



The South Australian Community Visitor Scheme

**Principal Community Visitor**

**SPECIAL REPORT**

**Disability Services 2016-17**

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Hon. Michelle Lensink, MLC

Minister for Human Services

Level 12 South,  
1 King William Street  
ADELAIDE SA 5000

Dear Minister

It was great to meet with you on Monday the 4<sup>th</sup> of May to discuss my Special Report on Disability Services for 2016-17 and to also share my concerns about the uncertainty of SA's Community Visitor Scheme into the future. You will see the evidence and value of our visits, reports and follow up actions with both Government and NGO agencies to ensure that issues affecting people with disabilities in their care, are resolved. We have many documents and correspondence from the services that we visit, that express their appreciation of both the visits and the visit reports that are relayed back to them. In essence, they use these as a 'quality improvement' strategy and communicate both the positive elements of the reports and the constructive comments about where there is a need for improvements to specific staff in their services.

In accordance with Regulation 6(3) of the *Disability Services (Community Visitor Scheme) Regulations 2013*, it gives me great pleasure to submit to you this special report. This report provides an account of the work of the South Australian Community Visitor Scheme (CVS) during the financial year ending 30 June 2017 and an update on issues to the end of 2017.

You will note that the report contains a total of 25 recommendations, 13 related to Disability Services, 6 to Supported Residential Facilities (SRFs) and 6 related to Day Options Programs.

I would also like to draw your attention to the more strategic issues covered in section 2.5.2 Systemic Advocacy commencing on page 17. This highlights the importance of the State Government giving consideration to those specialist services that will not be provided under the NDIS but will be required by those with complex needs including comorbidities and dual disabilities.

In generating this report with my team and community visitors, it has further reinforced to me the importance of independent monitoring of the services provided to some of our most vulnerable citizens in SA and the many and varied issues that the Community Visitor Scheme has identified and followed up with service providers. Our visit enquiries also provide us with a unique exposure to the interface between disability services and many health and mainstream services both within the public system and across to the private sector. This further enables us to reflect and report to government on the experience of many South Australians with a disability who face challenges in engaging with these services from both an individual and systemic perspective.

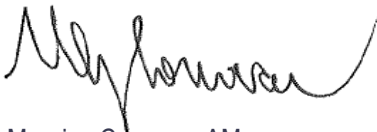
I also note that we meet many individuals with disabilities who have a low level of expectation and care which reflects their past experiences and limitations placed on them by those who supported or cared for them. This 'burden of low expectations', in most cases, reflects long standing institutional thinking rather than intentional poor practice. Hopefully, the NDIS will provide an opportunity for those people with a disability who have capacity with their own funds to escape this paradigm.

However, the CVS is aware of many disability clients who due to their intellectual disability and lack of family involvement and/or informal support, do not have the capacity nor support to argue for improvements to their lifetime support and plan. We would argue that this cohort will be reliant on visitation by people such as community visitors who have a non-blinkered perspective to identify and challenge many of the established norms and low expectations. We will argue that it will be even more important to have Community Visitors checking that individuals have reasonable NDIS plans in place that are responsive to their needs, goals and aspirations and that they are being implemented to enable individuals to reach their full potential and accelerate the raising of the bar.

Lastly, as stated at our last meeting, I need to report that there is a great deal of concern and uncertainty about the future of the Community Visitor Scheme in disability accommodation after 30 June 2019. Under the Bilateral Agreement between the Commonwealth and the SA government, it was agreed that the Commonwealth would lead an evaluation of the various Visitor Schemes for the purpose of recommending what would work best once we have the full rollout of the NDIS and have a Quality and Safeguards Commission in place.

It is only a few short years since the then Premier and Minister for Disability announce the expansion of the CVS into disability accommodation and SRFs and I would argue that the need for our scheme is even more important now as we transition across to the NDIS and the Commonwealth being responsible for the delivery of these services. I believe it is crucial that independent visitors continue to monitor and report on this transition to ensure that tax payers' funding through both State and Commonwealth contributions are delivering quality services to some of our most vulnerable citizens.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Maurice Corcoran', with a stylized, cursive script.

Maurice Corcoran AM

8 May 2018

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# 1. Introduction

## 1.1 Message from the Principal Community Visitor

In my 2016-17 Annual Report, I offered apologies to those who have appreciated the extent of our reports and how both quantitative and qualitative information in previous reports have both informed and told a story about our visits and the issues that have emerged.

This year the reporting template and requirements of Premier and Cabinet Circular PC013 for Annual Reporting was very different to previous years and encouraged agencies to reduce the number of pages that limited our ability to discuss in detail issues of concern. However, following positive discussions with the Minister for Disability who encouraged us to proceed with writing this Special Report, this now aligns with our previous Annual Reporting format and includes narrations from those we have met and issues we have encountered. The report also draws comparisons with previous years.

This report represents the work of the South Australian Community Visitor Scheme (CVS) for 2016-17 and is prepared on behalf of the great team of Community Visitors that I have the pleasure to work with, and alongside of, as well as an outstanding team in the office who coordinate and manage the Scheme as a whole. Although this is the Special Report of the Principal Community Visitor, it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

## 1.2 Highlights and achievements

A highlight of this year's visits and inspections has been the ongoing expansion of the Scheme. Commencing in July 2016, visits are being undertaken to all Day Options programs within South Australia. Additionally, employment of a Project Officer, specifically responsible for scheduling visits to disability accommodation, has seen the average number of visits conducted each month increase by 10% since the last financial year.

During 2016-17, the CVS continued to work with Supported Residential Facilities (SRFs), maintaining a regular visitation schedule as well as advocating for the specific needs of SRF residents within the NDIS transition.

The CVS prioritises the establishment and maintenance of strong relationships with management and staff of the government and non-government organisations providing services across the disability and SRF sectors. The team strives to build confidence and respect for the role the CVS can play for identified client groups, as well as managing any apprehension and anxiety that services may have about how identified issues would be reported and managed by the Scheme.

There have been significant learnings gained by the CVS from the Oakden enquiry and especially the ICAC investigation that examined how and when the CVS escalated issues of concern to Ministers or senior officers within the Northern Adelaide Local Health Network (NALHN). This has also highlighted the importance of our monitoring of issues raised through visits and it has been an area that I am very proud to say, has been significantly improved over the past 2 years through our internal and external processes that communicates issues to service providers and seeks responses.

We have also increased the number of unannounced visits we do to facilities where there has been concerns flagged or even where CVs had a 'gut-feeling' that something was not right. We have enlisted our most experienced CVs in these unannounced visits and those who have backgrounds and professional qualifications in investigative processes and interviewing techniques.

## 1.3 Recognition of Community Visitors

Another highlight during this past year has been the ongoing recruitment and retention of exceptionally qualified and experienced Community Visitors (CVs). The CVs have impressive backgrounds, skills and passion that have helped to deliver the Scheme's key outcomes of monthly visits and inspections and associated reports at a very high level. A number of them have relayed to the office how much they appreciate their involvement in the scheme, with examples of their feedback below.

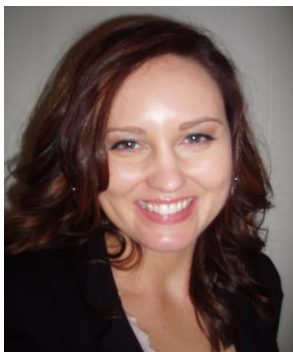
*"It is very satisfying to know that our collective effort actively contributes towards peoples' lives being that little bit more comfortable and enjoyable ☺."*

*"Thanks for your feedback. It is nice to know we have some currency in the community that we can spend in future visits. AND it emboldens me to believe that we are actually making a difference."*

With the expansion into Day Options programs and the increase to, where possible, bi-annual visitation to disability accommodation, SRFs and Day Options programs, the demand for CVs has grown and targeted recruitment campaigns are continuing to increase our workforce.

Community Visitors are an integral and valued component of the Scheme and it is with great pleasure that we introduce two of our Community Visitors who have been volunteering with us since our inception:

**Carly Luzuk – appointed 7/7/2011**



As a Community Visitor I enjoy being able to provide support and understanding to those in the community who are unwell and in some cases, feeling very vulnerable. It is a privilege to be able to provide feedback, with the aim of improving government health policies and facilities. The ultimate goal is for each and every person to receive the best care possible

**Joanie Cunningham – appointed 7/7/2011**

Until recently, I worked in the mental health area only, however I am currently on a steep and rewarding learning curve in beginning to undertake some disability visits as well. I am lucky enough to have some brilliant CVS 'buddies' and CVS staff, mentoring me in these. This collaborative feature of working together is a very important, strengthening and organic part of what we do as well as advocating for the rights of some of the most vulnerable people in our society. Being involved in the CVS program is a way of affirming the importance of the values that are incorporated in the Act under which we operate. It is also personally fulfilling, to be working alongside some wonderful people who hold human rights and wellbeing as a priority.



Below is a list of all the Community Visitors who have contributed during the 2016-17 reporting period:

Adil Saleem	Alfred Piu
Angela Duigan	Angelikh Koutsidis
Ankur Patel	Ann Rymill
Annette Glover	Anthony Rankine
Anwitha Allam	Brian Day
Bryn Williams	Carly Luzuk
Cecil Camilleri	Chandani Panditharatne
Colleen Gavan	Elle Churches
Erika Davey	Fiona Pullen
Garry McDonald	Gregory Wilton
Hannah Allison	Helen Winefield
Ingrid Davies	Jacy Arthur
Jim Evans	Joan Cunningham
John James Leahy	John Lykogiannis
John Sheehan	Judith Harvey
Julie Margaret	Karen Atkins
Kim Steinle	Lindy Thai
Marianne Dahl	Mark Rogers
Michele Slatter	Mitali Chand
Ron Oliver	Sally Goode
Sara Elfalal	Sharon Hughes
Shipra Sareen	Sophie Dai
Stephanie Keightley	Sultana Razia
Susan Whittington	Tracy Haskins
Wendy Norman	William Zhao
Yinzi He	Maurice Corcoran AM (Principal Community Visitor)



## 2. Functions of the Community Visitor Scheme

### 2.1 The purpose & objectives

The purpose of the Community Visitor Scheme, as described in the *Disability Services (Community Visitor Scheme) Regulations 2013*, is to further protect the rights of people with a disability who live in disability accommodation, Supported Residential Facilities (SRFs) or attend a disability day options program, through the conduction of visits and inspections and the provision of support with advocacy, and to:

- » conduct regular visits and inspections of disability accommodation, Supported Residential Facilities (SRFs) and disability Day Options programs in order to assess and report on services provided to clients, identify any gaps in service provision and report on this to improve the quality, accountability and transparency of disability services
- » recruit and train enough volunteers to ensure there is a sufficient number of Community Visitors, appointed to undertake the required visits and inspections of facilities
- » act as advocates for disability clients to promote the proper resolution of issues relating to their care, treatment or control, including issues raised by a guardian, medical agent, relative, carer, friend or any other person who is providing them support
- » refer matters of concern relating to the organisation or delivery of disability services in South Australia or the care, treatment or control of an individual to the Minister, Ministers delegate, the Senior Practitioner or any other appropriate person or body
- » ensure plans, policy and practise development is influenced by the experience of people with a disability and their relative, guardian, carer, friend or supporter.

