the basis of relative need and available resources.

Standard Two - Individual Needs

Each person with a disability receives a service which is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

Standard Three - Decision Making and Choice

Each person with a disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his or her daily life in relation to the services he or she receives.

Standard Four - Privacy, Dignity and Confidentiality

Each consumer's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

Standard Five - Participation and Integration

Each person with a disability is supported and encouraged to participate and be involved in the life of the community.

Standard Six - Valued Status

Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

Standard Seven - Complaints and Disputes

Each consumer is free to raise and have resolved, any complaints or disputes he or she may have regarding the agency or the service.

Standard Eight - Service Management

Each agency adopts sound management practices which maximise outcomes for consumers.

Standard Nine - Family Relationships

Each person with a disability receives a service which recognises the importance of preserving family relationships, informal social networks and is sensitive to their cultural and linguistic environments.

Standard Ten - Protection Of Human Rights And Freedom From Abuse

The agency ensures that the legal and human rights of people with a disability are upheld in relation to the prevention of sexual, physical and emotional abuse within the service.

APPENDIX 6

Audit Criteria

Audit Procedure 1

1.1 Policy Development

Criteria

- Written policies should be:
  - ◊ developed in consultation with staff and consumers and their family and other advocates
  - ◊ regularly reviewed with staff and consumers and family and other advocates.
- Policies should be refined by the development of procedures that will account for local factors that influence service delivery

1.2 Policies in Place, Cover Critical Areas and are Adequate

Criteria

- Policies and procedures should be in place to address the human and legal rights, safety and dignity of consumers
- Policy documents should be appropriately endorsed, dated, reviewed and maintained
- Operational aspects of policies and procedures should be sufficiently clear, relevant and concrete to be readily applied by staff
- Policies and procedures should conform with the requirements of the Disability Service Standards
- Policies and procedures should address the following key areas:
  - ◊ behaviour management
  - ◊ management of incidents including injuries and assaults
  - ◊ medication controls and consents
  - ◊ nutrition, hygiene and health care
  - ◊ community access
  - ◊ promoting access to family and friends
  - ◊ privacy and dignity
  - ◊ individual service planning and skill development
  - ◊ safety
  - ◊ dealing with complaints and concerns.

1.3 Policies and Procedures are Accessible

Criteria

- Policies and procedures should be accessible. There should be full and free access to policies by staff and consumers
- The language and physical form of the policies should be appropriate and meet the communication needs of staff and consumers.

1.4 Implementation

Criteria

- Policy implementation should be a planned activity
- The implementation of new policies or procedures should be accompanied by training for staff and consumers
- Support mechanisms and guidance should be available to those responsible for implementing policy
- Staff should be aware of the current version of policies, coverage and impact on service delivery
- Staff should have the appropriate skills and training to implement policies and procedures.

Audit Procedure 2

2.1 Practices in Critical Areas

Criteria

- Practices should be consistent with government and service policies and procedures in the critical areas listed in Criteria 1.2 and be effective in protecting the human and legal rights, safety and dignity of consumers.

2.1 Barriers to Effective Implementation of Policies and Procedures

Criteria

- Any barriers to effective implementation should be recognised and managed. There should be genuine attempts to overcome such barriers. Examples of barriers might be the physical layout, culture, industrial issues or insufficient resources.

Audit Procedure 3

3.1 Roles and Accountabilities of Management and Staff

Criteria

- With regard to the critical areas of policy and procedures listed at Criteria 1.2:
  - ◊ Responsibility for the development, dissemination implementation, monitoring and review of these policies should be assigned to a specific body
  - ◊ Those practices requiring authorisation should be identified in the policies and procedures. The roles and responsibilities of management and staff in implementing the policy should be clearly defined
  - ◊ Practices requiring authorisation should be accompanied by the necessary approvals and documentation. The individual with the authority to approve these practices should be known by all staff
  - ◊ Responsibilities of management and staff should be clear and unambiguous. Each member of staff should know to whom and for what they are responsible and accountable. Consumers should also be made aware of the roles of staff
  - ◊ Locally developed policies and procedures should specify positions that have responsibility for implementation.
- All staff (including relief staff) have access to a service familiarisation or induction program when taking up duties.