### 2.2 Monthly visits and inspections

During this reporting period, the Scheme has focused on visiting houses supported by non-government organisations (NGOs) not previously visited and on revisiting a large number of houses (both from the government sector and NGOs) for the second or third time. Visits have also occurred to SRFs and Day Options programs. SRFs have been revisited for the second or third time and the majority of Day Options programs for the first time.

The CVS has also undertaken a number of regional visits, including to Murray Bridge, Strathalbyn, Fleurieu Peninsula, Port Pirie, Yorke Peninsula, Port Augusta, Whyalla, Port Lincoln, Riverland, and the South East. Visits to Kangaroo Island are yet to occur, but are planned for early 2018.

During 2016-17, the CVS undertook 583 visits as summarised below:

- 453 visits to Disability Supported Accommodation
- 41 visits to Supported Residential Facilities (SRFs), and
- 89 visits to Day Options programs.

Following later in the report (Sections 3-5), is a summary of the outcomes and themes emanating from visit reports to these different service components of the Scheme.

With the ongoing increase in the number of Community Visitors recruited, the average number of houses visited a month has increased from 35 last year, to 39 in 2016-17.

Further to the monthly 'scheduled' visits as described above, the Scheme also conducts 'requested' visits. As the name suggests, these visits occur when a client, carer, guardian, relative, friend, or any person or organisation who is providing support to a client, makes a request for a visit by a Community Visitor. If a request is made to a manager of, or a person in a position of authority at, disability accommodation premises, SRFs or Day Options programs, that person must advise the CVS office of the request within 2 working days. The CVS may on occasion also undertake unannounced visits as deemed necessary.

There was a total of 51 Disability/SRF/Day Options requested visits/advocacy requests in this financial year. Examples of typical cases the CVS acted on are outlined later in the report (refer to 2.5).

## 2.3 Conducting visits

The CVS has developed a visitation and inspection protocol that is implemented in a consistent manner, whilst incorporating the slight variations required by each of the Scheme's components. The majority of visits are scheduled with prior notification being provided to the sites. However, unannounced and requested visits are also undertaken when required and the CVS have done a number of these at the request of DCSI.

The CVS notifies sites of the proposed scheduled visits and once confirmed, forwards details to the allocated Community Visitors. This includes provision of the report from the previous visit that provides context and highlights any areas that would benefit from follow-up.

Community Visitors work in pairs when conducting the visits and are required to report to the manager or identified contact person on arrival. Additionally, SRF visits require signing in and out of a 'Visitors Book', as per the *Supported Residential Facilities Regulations, 2009*. Visits incorporate time spent with staff, observation of the site and facilities and opportunity to converse with those clients who wish to engage with the CVs.

Family members and supporters are welcome to attend the visits. This occurs to a much greater degree with disability accommodation and has significantly increased during this reporting period.

Over time, the CVS has been able to identify the times that work best for visits with most visits taking approximately one hour. Visits to disability accommodation sites occur from 3.30pm to 5.45pm, allowing clients to return home from work or Day Options programs. Day Options programs are generally visited between 10.00am and 2.00pm and SRFs provide the most degree of flexibility with regard time of visits.

Where possible, CVs will provide the site staff with informal verbal feedback about any concern that has been identified and/or any positive observations. On completion of the visit, the CVs will submit a formal written report to the Principal Community Visitor (PCV). A copy of these reports and associated feedback is provided to the sites as well as any identified issues requiring action.

Issues of concern are referred to the PCV and tracked on the CVS *Issues Register and Tracking Documents*. When required, the PCV can escalate an issue to the appropriate body for action and resolution.

The CVS continues to receive positive feedback from sites, with visits being regarded as an opportunity to review service provision as well as recognising the value of the Scheme and its advocacy role for the identified client groups.

## 2.4 Recruitment and training of CVs

The CVS is a member of Volunteering SA-NT Incorporated, a non-profit organisation and peak body dedicated to promoting and supporting volunteers and volunteering in South Australia and the Northern Territory.

Recruitment advertising for Community Visitors (CVs) is primarily facilitated through the Volunteering SA-NT website. However, the CVS has also used other career sites such as Seek Volunteer and Go Volunteer. Volunteering SA-NT has provided training to allow agencies to manage their own online volunteer ads. This has resulted in a better process for managing changes in recruitment procedures.

People interested in applying to become a Community Visitor must be over 18 years of age and be willing to undertake both disability and child-related screening checks with DCSI. Before applying, interested people are encouraged to read the *Introduction to the Community Visitor Scheme* booklet, which outlines the attributes and level of commitment, required to undertake the role.

Two hundred and twenty-eight (228) Expressions of Interest were received during the reporting period. This was an increase of 83% compared to the previous year. Of these, forty-six (46) applications were received; an increase of 53% on the previous year.

Individuals submit an application form with a current curriculum vitae and three referees. If shortlisted, the applicant is invited to undertake the following activities for further assessment:

- » attend an interview
- » participate in a two day training workshop
- » undergo the required screening checks and referee checks, and
- » undertake a minimum of two orientation visits with the PCV.

Eighteen (18) applicants did not proceed to training due to withdrawing or being unsuccessful after interview.

If successful, the applicant is nominated for appointment and required to sign a *Conditions of Appointment* and a *Code of Conduct*.

A Cabinet submission is prepared recommending the appointment of the applicant to the role of Community Visitor and endorsed by His Excellency, the Governor of South Australia.

Twelve (12) applicants were appointed; five (5) were awaiting appointment; eleven (11) did not proceed to appointment after training and orientation due to not attending training, withdrawing, or being unsuccessful after training.

Once appointed, Community Visitors are provided with a photo identification security badge.

### **Initial training and orientation**

Potential CVs are invited to participate in a two-day training program aimed at providing them with the skills and knowledge required to fulfil the legislative functions of the role.

The training program is split into 11 modules and assumes no prior knowledge of mental health or disability services.

The content is delivered over two consecutive days with values, exercises, role plays and various guest presenters. The modules covered are:

- » Module One: Introduction, Overview and History of the Community Visitor Scheme
- » Module Two: Role, Functions and Scope of the Community Visitor Scheme
- » Module Three: CVS Visits and Inspections
- » Module Four: Practical Matters for Community Visitors
- » Module Five: Lived Experience
- » Module Six: Mental Health
- » Module Seven: Communication Strategies
- » Module Eight: Disability
- » Module Nine: Dual Disability and Gender Safety
- » Module Ten: Cultural Competencies, and
- » Module Eleven: Values Testing for Disability and Mental Health.

Sessions were held in September and November in 2016 and February and May 2017. Twenty (20) attended training sessions.

On completion of the program, an assessment of the two days is undertaken through an attendee satisfaction survey. Each questionnaire is completed anonymously to ensure all attendees can be open and honest about their comments.

The questions are designed to solicit information from the attendees as to whether they found the information clear, the style of presentation suited their needs, the presenters were knowledgeable, resource notes sufficient, there was opportunity for participant interaction and if they felt confident in meeting the learning objectives of that module.

An online tool, "Limesurvey" was used as the survey tool for the first time during the February 2017 training. Participant use of the tool was high and it provided a clearer means of being able to collect and analyse participant feedback.

One hundred percent (100%) of respondents either strongly agreed or agreed to the following 6 questions for 9 Modules:

- » the information was clear
- » the style of the presentation suited my needs
- » the presenters knowledge was sufficient
- » the resource notes were sufficient
- » participant interaction was adequate
- » I feel confident in meeting the learning objectives of this module.

Sixty-seven percent (67%) of respondents either strongly agreed or agreed to the above questions for Module 5. One

respondent felt the style of this presentation did not suit their needs, and one respondent would have liked resource notes. Module 10 is presented as information and readings only, therefore not assessed in the feedback process.

In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are comments from this reporting periods four sessions:

- *Very informative and enjoyable to listen and learn*
- *The training content was very in formative and stimulated a very high level of interaction, as for me the training left me feeling very excited for the future. Thank you Leanne and team for such a great professional team effort in putting together such an excellent package*
- *Really interactive which made it more interesting and loved the personal experiences.*
- *I loved listening and talking to Anne and Michele. Really appreciated their feedback*
- *It became very clear to me that because of the work done within the community visitors scheme, it would be pivotal in highlighting areas within the services areas that were in need of change and or further monitoring. Regular reporting lends itself to maintaining and improving standards across the board*
- *Absolutely excellent!*
- *Well presented*
- *Margie was excellent*
- *Excellent*
- *I enjoyed how it was broken up into different speakers and various videos/activities, however it was still a long two days of being in an office, any more variety possibly would be fantastic but I understand it is limited given the nature of the training*
- *I seriously could not fault this training. It was fun and I learnt so much. All the staff and trainers were so lovely and I really took a lot away with me. 10/10*
- *It was a very informative and inspiring workshop. Well done to all involved!*

Overall, training session participants “strongly agreed”, or “agreed” that the training sessions met their needs and objectives. The CVS team is confident that prospective visitors are receiving the necessary information to prepare them for the role.

A minimum of two orientation visits are undertaken with the PCV for further assessment. This provides the trainee Community Visitor with an opportunity to see the practical application of key areas covered in the training program. Thirty (30) orientation visits were completed with the PCV.

During the training and orientation process, the PCV assesses the applicant’s suitability and individual capacity to fulfil all of the functions of a CV, as described in section 51(1) of the Mental Health Act, 2009. Orientation feedback meetings were held with 15 prospective CVs.

From the number of viable applicants, 24% did not progress through to appointment, providing support that the current recruitment process and training program is thorough and robust in matching appropriate applicants to the role.

### **Ongoing training and support**

On 16th March 2017, a Day Options workshop was held for CVs to increase their knowledge of the sector. There was a range of guest speakers including Professor Richard Bruggemann, Senior Practitioner, Disability SA. Fifteen (15) CVs attended.

CVs continue to receive support with the online reporting tool either over the telephone, via email or in person. There were major changes to the online reporting tool with CVs being offered training on the new tool and report writing tips on the 7th June during a scheduled get together. Twenty (20) CVs attended.

CVs are invited to participate in the *Restrictive Practices*, and *Mental Health & Communication* training modules during training workshops. Twelve (12) CVs have participated in the training to date, and they have reported that attending the sessions has been very helpful in refreshing their knowledge in both the disability and mental health sectors.

A ‘Reflective Practice’ session is offered to CVs for the hour before the ‘get togethers’. This enables CVs to share their experiences encountered during visits and any challenges faced. They can share what works for them and provide peer support to one another.

Community Visitors have access to ongoing training and professional development opportunities through the SA Mental Health Training Centre (Department of Health and Ageing) and other external agencies such as Volunteering SA&NT and local councils.

CVs were offered 10 external training opportunities with twenty (20) CVs taking up the offer:

- » Northern Volunteering: Mental Health Awareness, Cultural Diversity, Mental Health First Aid – no CVs advised that they had attended any of these sessions
- » Southern Volunteering: Mental Health First Aid, Responding to Anger and Challenging Behaviours – 5 CVs attended
- » VSA-NT: Working in Teams – no CVs advised they they attended this session
- » NDIS introductory session – 1 CV attended
- » Southern Volunteering: Professional boundaries and volunteer self-care – no CVs advised that they had attended this session
- » HCSCC: Lorna Hallahan presentation – 11 CVs attended
- » Marion City Council: Child Safe Environments – 2 CVs attended
- » City of West Torrens: 2 day Provide First Aid – 1 CV attended

In addition, 5 CVs participated in the National Volunteer Week parade



John, Jacy, Marianne, Sharon and Tony enjoy the sunshine in the grounds of Government House during the National Volunteer Week parade May 2017

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Forty (40) yearly reviews were conducted throughout the year with CVs participating in performance and development discussions with the PCV. Community Visitors are encouraged to pursue development opportunities and discuss other interests with the PCV.

CVs are invited to meet with the PCV and the Recruitment and Training Officer to discuss any concerns and to work through strategies to assist them to improve their performance.

There are presently 48 active CVs, with 7 being reappointed for a second term of 3 years. Four (4) CVs have resigned due to gaining work and/or moving overseas.



CVs have had the opportunity to meet 5 times during the year to informally discuss their experiences during visits and provide group feedback for service improvement. Some of the ideas discussed have been:

- » August 2016 – Challenges and issues during visits – small group activity
- » October 2016 – Introduction to Day Options programs
- » December 2015 – Lorna Hallahan seminar
- » April 2016 – Training and development ideas for CVs
- » June 2016 – Updated online reporting tool

There were 75 attendances by CVs across the 5 'get togethers'. Notes from the August, October, December, April and June meetings have been included in monthly newsletters, which has been an important way of passing on relevant information to regional CVs.

These forums have encouraged a cohesive team approach, provided opportunity for shared learning among peers and been highly valued by the CVs.

The CVS Newsletter is distributed to the Community Visitors on a bi-monthly basis providing general updates and information regarding strategic direction and issues arising.

The Recruitment and Training Officer initiated the use of 'SharePoint' as another communication strategy for keeping in touch with CVs. Newsletters, policies and key forms are kept on SharePoint for ease of access and use by CVs.

Community Visitors can also access the SA Government Employee Assistance Program.

### **Recruitment strategies external to CVS**

Networking meetings continue with Volunteering SA-NT and Southern Volunteering. Attendance at relevant meetings has occurred with the Recruitment and Training Officer attending three Central Volunteer Managers meetings, and one Southern Volunteering meeting.

Local government offices in Port Augusta, Whyalla and Naracoorte Limestone Coast have been contacted regarding the recruitment of local CVs. Resources have been posted, and the CVS promoted in newsletters where appropriate. There has been interest from Whyalla and Peterborough with one regional trainee awaiting appointment.

Community Centres SA, the South East Junction Centre and COTA have been contacted with resources being sent for distribution through their networks, as well as a CVS recruitment ad developed for use in relevant publications. Liaison with Probus – Mitcham chapter has occurred and a date arranged for CVS to present to their members.

There has also been a call for volunteers through the DCSI Disability Update.

Training dates are posted on Facebook and CVs are encouraged to talk about their role within their networks to encourage others to take an interest in the Scheme.

## **2.5 Advocacy**

### **2.5.1 Individual advocacy**

A key element of the Community Visitors' role is to provide support and advocacy in referring matters of concern to the Principal Community Visitor (PCV). Throughout this reporting period the requests for advocacy assistance has significantly risen, due to a number of factors.

The CVS is now in its fourth year of undertaking visits and inspections to disability supported accommodation, with SRFs being incorporated in 2015 and Day Options programs in 2016. Awareness of the Scheme has grown correspondingly, both amongst clients, actual sites and service providers as well as family members, guardians and other personal supporters. Below are some examples of effective advocacy that achieved positive outcomes for clients.

## **Suitable accommodation**

Whilst CVS were undertaking a visit and inspection in a rural area, the following situation was brought to the PCVs attention:

*Resident X is a sensitive, quiet and gentle man who is an active participant at the local Day Options Program. He is a current resident of a respite facility through the week but is required to return home on weekends as the facility is used as a children's respite on weekends. In addition to his current condition, resident X suffers from acute anxiety, becoming very ill when he becomes anxious. Both the Day Options and respite providers were informed that the only option for resident X is to share a local house with a number of residents with autism, including some residents with a tendency for violence. Further, as soon as the required renovations to the proposed house have been completed, resident X will be moved to this shared accommodation.*

This situation was deemed unsatisfactory by the CVS and the resident's family. The CVS continued to advocate for an alternative arrangement. After considerable time, a suitably matched resident was identified to share a different accommodation site. The service model /staffing structure was considered, to ensure the accommodation met the requirements of the two residents. Resident X will continue with the respite service until the new long-term accommodation is finalised.

## **Long-term stay in hospital (October 2016 - April 2017)**

In October 2016 CVS became aware of client X, living with physical disabilities, who had been admitted to hospital due to a mental health episode.

Client X spent the next six+ months in a shared ward at the RAH even though he was deemed well enough by hospital staff to be discharged two months after initial admission. This placed client X at increased risk of infection and reflected inappropriate use of a hospital bed.

CVS attended case conferences to provide advocacy support for client X and his family, which were attended by representatives from the relevant stakeholders. Ultimately, client X was offered respite housing whilst a new accessible home was being built (completion date anticipated end of 2017).

## **Incompatible resident mix – resulting in volatile and dangerous living arrangements**

In May 2017, the PCV undertook a visit, which identified a volatile and dangerous incompatibility of the residents. This was reflected in a number of situations that had occurred, both between residents as well as to staff and respective guardians. Police were called regularly to the residence.

Given the serious nature of the allegations, CVS referred the situation to DCSI Care Concerns investigations.

The department investigated all options for alternative accommodation and this information was provided to the residents' families. At the time of writing, six-weekly meetings will occur with the service provider's management and family members, to discuss any concerns that arise while alternative accommodation is being sourced. In addition, a case conference for each client will be organised on a three monthly basis.

The CVS has undertaken an unannounced visit and has personally observed, and been informed, that the situation has settled quite significantly. Both residents are now undertaking much more activity during the day and spending considerably less time in bed. Additionally, a continence assessment has been undertaken and a plan prepared.

## **Provision of appropriate personal care**

During a scheduled Day Options visit, the CVS became aware that the site did not have the required equipment to ensure appropriate personal care provision for those clients unable to access the toilets themselves. Some clients were therefore at risk of spending all day in a soiled condition. The CVS contacted the organisation and relevant disability accommodation sites as well as forwarding the issue for departmental consideration. The process undertaken by the CVS required the organisation to audit their sites against the needs of the clients attending and guarantee that all sites being frequented by clients requiring full personal care support, had the necessary equipment available. The organisation responded in a very timely manner, incorporating the identified changes and future CVS visits have confirmed ongoing compliance. The department followed through with the relevant disability accommodation sites regarding their responsibility in ensuring appropriate standards of care are maintained.

## SRF request for assistance managing complex clients

An SRF contacted the CVS requesting assistance with a resident whose behaviour was inappropriate and threatening to other residents. The background history demonstrated a long-term and complex set of issues. CVS made contact with the organisation's management as well as the local council. A CVS visit that had already been scheduled went ahead. At the time of the visit, the situation had escalated irretrievably and an eviction process was underway. The CVS assisted with that process.

Further to this visit, the CVS recommended that a community meeting be held to assist with collaboration and service co-ordination between key stakeholders concerning complex clients who may or may not be suitable for SRF accommodation. Inappropriate referral had been identified as an issue given SRFs are not established to be emergency accommodation.

The meeting was organised and attended by the CVS. The CVS also recommended to the organisation responsible for the SRF, that policies and procedures guiding selection and intake of prospective residents be made more robust in an effort to avoid similar difficulties.

### 2.5.2 Systematic advocacy

During this period the CVS has continued to lobby for systemic change that would deliver improved outcomes for service consumers. Three key focuses all of which have been long standing are:

#### Medication

In its 2014-15 annual report, the CVS highlighted an important *Chemical Restraint Project* being undertaken by Dr Tomasic and her team at the Centre for Disability Health (CDU) to look at the extent of chemical restraint being used with an aim to review their files and medication history and ultimately reduce the range of medications that individuals are taking. Early findings revealed that some people identified as receiving chemical restraint, actually had a previous diagnosis 'forgotten' and no ongoing psychiatric review. The lack of appropriate review was a recurring theme, as was a lack of clarity by staff about what constituted chemical review.

In response, the CVS facilitated a discussion with officers from the CDU, DCSI and SA Health with the aim to ensure disability clients with a co-occurring mental illness have ongoing access to specialist psychiatric care and to ensure these specialist services will continue to be available. This session highlighted how important it was for DCSI and SA Health to ensure there is continued access to mainstream health services, in particular state funded psychiatry services for clients with Intellectual Disability and explore how this can be improved given rates of mental illness are significantly higher in this population.

The decision by the government to retain specialist psychiatric services for people with disabilities is welcomed by the CVS. This enables the ongoing review of clients with disabilities identified to be on a range of psychotropic medications in order to ensure they are not being used inappropriately for restraint, are required for a current diagnosis and ultimately to reduce the use of medication.

The CVS continues to raise with both relevant departments the importance of retaining the CDH, the Exceptional Needs Unit (ENU) and Assist Therapy Services and that they be sufficiently resourced to ensure they remain sustainable. The CVS remains concerned about the CDH unit due to the reduction of its resources at transfer to SA Health, dilution with transfer of staff to other areas of health, loss of professional diversity and lack of specialist skills being developed for this specialist field.