3.2 Monitoring and Reporting Performance

Criteria

- Service providers should have a robust Management Information System to monitor critical areas
- Performance in critical areas should be regularly reported to the appropriate authority
- Monitoring systems should provide sufficient management information to trigger appropriate and timely intervention
- The service should evaluate and report its progress in an annual report which demonstrates consumer, service and financial outcomes
- There should be openness and disclosure of information about the service's activities and operations

- The agency should take account of information gathered from complaints and individual planning processes in developing and evaluating the service
- There should be regular monitoring of performance by external agencies

3.3 Quality Assurance

Criteria

- Documented procedures should be available to all staff to ensure practices are consistent
- A system should be established for the evaluation of service delivery to consumers against the objectives of the Disability Service Standards.

3.4 Independent Review

Criteria

- There should be an adequate level of review of the services by independent parties
- Recommendations arising from reviews should be acted on by management.

Audit Procedure 4

4.1 Gaps in Policies and Procedures and Practice Conformity

Criteria

- Policies and procedures should adequately address the objectives of the Disability Service Standards, the critical practice areas and reflect good practice
- Practices should conform to the requirements of the policies and procedures.

APPENDIX 7

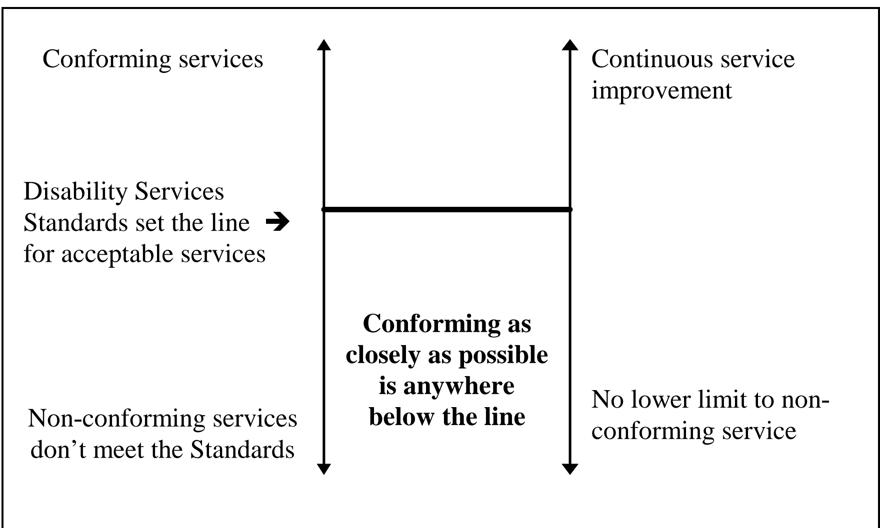
Definition of Conforming as Closely as Possible, Including Baseline Criteria for Resident Safety and Protection from Abuse.

Background

The Disability Services Act 1993 (s6) requires that all services provided or funded by the Minister for Community Services *conform* with the Objects, Principles and Applications of Principles outlined in the Act.

During the period when a service is developing its transition plan, and while the service is in transition, services must be provided in a way which allows the service to *conform as closely as possible* to the Objects, Principles and Applications of Principles (s6(4) and s7(4)).