#### Forensic Disability Services

This is an issue first raised in the 2011-12 PCV annual report. It is covered further in section 3.8. It is encouraging to note that the Birdwood Unit of James Nash House was refurbished to include a discrete area for those clients with disabilities and mental health and in-service training provided to staff which was focused on 'developmental care'.

The CVS is pleased to note the release of the independent review report<sup>1</sup> into forensic care and the response<sup>2</sup> to the report's recommendations by SA Health. The PCV notes that following recommendation which he strongly supported - 4.9 *Require the Minister for Disabilities to have oversight of the custody, supervision and care of forensic patients with a primary diagnosis of intellectual disability.*

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<sup>1</sup> Review of the South Australian Forensic Mental Health Service, July 2015: Assoc Prof. Ed Hoffernan, Ms Bobbie Clugston, Dr Steve Patchett

<sup>2</sup> SA Health response to the recommendations of the Forensic Mental Health Service Review, 2017



This recommendation was rejected on advice from DCSI stating that under the NDIS arrangements, the Minister for Disabilities will have no program funding responsibilities and therefore it would be inappropriate for the Minister for Disabilities to have oversight of the custody, supervision and care of forensic patients with a primary diagnosis of intellectual disabilities.

The PCV has written to the Chief executive officer of NALHN, highlighting that while he recognised the changes that the NDIS will bring, it is important that the future FMHS service model gives attention to this issue to ensure the special needs of this client group are given the required attention and their integration into the community is skilfully managed.

### Comorbidity

Comorbidity has been a long-standing issue advocated on by the CVS. It was optimistic that the Social Development committee's "Inquiry into Comorbidity"<sup>3</sup> would deliver some innovative and tangible responses to the issues raised. It was somewhat disappointed to find that the response from the Minister for Disabilities, Mental Health and Substance Abuse<sup>4</sup> presented the NDIS as the potential solution to many of the recommendations. The PCV is fully aware that the NDIS is about funding individuals to purchase support in accommodation and daily living and will not provide clinical or complex care management. It is difficult to imagine as recommended in the report *"It is imperative that they experience an integrated treatment and service system that has a 'no wrong door' approach. A system where they receive timely and appropriate screening, and assessment, and are assisted with all of their treatment and service requirements"* that a person with complex needs with their own funding could realise this experience.

The PCV was encouraged to note that the responses to recommendations 2, 8, 33 and 38 highlighted the role of the Exceptional Needs Unit (ENU) would play in progressing these issues.

Given the issues and recommendations raised in the above mentioned *Comorbidity*, *Forensic* reports and *Chemical Restraints* project combined with uncertainty regarding the SRF sector, the CVS will continue to advocate the importance of the state having well-resourced and supported specialist disability services such as the CDH, ENU and Assist Therapy Services.

## 2.6 Referring matters of concern

A key component of the role of the CVS is to refer matters of concern raised in visit reports to the appropriate organisation for resolution. Dependent on the nature and scope of the issue, these referrals can be to management of the service provider, the Minister's delegate or to the Minister.

A protocol for the referral of matters of concern to the Minister for Disabilities has been developed. The purpose of this protocol was to set out an agreed process for managing issues of concern raised with a CV and the requirement to, where necessary, refer matters of concern to the Minister for Disabilities, in line with the *Disability Services (Community Visitor Scheme) Regulations 2013*.

The protocol also covers the circumstances in which the advocacy role of CVs, as provided for by the Regulations, results in contact being made with other agencies, including the Office of the Public Advocate (OPA) and the Health and Community Services Complaints Commission (HSCCC).

Any significant issues of concern or reoccurring themes indicating a possible systemic issue that are raised within visit reports are transferred onto the *Issues Register* and referred to the CVS Advisory Committee meeting for discussion. The Advisory Committee provides advice to the PCV about potential actions and develops shared, cross agency strategies and responses where there are common issues.

Of the reports prepared by CVs this reporting period, 176 highlighted a varying number of points of concern/issues raised at visits. The numbers varied from 1-6 points of concern per report. At the time of writing this report, 118 of the reports had the issues resolved or completed, 30 required advocacy assistance and 28 (16%) remain ongoing or are outstanding. The respective Coordinators will continue to monitor the outstanding issues and follow-up with the respective services.

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<sup>3</sup> Inquiry Into Comorbidity, thirty eight report of the Social Development Committee  
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

<sup>4</sup> Social development Committee – Inquiry into Comorbidity Submission from the south Australian Government 8 February 2016  
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

## 2.7 Influence plans, policy and practice development

A significant and important role the CVS plays is its contribution to planning, policy, strategy, reviews and investigations at both a commonwealth and state level. The PCV has been invited to attend committees and discussion panels and been asked to contribute to an array of reviews, investigations, reports and discussion papers. Examples include:

- » Attorney General Department's Disability Justice Plan
- » SA Mental Health Act Review
- » Disability Inclusion Bill
- » The Review of South Australian Forensic Mental Health Services;
- » NDIS Quality Framework, and
- » Commonwealth Senate Community Affairs References Committee Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings.

In addition, the CVS has an important role to play to ensure policy and clinical practise development is influenced by the experience of people with disability and their relative, guardian, carer, friend or supporter. The CVS therefore takes every opportunity to through representation on committees, through its own advisory committee and through input/comment on planning, policy and clinical practice documentation as listed below:

- » measuring impact of NDIS expert group in Melbourne
- » Healthy Eating Seminar – Disability clients
- » NDIS Stakeholder Forum SA - Key Influencers
- » Meeting with the Ombudsman and chief psychiatrist regarding the shackling of prisoners
- » Disability Justice plan update and new Disability Discrimination Commissioner
- » Discussions regarding the draft Euthanasia Bill
- » HREOC consultation
- » Contribution to the HCSCC paper re systemic issues in mental health;
- » ICAC investigation into Oakden
- » Attorney-General's Department assessment of whether existing inspectorate/oversight bodies in South Australia are Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) compliant
- » national survey of CVS Schemes
- » Disability Inclusion Bill
- » SA Health Oakden Oversight committee, and
- » The End of the Road – Rooming Housing in SA Roundtable with Minister Bettison.

## 3. Disability outcomes and themes

### 3.1 Visit statistics

Data acquisition from the CV reports to the PCV throughout the 2016-17 period, has demonstrated a number of trends that are further explored through this section.

Figure 3.1.1 and 3.1.2 to follow relate to the number of issues or positive comments raised within reports. Of the total 813 reported comments during this reporting period, it is pleasing to note that 566 (70%) were positive comments that highlighted innovative and positive actions that have taken place in homes for which we have been able to commend staff and organisations.

2013-14 Total	2014-15 Total	2015-16 Total	2016-17 Total	2016-17 (Positive)	2016-17 (Issues)
123	196	774	813	566	247

Figure 3.1.1 - the number of issues/positive comments raised during visits.

### Reporting classification

Issues identified within written reports are assessed by staff within the CVS office and a two level issues classification scheme [Appendix 6] is used to categorise issues that are raised.

#### Level 1 Categories

- » Rights and Responsibilities
- » Access
- » Communication
- » Environment and Residence Services
- » Grievances
- » Treatment, Services and Care

Figure 3.1.2 highlights that there were notably more positive observations made relative to negative issues identified in the majority of the level 1 categories.

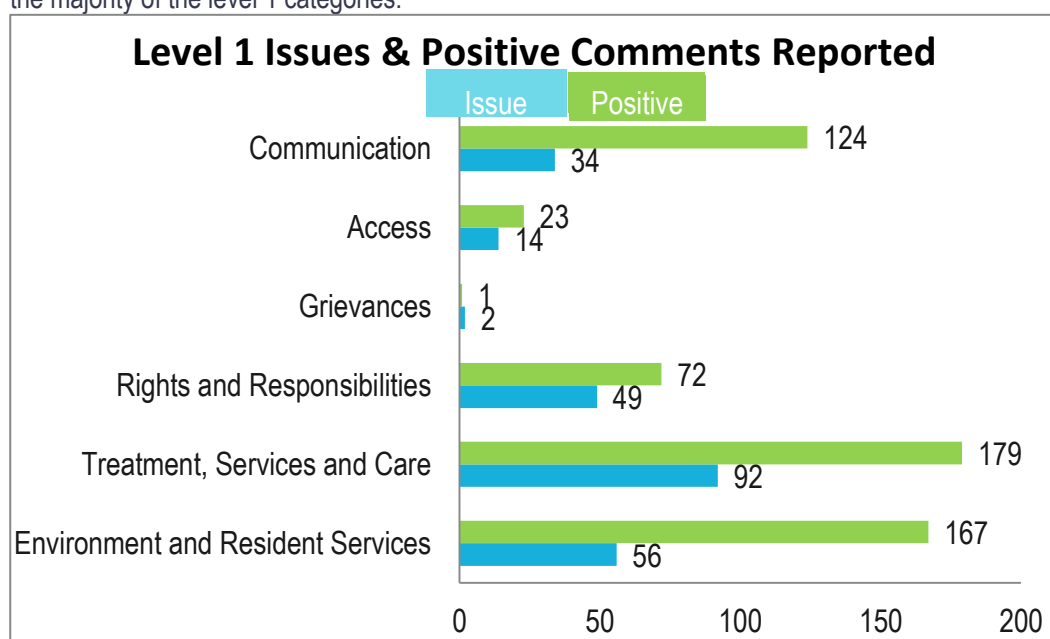


Figure 3.1.2 - Number of Positive and Negative Comments by Level 1 Categories

The vast majority of positive observations were in relation to the *Treatment, Services and Care* provided to residents. Being supported to live as independently as possible and the provision of activities and structured programs were highlighted as assisting residents to enjoy a fulfilling life.

Under *Environment and Residence Services*, the majority of facilities visited were assessed as having suitable facilities and that food provisions were of a high standard.

*Communication* was also a highlighted positive with observations of respectful interaction and communication between residents and staff being made.

*Rights and Responsibilities* indicated that family/guardian involvement was positive and this was observed during many of the visits with the increased presence of family members at a number of the visits being noted.

Examples of positive observations include:

*Staff here fulfil the role of supporters in the truest sense. They know and genuinely care for the residents in both houses, and strong focus is placed on allowing them to strive for their own dreams and goals. Guidance is gentle and client-centred and the residents are encouraged to engage in the widest range of experiences possible.*

*One resident spoke of going to the Community Centre at X where there is a commercial kitchen and they are involved with preparation of 'brain boost bars' to provide breakfast to children at local schools.*

*The pond that received criticism during the last visit no longer exists.*

*A father informed us of how much his child had improved since moving into this house late last year after 12 years living in a large place. An example of his improvement was that having been unkempt, he now was shaved, had his hair cut, says what he would like for dinner and staff prepare it.*

*Staff were amiable with residents and vice versa. Staff were particularly commutative and affirming with X who enjoys constant, repetitive conversations, not necessarily related to the topic at hand.*

*When the residents returned from Day Options, each individual was warmly greeted by staff who then explained that they had 'visitors' who had come to see them. One resident appeared to be slightly alarmed seeing 'strangers' but he was quickly reassured by staff.*

Figure 3.1.3 shows the Level 1 Category most commonly reported during 2016-17 was *Treatment, Services and Care*, and provides comparative data for the last four reporting periods.

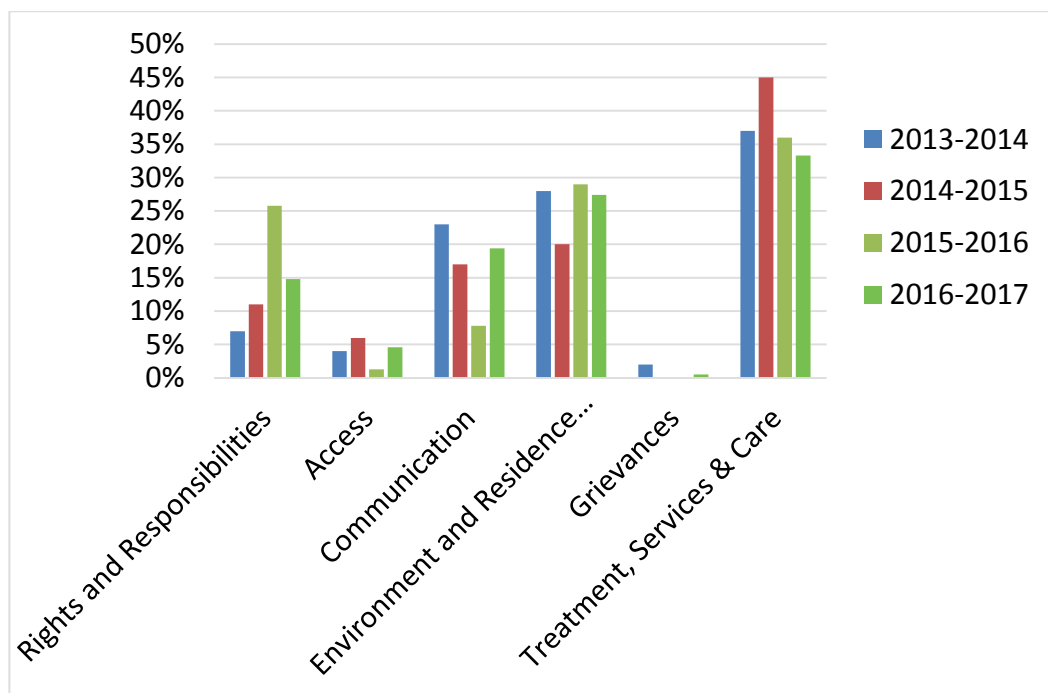


Figure 3.1.3 – Comparison of comments by Level 1 classified Categories for the 2013-14, 2014-15, 2015-16 and 2016-17 reporting periods  
[Percentage of total comments made]

Figure 3.1.4 provides a summary of issues reported during the 2016-17 reporting period by both Level 1 and Level 2 Classification. As noted earlier, the positive comments outweigh the issues raised in this reporting period 70% - 30%.

The most positive Level 2 classified observations were *Resident and staff interactions/respectful communication*, *Suitable facilities*, *Supporting independent living* and *Activities and structured programs*.

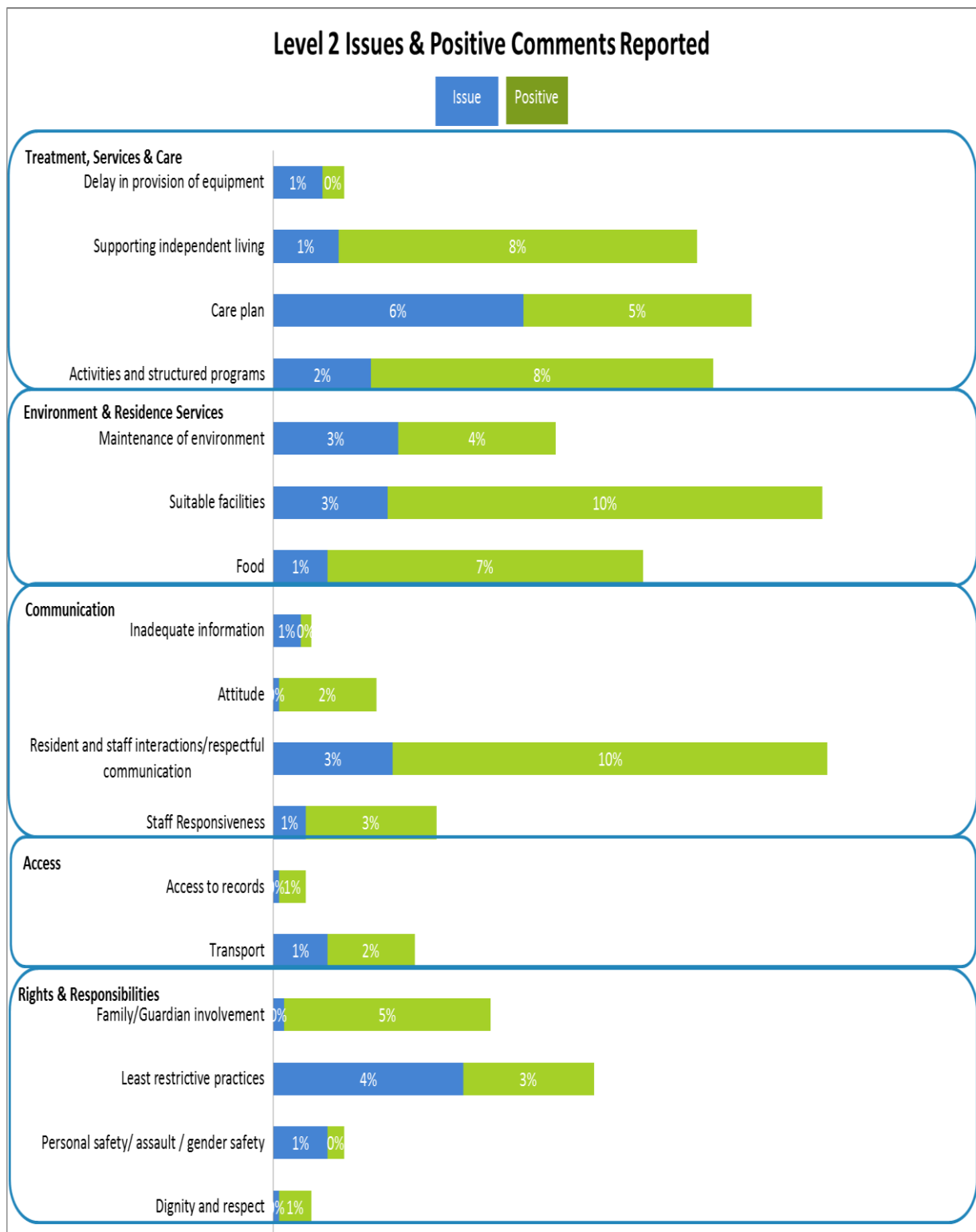


Figure 3.1.4 – Classification Level 2 issues and positive comments as a percentage of the total issues/positive comments raised during 2016-17 reporting period

### 3.2 Communication - resident and staff interaction/respectful communication

Of the total comments (N=831) provided during the reporting period 80 (10%) were positive in relation to resident and staff interaction/respectful communication and this was observed at a number of visits. The importance of consistency in staffing continues to show positive and stable outcomes for both residents and staff and many service providers have placed a high level of attention to this.

CVs reported on the welcome they received by relevant management and staff on arrival at the house and took great interest in observing the interaction between residents and staff. The sector is continuing to perform well in this area and staff should be commended on the observations made by the CVs.

Hand in hand with respectful communication and high levels of interaction, is staff responsiveness and attitude and a number of the comments provided by CVs were positive (42 [5%] of total comments).

Following are excerpts from visit reports, which provide evidence to these positive observations:

*Staff seemed very committed, respectful, focussed, caring and feeling very rewarded by X's improvement under consistently applied behavioural support plan.*

*The staff have meals with the residents to increase the interaction between the staff and residents and for good modelling.*

*The staff member welcomed us and made the visit a very positive experience for residents and CVs.*

*There is a deeply genuine, friendly and yet most professional rapport between the staff and residents.*

*The residents have lived here for about 8 years and previously shared accommodation in two pairs. X has known them all for ages and builds teams of staff who enjoy working with these women who themselves are energetic, engaged and interested in a wide range of topics and activities. The house has a very positive vibe.*

However, 22 (3%) comments raised issues of concern. The Disability Coordinator followed up each of the issues with the respective service provider and below are some of the responses received with excerpts from visit reports:

*A resident's Neurologist, Mother and GP have all provided support in writing for the provision of "active" night care. At the time of the visit, none has been provided, with only "passive" care being provided at night. From discussions with the staff, these arrangements appear to be adversely impacting upon the resident's health and wellbeing. Furthermore, the location of the staff room in relation to the residents' bedrooms presents a challenge in ensuring the quality of care and residents' needs.*

The service provider responded stating that "active" night care has been provided for resident X (short-term) and is no longer required. As for the resident described above, her specialist has now indicated with reduced days at Day Options she is having less seizures and therefore "active" night care is not required. With regards to the location of the staff room, we may look into an intercom system being placed in the bedrooms of the 3 residents furthest from the sleepover room and will discuss this with staff.

*A resident mentioned to the CVs one of his personal goals is to become engaged and marry X (resides in a separate Unit). He is quite certain this will occur and he will then move in to her unit. While the CVs did not return to the staff on duty to verify if this is accurate or otherwise they felt because of the complicated situation, particularly relating to resident X's family, it could completely change the current dynamics of the units and residents. While this is obviously a strong independence move, CVs wondered firstly if the service provider is aware of this and if so, how does the organisation handle such a situation and secondly if it is not a reality, is this a concern regarding resident X's mental health.*

The response from the service provider highlighted that they and the family members of both residents are aware of, and are monitoring, the situation. Further, they advised, they would not permit/refuse the wishes of resident X (that is up to family members to work through) but are supporting the relationship at a suitable level.

*It is very apparent to CV's that resident X is unhappy where she currently resides and that she needs support and assistance from someone to seek options regarding accommodation and take into account her preferences with a future disability services provider.*

In contacting the service provider concerned, they stated that they and a DCSI case manager have been, and will continue to work with the resident regarding her concerns.