Current Model

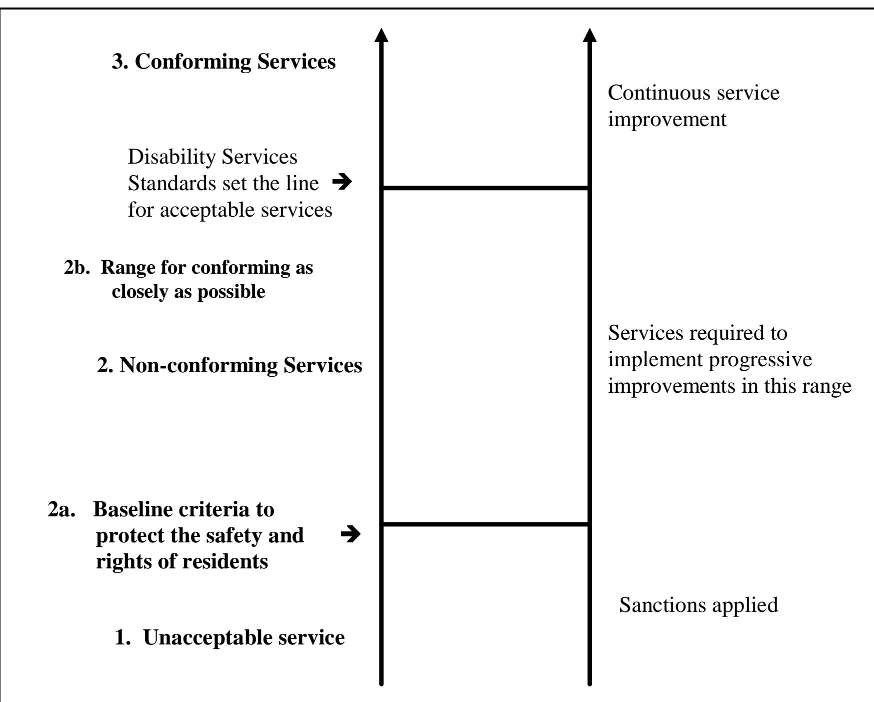


- Services are required to *conform as closely as possible.* As there are no criteria for defining *conforming as closely as possible* services can operate anywhere in the range of non-conformity.

- As there is no lower limit to non-conformity, there are no criteria which define when a service is so far from *conformity* that it should not be permitted to continue. For example when the service fails to keep consumers safe, or breaches their human and legal rights.

- Non-conforming service delivery (and therefore *conforming as closely as possible*) can range from very poor and dangerous, to almost conforming.
- There is no mechanism for assessing whether services are *conforming as closely as possible* other than through the initial assessment of transition plans.
- It is expected that transition plans will outline how services are to *conform as closely as possible* during transition. However, transition plans for institutions assume funding for reconfiguration to community based services.

Proposed Model



1. Level 1 services are unacceptable because they do not meet baseline criteria for the protection of residents' safety and rights. These services should not receive funding, nor be permitted to continue operating.

2a. Level 2a. Baseline criteria for protection of resident safety and rights derived from the 10 critical practice areas.

Any service which does not meet the baseline criteria within 12 months should not continue to operate, and residents should be provided with alternative services.

2b. Level 2b. Once services meet the baseline criteria, they commence a series of progressive improvements in practices in the 10 critical practice areas and the Disability Service Standards.

3. Level 3. Acceptable level of service. Services *conform* with the Disability Service Standards and Principles and Applications of Principles of the Disability Services Act, 1993.

Features of Conforming as Closely as Possible for Large Residential Centres

- A temporary status while services gradually improve their practices to bring them closer to the Principles and Applications of Principles of the Disability Services Act 1993, as part of the transition process.

- This status would not exceed 7 years (as that is the limit proposed for all institutions to have completed transition under Recommendation 1.2 of this report).

- Other than meeting the baseline criteria for the protection of safety and rights of residents, the service improvements required for a service to *conform as closely as possible* will be specific to each individual service and determined by the service provider in conjunction with the Ageing and Disability Department.

- Priorities for *conforming as closely as possible* should be:
  1. meeting baseline criteria for protection of safety and rights of residents
  2. implementing environmental adaptations within services which reduce the number of activities conducted in large groups
  3. adapting service routines, activities and supports to meet the individual needs and preferences of residents, as determined through individual plans
  4. increased community contact and integration, in line with needs and preferences of residents identified in individual plans.

- Service improvements for *conforming as closely as possible* (including baseline criteria for safety and rights protection) to be included in service Funding Agreements or contracts in the case of government services. The achievement of these improvements should be assessed by the Ageing and Disability Department as part of the annual service application for financial assistance. The Funding Agreement and contracts should include sanctions for failure to *conform as closely as possible.*

Baseline Criteria for Resident Safety and Protection from Abuse

1. Policies and Procedures

1.1 Policies should cover the critical practice areas:

- behaviour management
- management of incidents including injuries and assaults
- medication controls and consents
- nutrition, hygiene and health care
- community access
- promoting access to families and friends
- privacy and dignity
- individual planning and skill development service
- safety
- dealing with complaints and concerns.

1.2 All policies should be consistent with the Disability Services Standards, legal requirements and government policies.

1.3 Policy documents should be appropriately endorsed, dated and reviewed at least every two years.

1.4 Operational aspects of policies and procedures should be clear, relevant and concrete and readily understood by staff.

1.5 Policies and procedures should be freely accessible to staff, consumers, families and advocates.

1.6 Consumers, families and advocates should be informed of the existence of policies and procedures.

1.7 Introduction of policies should be a planned activity which includes staff training to facilitate implementation, and the provision of support and guidance for those responsible for implementation.

2. Critical Practice Areas

2.1 Behaviour Management

2.1.1 Policy should include:

- identification of restricted and prohibited practices
- identification of authorisation and consent requirements
- identification of responsibilities for developing and reviewing behaviour intervention plans
- identification of responsibility for monitoring compliance with policy
- outline approach to behaviour intervention
- identification of timeframes for reviewing behaviour intervention plans.

2.1.2 All residents whose behaviour poses a safety risk to themselves or others (or are prescribed psychotropic medication for behavioural purposes) have a behaviour intervention plan.

2.1.3 Plans include prevention strategies, and responses to behavioural incidents, and should be based on an assessment of the purpose of the behaviour.

2.1.4 Plans are developed in consultation with consumer and their family/advocate, and with specialist input and advice where required.

2.1.5 Centre has a system for introducing behaviour intervention strategies to all relevant staff, and ensuring implementation.

2.1.6 Centre has a system for monitoring and reviewing behaviour intervention plans.

2.2 Management of Incidents Including Injuries and Assaults

2.2.1 Policy should include:

- definition of incidents which are to be reported and followed-up. Definition should include accidents, injuries, assaults or other events which pose a potential risk to residents
- a process for recording and reporting incidents, within the service

- the types of incidents which require external intervention or reporting (eg assaults or allegations of assault which should be reported to police)
- a process for follow-up and review of incidents by management.

2.2.2 Staff are trained in identifying, responding to, reporting and following-up incidents.

2.2.3 Centre management reviews incidents, and ensure appropriate responses for prevention and follow-up.

2.2.4 Incident information is used as performance information to evaluate and develop the service. This information should be used by management, and the Board (of non-government agencies) or area management (in government services) to monitor service delivery.

2.3 Medication Controls and Consents

2.3.1 Policy should include:

- authorisation and consent requirements for different types of medication (consistent with relevant legislation)
- security of, and access to, medical supplies
- procedures for controls over administration of medication
- safeguards to ensure that medication is used for its intended purpose
- review procedures for the administration of medication
- use of appropriate specialists for prescribing and reviewing particular types of medication
- positions responsible for monitoring policy compliance.

2.3.2 Centre has appropriate and effective system for recording consents, authorisations and administration of medication.

2.3.3 Centre has a mechanism for monitoring the administration, consent and authorisation requirements.

2.3.4 Centre ensures that specialist advice and reviews are obtained where required.

2.4 Nutrition, Hygiene and Health Care

2.4.1 Policy should include:

- specific health indicators to be monitored by service, and frequency of monitoring
- provision for regular health checks including preventative and responsive checks
- procedures for access to specialists
- standards and review process for menu planning, including reference to specialist advice
- positions responsible for monitoring health care practices.

2.4.2 Centre has a mechanism for identifying consumers who are at risk of poor health, and to ensure appropriate medical attention is obtained.