## Recommendations

1. The CVS to continue to monitor interactions between staff and residents and report on whether these observations are either positive, sensitive and respectful or to the contrary.
2. The CVS to highlight the above observations and continue to report these to senior management in DCSI and the relevant NGO managers.

### 3.3 Environment and residence services - suitable facilities, maintenance of environment & food provision

A key component of any visit and inspection is to assess the appropriateness, accessibility and standard of the house and facilities, including whether they are well maintained. This includes assessing:

- » What was the ambience/atmosphere in the residence during the visit and was it conducive to quality care?
- » What was the general maintenance and cleanliness of the residence and amenities like (including the residents' rooms, grounds and garden)?
- » How does the place feel e.g. warmth, private and personalised spaces for residents?
- » Is there sufficient provision for space for residents to spend time in, participate in a range of activities as well as conduct confidential conversations with CVs?
- » Is the facility designed in a manner that is accessible, allows easy movement throughout including access to bathrooms, kitchen, cooking and cupboards?

In general, the standard of most facilities/accommodation the CVS has visited is rated high and there is evidence the standard across the sector is continuing to improve. There is evidence that the design, function and condition of a house impacts on the quality of care provided to residents. There is a distinct correlation in CV reports between quality of house, quality of care and staff satisfaction.

Eighty (80) (10%) of the total comments provided during the reporting period were positive in relation to the suitability of facilities. This is pleasing to see and will hold those services in good stead when the sector transitions to the NDIS. Other services that have below satisfactory facilities &/or maintenance support will need to consider the impact this may have on their future client base.

In relation to the provision of food and maintenance of environment, 87 (11%) of the total comments provided, respectively, were also positive.

When CVs look at the provision of food, the preparation of meals and how much involvement residents have in choosing the menu, questions are asked such as:

- » Whether residents were happy with their food.
- » Is there a menu plan that residents have been consulted on that reflects their preferences and dietary requirements?
- » Are residents being encouraged to make healthy choices?

It is reported that healthy food choices are evident in most accommodation settings however, there have been times where residents have expressed unhappiness at being forced to eat healthy meals even when on excursions. The CVS recognises that poor diet and obesity is a significant issue amongst people with a disability, especially those who find it difficult to do physical exercise. There is also a high prevalence of diabetes amongst this cohort.

The CVS recognises that services do have a duty of care to educate and support cessation of behaviours and food choices that would contribute to long-term poor health for people with disabilities, especially those who lack reasonable capacity for such decisions. Residents need to be properly informed and empowered to determine their own best interests, including the right to decide on healthy food choices and exercises that they will benefit from. However, services and the CVS do need to also respect that individuals may decide not to always eat healthy meals or to exercise as happens in the general population.

Following are excerpts from visit reports, which provide evidence to these positive observations:

*There was a nice relaxation room with bubbles/water in tubes from floor to ceiling which looks great - beanbags, ball box - great to play and relax in for the residents in this house with Autism or ID (Intellectually Disability).*

*The house is well organised and has a lot of supporting equipment such as great lifters. There is a state-of-art bath for the resident's use.*

*The facility is incredibly well resourced with 3 different lounge areas and a gym with treadmills and bike machines, which would rival a commercial operation. All residents have highly personalised rooms, which include lounge areas as well as the obvious sleeping areas, with TV and all individualised requirements.*

*The pond that received criticism during the last visit no longer exists.*

*A 4-week menu plan was on display and staff try to rotate the days to add variety.*

Twenty-one (21) (3%) of the total comments provided were noted as issues of concern regarding the suitability of facilities. Further, in relation to the food and maintenance of environment, 33 (4%) of the total comments provided, respectively, were also noted as issues of concern. Again, each of the issues were followed up with the respective service provider and below are some of the excerpts from visit reports with responses received:

*The kitchen has had some improvements - CV's were told this was done Aug/Sep 2016. Since the last visit, a new oven and stove, new cupboard fronts and bench tops have been installed over the old kitchen carcasses. (The previous report flagged the need for this to be addressed - Dec 2015). Some interior painting has also been completed since the last visit.*

*The issues with the alignment of the lifter in the bathroom noted in the previous report has been resolved.*

*The driveway still needs to be looked at - recommends concrete throughout as the areas can get very muddy in winter and a dust bowl in summer making it difficult for some residents to get in the van. This will be exacerbated when resident X needs to use a wheelchair. Staff contacted the property owner (Housing SA) quite some time ago but the response time is taking too long. So far, the only remedy has been to dump some gravel in some potholes. The driveway presents a hazard for residents X and Y. Two years ago, staff made applications to 2 independent agencies, for grants for remedying the driveway, without success. Although some rooms have been painted, the residence is still waiting for security locks on fly screens in 2 bedrooms.*

The service provider responded to the concerns regarding the driveway, stating that the delays reported by CVs was an accurate reflection of conversations had and appreciated the fact that CVS offered to follow up the concern with Housing SA. CVS followed the concern up with Housing SA and was informed they will confirm the next steps with the area maintenance inspector and assess from there for the next steps to be taken.

*Resident X lives alone in this new 2 bedroom house but it seems that the challenge of keeping it clean in the face of his behaviour is defeating the staff. Staff informed us that the service provider have just (this week) stopped employing cleaners and the client support staff are now expected to clean alongside their other duties. Resident X's mother recounted that he often blocks the toilet with toilet paper rolls or flannels and she is the person who has to unblock it.*

On receipt of the above report, CVS raised the concerns as a priority with the service provider and requested an immediate response. The response that followed was favourable and forwarded immediately to those concerned... "regular staff now attend daily, regular phone calls are made to the resident's mother keeping her up to date with her son's movements and daily cleaning is now occurring".

*Staff raised the concern that the air conditioner in X's unit requires urgent replacement. The property owner was advised 12 months ago. NO ACTION has been taken. It affects the other two residents as well.*

In verifying the above comment with management of the respective service provider, CVS contacted the property owner and was informed they had been notified of the concern and will send an air conditioner mechanic to assess/replace the faulty unit.

## Recommendations

3. CVs continue to thoroughly inspect all areas of the facilities they visit and report on any environmental concerns or inadequacies, especially where this has an impact on the provision of client centred care.
4. The CVs continue to monitor and report on food choices, menu plans and exercise opportunities that are developed in consultation with residents and which reflect their preferences, dietary requirements and ability to



exercise.

### 3.4 Treatment, services and care - supporting independent living, activities & structured programs and care plans

One hundred and twenty-nine (129) (16%) of the total comments provided during the reporting period were positive in relation to activities and structured programs and supporting independent living. The sector appears to be performing well in this area and it has been pleasing to see the support service providers are continuing to provide to encourage residents to live their lives as independently as possible.

CVs reported on the provision of a therapeutic environment, exploring this area by seeking responses to questions about activities/facilities that were available. CVs took a close look at care plans that were available to assess if activities and programs the residents were involved in aligned with their assessed capability and provided further comment if there was a lack of activities/stimulation found.

Most residents reported involvement in daily activities at levels commensurate with their level of function. Some residents are working, some attend Day Options and others have a mixture of Day Options or staying at home. It was further reported that a number of residents were participating in activities such as swimming, bowling, music and sport in the evenings.

Several innovative activities and encouragement in independent living opportunities were identified. Below are some examples and positive excerpts from visit reports:

*The CVs interacted with all the four residents and it was found they were involved in making choices. Staff member X was also helping one of the residents in being placed as a volunteer at a nearby library.*

*There have been negotiations with the local bus service so that one of the residents is able to travel home from Day Options independently on the bus (a distance of about 23 kms).*

*Resident X has a regular outing on Saturdays for 3 hrs, which staff will attempt to increase the number of hours he can tolerate away from home. His goal is to go on a mini holiday overnight and staff aim to fulfil this goal via small steps.*

*Service provider X has instituted various mechanisms for developing and encouraging residents to be as independent as possible. Residents' access to their funds is now completely in their own control, by the use of PayWave. X has negotiated with residents' Guardians or the Public Trustee to put a predetermined amount on their cash cards each fortnight. X has consulted with clients and assisted them to take control of their own budgeting and spending, and residents use their PayWave cash cards when they go shopping. Staff have no access to residents' finances, and all spending is transparent through bank statements.*

*One of the residents is taken regularly to a local Fitness Class - this is a general community activity open to any resident of the local area. Staff reported that the Fitness Class had considerably improved the resident's personal fitness, well-being and social development.*

*Resident X likes going out if he is in the right mood. Staff said that he responds best to sensory stimulation. Staff are encouraging X to walk around the block and during 1 walk, X was observed to be enjoying picking up leaves and crumpling/squeezing them in his hands. Recently he had his first trip into the sea when he went with staff to an Access Day at Henley Beach with wheelchairs that went into the sea: a great success!*

Concerns with Day Options has been raised in a number of reports. Regular comments made by house staff indicated their residents are attending "unimaginative" Day Options. Further comments have been made stating "residents have been sitting around doing nothing" and there is a "one size fits all" approach. Other staff have expressed concern that their aged residents have to attend Day Options rather than spend time at home/in their local community or home where it is less 'cramped' and they would be more comfortable.

Since the expansion of CVS visits into Day Options, it has been found that visiting people both in their residential setting and in Day Options Program has provided a great opportunity for them to open up about issues they have. It has also enabled CVS to assess how effectively their care is coordinated through the cross correlation of information. Further information can be found in Section 5 of the report regarding Day Options.

The lack of case management resources and support available to link clients to suitable activities, therapy sessions and support services has also been raised in a number of reports. CVS has continued to refer matters pertaining to this to

ASSIST Therapy and will continue to monitor and follow up as required.

The provision/updating of information in care plans has continued to concern the PCV as it appears a number of service providers have continued to not pay as much attention to this as is necessary. A range of excuses for why they are not in place or are outdated include comments like; *“the old plans have been archived and new ones will be prepared when the NDIS comes along; we simply don’t have time; they are not our responsibility; these are in Health Care Plans; and we have had resistance from residents/family members”*. Whilst in many instances, basic standards of care were observed, it does mean that their residents are not in receipt of support to a standard outlined in the National Disability Standards most notably; services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.

The PCV has continued to express concern to the Minister’s delegate, the Chief Executive and Minister Vlahos that a number of accommodation services do not have plans in place for all residents and they should have.

The services that do this well highlight how important they are for all staff working with and alongside of residents. In these services, new staff are required to read and familiarise themselves with these plans prior to having direct contact to ensure they understand what the support needs are and how best to deliver this support.

High performing services say that failure to do this could result in a higher likelihood of risk in a range of areas including but not limited to, staff:

- » not complying with a behaviour support plan
- » providing food or drink that could potentially be a choking risk or allergy risk, and
- » supporting a person with a mobility disability to transfer in or out of bed and not complying with that individual’s manual handling procedure.