2.4.3 Centre has mechanisms for regular health monitoring of individuals and intervention occurs when appropriate.

2.5 Community Access

2.5.1 Policy should include:

- definition of purpose and parameters for community access
- identification of responsibility and process for decision making about community access activities.

2.5.2 Centre has a mechanism for ensuring that all consumers have an opportunity to participate in community access.

2.5.3 Centre has a mechanism which links community access activities to individual needs and preferences as identified through individual planning.

2.5.4 Community access activities offer opportunities for interaction with members of the community and use of community facilities.

2.5.5 Community access activities are either individual or small group based.

2.5.6 Centre has a mechanism for the monitoring of the quality and equity of community access activities.

2.6 Promoting Access to Family and Friends

2.6.1 Policy should include:

- statement that free and open access and contact between families, guardians, advocates and friends and consumers of the centre is available
- identification of the centre's role and responsibility in promoting involvement with families, guardians, advocates and friends
- statement of centre's responsibility to identify those consumers without family or advocate involvement, and refer to either the Guardianship Board or the Department of Community Services or link with an advocacy program
- centre's responsibility for providing information to families, guardians and advocates.

2.6.2 Centre imposes no formal restrictions on visits or contact between consumers and their families, guardians, advocates or friends.

2.6.3 Centre has mechanisms to promote involvement of families, guardians, advocates and friends in key decisions such as individual planning, medication, behaviour intervention, day placement options etc.

2.6.4 Centre has mechanisms for regular communication with families, guardians, advocates and friends regarding service issues and developments.

2.6.5 Centre identifies and minimises any environmental or structural features which might discourage contact with families, guardians, advocates and friends.

2.7 Privacy and Dignity

2.7.1 Policy should include:

- consumers rights in relation to privacy and dignity
- procedures which outline how the centre will provide for:
  - ◊ confidentiality and access to consumer information
  - ◊ protection of physical privacy of consumers
  - ◊ protection of the dignity of consumers
  - ◊ sexuality needs of consumers.

2.7.2 Centre identifies and minimises the impact of routines and group living on the privacy and dignity of individuals.

2.8 Individual Service Planning and Skill Development

2.8.1 Policy should include:

- process for identifying individual needs and preferences and how the centre will plan to meet these needs
- timeframes for developing, monitoring and review of plans
- identification of responsibilities for individual planning
- framework for skill development
- definition of objectives of day programs.

2.8.2 Centres ensure that every resident has access to a day program that is appropriate to the resident's needs and preferences.

2.8.3 Individual needs and preferences are taken into account in providing services.

2.8.4 Centre seeks expert advice and assistance to meet individual needs as required.

2.8.5 Centre has mechanisms which support the involvement of families, advocates, guardians and friends of consumers in developing individual plans for consumers.

2.8.6 Centre has a system for monitoring the development and implementation of individual plans for consumers.

2.8.7 Centre maintains records which document consumer needs, preferences and centre responses.

2.9 Safety

2.9.1 Policy should include identification and response to:

- fire safety risks
- environmental risks
- risks posed by the behaviour of other consumers
- health related risks.

2.9.2 Procedures should be established for:

- external fire safety assessments
- fire evacuation drills
- other emergency procedures
- prevention of abuse and assault of consumers.

2.9.3 Strategies minimise risks to consumers, but with due regard to their rights.

2.9.4 Safety procedures and strategies which require any restriction on consumers rights (eg restricted freedom of movement) are regularly reviewed.

2.9.5 Centre has a mechanism to ensure that safety procedures are adhered to and regularly reviewed.

2.9.6 Centre has a mechanism to review any incidents which pose a safety risk to consumers or others, and implement preventative strategies.

2.10 Dealing with Complaints and Concerns

2.10.1 Policy should include:

- procedures for making complaints
- protection of confidentiality of complainants
- statement that complainant (and consumer) is safe from retribution and procedures for dealing with allegations of retribution
- position responsible for managing complaints process
- timeframes for resolution of complaints
- type of complaints that should be referred to external agencies for resolution or follow-up
- availability of support for consumers, or their representatives wishing to lodge a complaint
- requirements for recording and documenting complaints, action taken and outcome
- feedback mechanisms to consumers, their families and complainants, during, and at the completion of, an investigation of a complaint.

2.10.2 Centre has mechanisms for consumers and their representatives to raise issues and concerns other than through formal complaints process.

2.10.3 Centre uses information arising from complaints, issues and concerns to improve service practices and procedures.

2.10.4 Centre uses complaint information for performance monitoring by management and Board or area management.

2.10.5 Centre advises consumers and their families, guardians, advocates and friends about Community Visitors and their role, and encourages consumers to raise issues of concern with them.

3. Management Responsibility and Accountability Mechanisms

3.1 Centre has clearly defined responsibility for the development, dissemination, implementation, monitoring and review of policies in critical practice areas.

3.2 Position descriptions are available for all positions. Position descriptions clearly define the roles, responsibilities and accountabilities of management and staff, and include responsibilities for monitoring, implementing and complying with policies and procedures in critical practice areas.

3.3 All staff are provided with a centre induction program when taking up duties which includes familiarisation with policies and procedures in critical practice areas.

3.4 Centre has procedures for identifying and dealing with any breaches of policy and procedures, and any practices which place residents at risk.

3.5 The roles and responsibilities of the Board and consumer committees are clearly defined, particularly in relation to the development of policies and procedures in critical practice areas.

3.6 Centre reports to broader community and stakeholders at least annually on centre and resident activities and outcomes, and any significant changes in centre policies or practices. This should include reporting the outcomes of audits or self assessments.

3.7 Centre provides printed information to residents and their representatives outlining the obligations and responsibilities of the centre, and the legal rights and responsibilities of residents and their representatives.

APPENDIX 8

Glossary of Terms

Abuse	Includes inflicting, or threatening to inflict, physical or emotional pain or damage and includes any unwanted, harmful or offensive touching or verbal abuse.
Accommodation Support	Services that assist people with a disability to develop and maintain suitable residential arrangements within the community. A range of service models currently make up the spectrum of accommodation support services in NSW. This range includes drop in support to consumers in their own home, group homes, hostels and large residential centres.
Advocacy	Advocacy is the process of promoting, supporting and representing the rights and interests of people with a disability. It also involves the protection of an individual's rights and interests of the person, and therefore emphasises their identity, rights, development and potential growth and citizenship. Advocacy can involve acting, speaking, or responding on behalf of the person with a disability to ensure they have access to and receive services that meet their individual needs and respect their right to choose.
Assault	Assault is any act which intentionally or recklessly causes another person to think they may be subjected to immediate and unlawful violence.
Behaviour Intervention	Formal intervention that occurs in addition to, rather than part of, the individual's daily activity, community living or residential program. The aim of the intervention is to provide support in ways that can enable the individual to participate in day to day activities in a similar manner to others, as well as preventing and decreasing the frequency and impact of challenging behaviour.
Challenging Behaviour	Describes behaviours that are performed by a person that are of such intensity, frequency or duration that the physical safety of the person or others is placed at significant risk, or which limit the person's access to ordinary settings, activities, and services, and that substantially interferes with the individual's lifestyle and that of their peers and carers. The term `challenging' refers to the challenge faced by the individual's family/guardian, staff members and other people to provide support in an ethical, appropriate and effective manner.
Child	In NSW a child is a person under 18 years of age.
Community Integration	The right for people with disabilities to be part of, and participate in, the community. Achieved through community access arrangements.
Consent	Consent, as it relates to a child (a person under 18 years of age) or adult consumer, is the permission given by those with the relevant authority for the consumer to receive the service.
Containment	The withdrawal of a person from the setting to assist them in response to a crisis situation in order that the events/conditions maintaining their use of challenging behaviour are removed.
Critical Incident	A significant event that has the potential, due to the nature or circumstances under which it occurs, to cause psychological disturbance or physical injury to healthy people.