Of the total comments provided 46 (6%) were regarding issues of concern with care plans. As previously mentioned the Disability Coordinator followed up the lack of care plans with the respective service providers and received a less than favourable response on many occasions. The importance in having care plans and keeping them up to date was reinforced on many occasions and service providers are continuing to be reminded that for their residents to be eligible for the NDIS, care plans must be prepared.

Thirty (30) (4%) of total comments provided were issues of concern in relation to activities and structured programs and supporting independent living. Below are some of the responses received when following issues up with relevant service providers:

*Staff informed CVs they had been told by management that taking of holidays is no longer permitted. Whilst a lot of work for staff, it was something that the residents enjoyed and from which they got great satisfaction. Staff are disappointed that holidays for the residents are no longer provided and would like to see this decision reversed.*

The service provider’s response was *“Yes, the provisions for holidays have changed as the people we support now have to pay for all staffing costs associated with a holiday – historically the organisation would pay so it does affect people’s ability to have holidays but it does not mean they cannot have a holiday. This is an ongoing concern CVS continues to discuss with the Strategic Advisory Committee and will be an interesting area to watch as the NDIS comes into full operation”*.

*One of the residents in Unit 1, would like to undertake pottery and woodwork, hobbies she has enjoyed in the past. Staff said they have made some enquiries in the past, but it was seen as #1 being too difficult to arrange transport, #2 the timing was wrong and #3 the availability of a care worker was limited.*

The response from the service provider was that staff spoke with the resident again over the weekend & she responded that she felt her activities at X every Friday are sufficient at the moment. The use of the share-vehicle (around the corner), a fleet vehicle from the campus & taxi vouchers are available.

## Recommendations

5. That Community Visitors continue to monitor and report on activities and structured programs that residents are involved in and that they are consistent with the preferences and capability of residents.
6. That CVs continue to monitor and report on lifestyle/person centred plans and NDIS plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
7. That CVs enquire into the implementation of plans and seek evidence that the plans are being implemented and regularly reviewed.
8. The CVS continue to monitor the level of encouragement and support by staff to assist residents in developing

independent living skills.

9. The CVS continue to monitor and report on activities residents wish to undertake but are unable to afford to do so.

### 3.5 Rights and responsibilities - family/guardian involvement & least restrictive practices

When conducting visits, the CVS consider the issues set out in the Disability Accommodation Services Visit and Inspection Prompt [Appendix 3]. One of the matters to be considered, and is a clear instruction during the training and induction of CVS, is the importance of monitoring restrictive practices. This includes medication specifically prescribed to manage challenging behaviour(s).

There was evidence from visit reports that where there was observation of restrictive practice there was in most cases, supporting documentation and positive evidence where staff were working hard to manage behavioural challenges without the application of restrictive practice. As example:

*The refrigerator is kept locked to prevent one or more of the residents from over-eating or eating unhealthy items. Records exist to show that this is an agreed practice between carers/parents and staff.*

*X uses a wheelchair and has epilepsy. He is meant to wear a helmet to protect his head if he has a convulsion, however he does not like to comply with this recommendation so his dignity of risk is upheld. However, X does use a belt to keep him secure in his wheelchair. CV's were told there is current documentation for this and this restrictive practice is reviewed on a yearly basis prior to renewal.*

*Privately staff informed us that there is only one restrictive practice, where resident X has his medication crushed into his food. He denies the need for any medication. His family is well aware of his condition and the need to take his medication and have provided consent in doing so.*

A couple of cases where family members/guardians placing restrictive practices on their child were brought to the attention of the PCV. In the case noted below, the CVS and service provider, respectively, raised the issue with the PCV after a visit had taken place. Further discussions occurred and CVS arranged a meeting with Professor Richard Bruggemann and the service provider to discuss this further. Excerpt from visit report is below with the outcome after contact was made with the service provider:

*According to staff, resident X's father does not allow X to be in public. Whilst X was not present during the visit, staff have commented they have considerable concerns over this restriction. There is no reason given (other than apparently there was a minor incident some time ago, and this habit has not been experienced to any great degree since). Notably X likes to dance and enjoys music however, according to staff, his father has restricted such activities. Again, there is no reason given, and again staff have concerns over this restriction. Further, documentation/personal care plan sighted for this resident showed that he has an ongoing issue with his teeth and gums bleeding, however as his father is in charge of his medical and dental care, this has been left, with no improvement and continued reporting of the issue. Finally, according to staff, the resident's father does not knock but simply walks in to the house. Staff commented they are "walking on egg shells" so as not to upset him. This makes it very difficult for staff to adequately care for X. The father's approach of barging in to the house as he sees fit, without knocking, is a real issue of privacy for those living and working within the house. Further, the restrictions placed on X regarding not being seen in public, and not participating in music and dance (activities which he enjoys) are undocumented and apparently without good reason.*

On receipt of the above information, the PCV arranged a meeting with the service provider concerned and Professor Richard Bruggemann. The outcome from the meeting was positive and the PCV followed up in writing with the service provider concerned highlighting the outcome from the meeting and to formalise the concerns both CVS and Professor Bruggemann have regarding restrictive practices currently placed on their resident. It was hoped this would assist the service provider when next meeting with the resident's parents to talk through the current situation with their child and highlight the dilemma placed on the service provider who would like, and is meant to be delivering services in the least restrictive manner. Furthermore, Professor Bruggemann was about to meet with Board members of the service provider and offered to meet with family groups and attend other meetings as required to discuss restrictive practices and the formal approval and paperwork that is required for all restrictive practices placed on any resident in accommodation services.

At the time of writing this report, Professor Bruggemann recently launched the *Restrictive Practices Reference Guide for the South Australian Disability Service Sector* and a paper titled *Restrictive Practices – A Guide for Families of Adults*

with a Disability. Copies of the guidelines and paper are readily available and have been distributed through various means.

The CVs will continue to enquire as to whether restrictive practices are in place and seek evidence of paperwork to support its application. There remain examples where this is not occurring and these instances will continue to be followed up by the CVS and responses sought from the service provider.

As previously mentioned, there was a definite positive uptake in the number of family members present at visits. Further to this, family/guardian involvement was noted as a positive in 38 (5%) of the total comments made. Following are some positive excerpts from reports:

*X grew up with his grandmother and she is still involved as much as possible. As she is an elderly person, house staff are kind in that they pick her up and take her back to the house to visit X and drive her back home afterwards.*

*X and Y have close relationships with their families who are also very involved in shaping the support program.*

*Family are good advocates for the residents in this house and apparently the staff are not allowed to assist unless requested by residents.*

### Recommendation

10. The CVs continue to check on the use of restrictive practices and report undocumented or unusual practices to the PCV who will report to the Senior Practitioner.

## 3.6 Rights and Responsibilities - personal safety of residents and staff

The issue of personal safety (for both residents and staff) remains a key area of interest and is regularly a point of discussion at the CVS Advisory Committee meetings.

The CVS continues to monitor personal safety at all visits drawing attention to situations and environments, which could potentially expose individuals to risk.

Further to this, finding suitable placements for some residents continues to present as a challenge for organisations and the CVS recognises the challenges faced in accommodating those with more challenging behaviours into environments without adversely impacting on the other house residents. With the ongoing transition to NDIS, individuals will (and should) be directly involved in the decisions about who they share a house with or indeed if they want to share at all. A couple of examples being

*We (CVs) have concerns that X's needs and the high-level staff responses to them, create a dynamic where the other resident's needs may take second place. This may for example, mean that he goes to bed early, or that the dynamics in this environment are highly charged and stressful. If this is a regular state of affairs, it raises issues of whether in effect, resident X's daily living is restricted.*

When following up the above concern with the service provider their response was that they are continuing to advocate for additional funding and extra support hours and in the interim have discussed strategies to try and minimize X's behaviour.

*There appears to be danger to residents and staff from the incompatible resident mix, difficulties in providing adequate support and inappropriate premises. CVs would like the PCV to look into this situation further and advocate with the service provider and Disability SA (DSA) for changes in placements and support for these residents. Currently discussions have begun between the service provider and DSA but as none of the 3 men is 'homeless' DSA apparently has said the matter has no priority. CVs were struck by the sense of threat and danger expressed by X towards X and staff and the absence of any apparently reliable prediction of factors likely to spark a violent or threatening breakdown. We feel this is URGENT.*

The CVS immediately contacted the Executive Director of Disability SA requesting the report be perused as a matter of urgency and that a review of the situation occur in hope a better outcome could be achieved. An immediate response was received and CVS was informed DSA have begun their internal processes to investigate the situation at the house and will liaise with the service provider and keep in contact with us as the investigation progresses. A meeting was planned to bring all the information together and a report was prepared on the actions. An interim measure was put in place between the service provider and DSA to work closely together to find a solution. A case conference was held and it was agreed that a move for X was in his (and others) best interests. Interim respite was being sought.



The most recent update provided to CVS was that the Executive Director advised DSA is actively seeking alternative accommodation for X but in the interim 2:1 support is being provided to ensure the safety of all within the house.

### **Recommendations**

11. That the CVS continues to monitor personal safety of both residents and staff.
12. That the CVS looks into undertaking a focus on personal safety.

## **3.7 Access - transport and service availability**

Access to suitable transport and the availability of services are further areas CVs explore when speaking with residents and staff at visits and a number of comments were recorded pertaining to these areas. Of particular note, the importance of residents being able to readily access transport to attend activities was noted and many of the residences visited had an appropriate vehicle allocated to them. Other residences that were not as fortunate to have an allocated vehicle, either shared a vehicle with another house nearby or had access to taxi vouchers/other means of transport. Many service providers expressed their concern regarding the funding of vehicles when the NDIS comes into effect. It is hoped service providers will take this into consideration when assisting their resident's in preparing their plans and discuss this with all family members/supporters involved (resources required, etc).

An ongoing concern that has been discussed for some time with the CVS Advisory Committee is accessibility to respite and emergency accommodation services and that ongoing long-term stays within such facilities appears to be continuing. CVs have continued to report that there are situations where residents have been in respite accommodation for 1-2+ years. It concerns CVS with the introduction of the NDIS, clients will be afforded more flexibility to attend respite programs but there is currently a large demand for these services. Some services have waiting lists.

### **Recommendation**

13. The CVS to continue to monitor whether the residents have access to a vehicle to enable access to a diverse range of activities in line with their care plan.

## **3.8 Clients with disabilities such as intellectual disability, brain injury or autism in acute mental health units**

The issue of clients with dual-diagnosis of intellectual disability and/or acquired brain injury with mental illness remains a significant agenda item for the CVS.