Day Program — On site facilities providing day services for residents, to develop their living/employment/recreation skills.

De-Institutionalisation — A term describing the policy closing large residential facilities for people with a disability, and moving them to community based accommodation, or returning them to their families.

Dignity — Treating someone with honour, respect and worthiness that reflects their culture, community and that positively influences their self esteem.

Duty of Care — The obligation to take reasonable care to avoid injury to a person who it can reasonably be foreseen might be injured by an act or omission. It is the basis for the civil (court) action of negligence.

Guardian — Someone who has been given the legal power to make important personal decisions on behalf of another adult, such as where the person should live or what health care and services the person should have. For adults and disabilities, guardians are appointed through the Guardianship Board.

Guardianship Board — A board established by the provisions of the NSW Disability Services and Guardianship Act 1987. For each case heard the Board will be comprised of 3-5 people, including a senior lawyer, a professional such as a psychologist or social worker, and a lay person experienced in dealing with people with a disability. Some decisions affecting a person with a disability (eg. major medical procedures such as sterilisation) can only be made by the Guardianship Board. For other decisions the Board may appoint a person who can act on behalf of the person with a disability in specified ways and for a specified time.

Human and Legal Rights — Human rights are articulated in international instruments such as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, International Declaration on the Rights of Disabled Persons and the UN Declaration of the Rights of the Intellectually Handicapped. Examples of these are the right to life, liberty and security of person; the right not to be subjected to inhuman or degrading treatment; the right to a standard of living adequate for health and well-being.

Legal rights include those provided through civil and criminal law for citizens as well as specific legislation relating to people with a disability eg. guardianship legislation.

Individual Plan — A written plan of action developed in collaboration between staff and the individual and his or her advocate/parent/guardian. It specifies agreed priorities, goals and strategies designed to meet the needs of the person with a disability who receives a service.

Office of the Public Guardian — The Public Guardian is a public official appointed by the Guardianship Board to make personal decisions on behalf of adults who have a disability and need a guardian. The Public Guardian is only appointed if there is no relative or friend available or suitable to be guardian.

Office of the Protective Commission — The Protective Commissioner acts as a financial manager to manage a person's money, other property and financial or legal affairs. The Protective Commissioner is appointed by the Supreme Court or Guardianship Board if a person is incapable of managing their own affairs and needs a financial manager. The Court or Board may appoint either the Protective Commissioner or a private financial manager who is supervised by the Protective Commissioner.

Person Responsible Someone who can act as the substitute decision maker for a person who is unable, for some reason, to give valid consents for his/her own medical or dental treatment for residents of large residential centres, their person responsible is generally the person who cared for them prior to entering residential care (usually parents) or a close relative or friend.

Physical Restraint Involves the use of any device/strategy applied to part(s) of a person's body to restrict the person's movement to prevent injury to themselves or others. Physical restraint, for example, may be planned as a reactive strategy aimed at minimising a person's harm to themselves, used as part of an overall intervention plan.

Respite Care Short term and time limited break for families and caregivers of people with a disability to assist in supporting and maintaining the primary caregiving relationship.

Restricted Practices Restricted practices are subject to particular procedures and approvals. Restricted practices involve some intrusion on the consumer's freedom in an attempt to achieve the curtailment of, or a decrease in, a particular way of behaving. Restricted practices (eg. withdrawing of privileges) usually involve some cost to the consumer for behaving in a particular way, feedback on the inappropriateness of their actions, and alteration of the circumstances maintaining the undesirable behaviour. Restricted practices are non-exclusionary time out, containment, response cost, extinction, over correction, physical restraint, restricted access, seclusion and exclusionary time-out.

APPENDIX 9

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NSW Health Department	*Immunisation in New South Wales*	12 June 1997

Agency or Issue Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
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Department of Community Services and Ageing and Disability Department	*Large Residential Centres for People with a Disability in New South Wales*	June 1997

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