As reported in previous PCV Annual Reports, research has been undertaken on this issue with state government reports prepared such as the *Gaps in Secure Services Brief* (SA Health, February 2012) and *Forensic Disability: The Tip of Another Iceberg* (Exceptional Needs Unit, September 2011). The reports recognised that both correctional and forensic services are ill equipped to adequately cater for the specific support and developmental needs of those with both a mental health and intellectual disability or brain injury or autism.

### **CVS Findings**

During the course of visits and inspections of forensic mental health units by the CVS over the last six years, numerous examples have been highlighted in relation to people with co-morbid disabilities and the inappropriateness of mental health services as they currently stand, to adequately meet the needs of this group.

There is an unfortunate mix of clients with intellectual disability and those with a mental illness who must cohabit because of their security status, despite having quite different support needs and management requirements. Skill levels for staff for both groups vary and the mixing leads to incidents and a failure to cater for differing needs. This situation is clearly driven in part because of the absence of a suitable facility specific to the needs of those with a disability. It is also due to the fact that any individual who meets the criteria for being classified as a 'forensic client' become the responsibility of the Minister for Mental Health and Substance Abuse.

The situation of clients with an intellectual disability being housed in a mental health unit is inadequate for them and unfair on staff. A number of these clients are not receiving medication or treatment interventions - but there is no other

suitable safe and secure accommodation for them.

## **Discussion**

It is encouraging to note that the Birdwood Unit of James Nash House was refurbished to include a discrete area for those clients with disabilities and mental health issues including intellectual disability, traumatic brain injuries and autism spectrum disorder. James Nash House has also conducted in-service training for staff which focused on 'developmental care' which in general terms, is a model of care and support that enables people with an intellectual disability to develop and maintain new skills. The CVS looks forward to continuing visits to these units to observe how this refurbishment and training has improved the services and outcomes for clients with comorbidities.

It is of great importance to the CVS that the work commenced to improve services for this client group continue, for if we fail to provide an appropriate service response to this specific, vulnerable client group, a serious or critical incident is likely to occur and questions will be asked as to why intervention did not happen.

While it is appreciated that setting up specialised services for clients with intellectual disability, brain injury or autism has significant financial implications and we live in challenging times of fiscal restraint, the costs associated with flow-on effects into the intensive care units and emergency departments of hospitals is significant and should be recognised.

Outside of the inpatient models, the CVS has observed multiple examples of residents with intellectual disability released on license with support by a non-government organisation (NGO) to live in the community (often under strict license conditions). This community-based model could be considered as an alternative to the resource intensive inpatient models and is likely to attract individualised funding under the NDIS.

The CVS is aware of an external and independent review of forensic mental health services that was conducted in July 2015. As part of that independent review, the PCV met with the interstate consultants undertaking the review. It was clear from this meeting that the consultants had completed a thorough assessment and were aware that there are clear service improvements that could be implemented in South Australia to ensure better outcomes for the clients in forensic care.

The report was released to the public on 7 July 2017 and provided everyone the opportunity to see what has been recommended as a means of improving forensic care in SA.

## 4. Supported Residential Facilities outcomes and themes

Supported Residential Facilities (SRFs) are accommodation services licensed under the *Supported Residential Facilities Act 1992* (the Act) to provide low level care services in a group setting, for people living with a disability or mental health issues. They are defined in the Act as “premises at which for monetary or other consideration (but whether or not for profit), residential accommodation is provided or offered together with personal care services (other than for members of the immediate family of the proprietor of the facility).”

A ‘pension only’ SRF is defined as such because in most cases the majority of residents are in receipt of a pension or other government allowance and rent assistance and pay the majority of their income to the facility for their ongoing care.

There have been 25 ‘pension only’ SRFs in South Australia during this reporting period, the majority of which are privately owned and operated. Of these 22 are located within metropolitan Adelaide, while two are located regionally. They have a maximum capacity of 907 with approximately 800 people living in SRFs at any given time. These are the facilities visited and inspected by the CVS (see Figure 4.1 –SRFs by location and NDIS region).

However, Peppertree Grove at Camden Park closed during this reporting period, requiring the re-location of 34 residents. Prospect Residential Care Services transferred its license in April 2017.

Local government is responsible for the auditing and licensing requirements of SRFs, under the Act. However, the Eastern Health Authority undertakes these responsibilities on behalf of the majority of local councils located in the eastern region of Adelaide.

SRFs in South Australia vary considerably in size from 12 beds to the largest being 68 beds. SRFs must provide a prospectus clearly identifying such things as the services provided; terms and conditions; type of accommodation and facilities; staffing levels; meals; medication management; and rights and responsibilities of both the facility and the residents.

The SRF Intake and Support Service (SRFI&SS), located in the Exceptional Needs Unit (ENU) of Disability SA, undertakes non-clinical assessment for individuals seeking SRF accommodation or for existing SRF residents who may require additional supports. The SRF Entry Point Assessment (SEP) considers a person’s needs and risks in the context of low level care, congregate accommodation. A person assessed as eligible will be approved for the government’s Board & Care Subsidy. These payments are made to an SRF proprietor on behalf of the eligible person to offset some of the cost of providing care. While this assessment process is actively encouraged, it is not a pre-requisite for entry to an SRF.

Further, if an SRF wishes to claim the Board and Care Subsidy, they can only charge a maximum of 79% of a person’s Centrelink entitlement. The Board and Care Subsidy is only payable to those who access the SEP.

The SRFI&SS team also undertake assessments of residents who may require additional psych-social and or health support to enhance a person’s tenancy, reduce social isolation and links to mainstream community services and activities. Support services are provided through a ‘package’ delivered by a non-government organisation (NGO) and department of Health & Aging.<sup>5</sup>

Residents of SRFs are recognised as a particularly vulnerable and disadvantaged population group, reflecting a range of complex needs. The majority present with a primary diagnosis of disability or mental illness, with a significant number having a dual diagnosis. Complex co-morbidities are a major issue in SRFs with health conditions associated with premature ageing clearly and consistently identified. For example, a study recently completed and published in *Nutrition*

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<sup>5</sup> Specific program information provided by the SRF Intake and Support Service (SRFI&SS) – Exceptional needs Unity (ENU) Department for Communities and Social Inclusion (DCSI)

and *Dietetics*, provided evidence to support dietetic and educational interventions for SRF residents with type 2 diabetes, whether or not obese. All but one had schizophrenia, an intellectual disability or other psychological conditions.<sup>6</sup>

While there is reasonable stability within the sector, there is also a degree of mobility of residents at any given time between SRFs and in and out of the sector. Under certain circumstances this may require that a person is reassessed through the SEP.

It is noted - and discussed further in section 4.9 - that the SRF sector continues to be impacted by the NDIS rollout. The SRF Association has been proactive in presenting its concerns regarding the sector to the relevant department. CVS and other stakeholders have continued to advocate for the specific needs of the SRF residents within this changing landscape.

The SRF Association is represented on the CVS Advisory Committee.

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<sup>6</sup> *Dietetic and educational interventions improve clinical outcomes of diabetic and obese clients with mental impairment* - Nutrition & Dietetics 2017; 74: 236 – 242 – Kerri HUNT and Kathy STILLER



SUPPORTED RESIDENTIAL FACILITY (SRF)	LOCATION	REGION (NDIS)
Aldridge Court	109-111 Young Street PARKSIDE SA 5063	Eastern
Clifford House Rest Home	4 Farrant Street/179 Prospect Road PROSPECT SA 5082	Eastern
Kingswood Hostel	26 Cambridge Terrace KINGSWOOD SA 5061	Eastern
Magill Lodge	524 Magill Rd MAGILL SA 5072	Eastern
Ocean Grove at Myrtlebank	494 Fullarton Road MYRTLEBANK SA 5064	Eastern
Prospect Residential Care Services	6 Dean Street PROSPECT SA 5082	Eastern
Rose Terrace Hostel	102 Rose Terrace WAYVILLE SA 5034	Eastern
Brooklyn Supportive Care	377 Henley Beach Road BROOKLYN PARK SA 5032	Western
Hindmarsh Lodge	15-19 Holden Street HINDMARSH SA 5007	Western
Peppertree Grove	407 Anzac Highway CAMDEN PARK SA 5038 (Closed September 2016)	Western
Mandeville lodge	296 Military Road LARGS BAY SA 5016	Western
The Oaks at Rosewater	7 Lincoln Street ROSEWATER SA 5013	Western
Seabreeze Villa	87 Hall Street SEMAPHORE SA 5019	Western
Semaphore Hostel	160-164 Military Road SEMAPHORE SA 5019	Western
Sunnydale Rest Home	247 Military Road SEMAPHORE SA 5019	Western
Walkerville lodge	6 James Street CHELTENHAM SA 5014	Western
Alexam Place Rest Home	24 Hazel Road SALISBURY SA 5016	Northern
Amber Lodge	4 Gordon Terrace MORPHETVILLE SA 5043	Southern
Brighton Ocean Grove	39 Beach Road BRIGHTON SA 5048	Southern
Glenelg House	37-39 Sussex Street GLENELG SA 5045	Southern
Glenelg Supportive Care	26 Byron Street GLENELG SA 5045	Southern
Russell House	16 Byron Street GLENELG SA 5045	Southern
Gawler Supportive Care	8 Bishop Street GAWLER EAST SA 5118	Barossa Light & Lower North
Lambert Lodge	87 Gray Street MOUNT GAMBIER SA 5290	Limestone
Southern Fleurieu Silver Circle	55 Victoria Street VICTOR HARBOUR SA 5211	Fleurieu & KI

Figure 4.1 –SRFs by location and NDIS region

## 4.1 Statistics on visits

During 2016-17, the CVS conducted 41 visits to SRFs, representing an increase of 60%.

The online reporting tool enables the CVS to record issues of concern or positive comments that they observe during scheduled SRF visits.

2015-16 Total Visits	2016-17 Total Visits	2016-17 (Positive Comments)	2016-17 (Issues)
26	41	56	47

Figure 4.1.1 details the positive comments and issues raised during the 2016-17 reporting period.

Of the 103 comments received during this reporting period, 54% (n= 56) were positive and 46% (n=47) were issues, presented in figure 4.1.2

Once CV reports are submitted, comments are assessed using a two tiered classification system to categorise issues that are raised and ensure consistent reporting (see Appendix 6).

The first tier, Level 1 is comprised of six themes, while Level 2 provides for detail within each of these themes. The Level 1 classifications are as follows:

*Treatment Services and Care*

*Grievances*

*Environment and residence services*

*Communication*

*Rights and responsibilities*

*Access*

Figure 4.1.2 presents the comparative percentage of positive comments and issues raised against each of the 6 Level 1 themes.

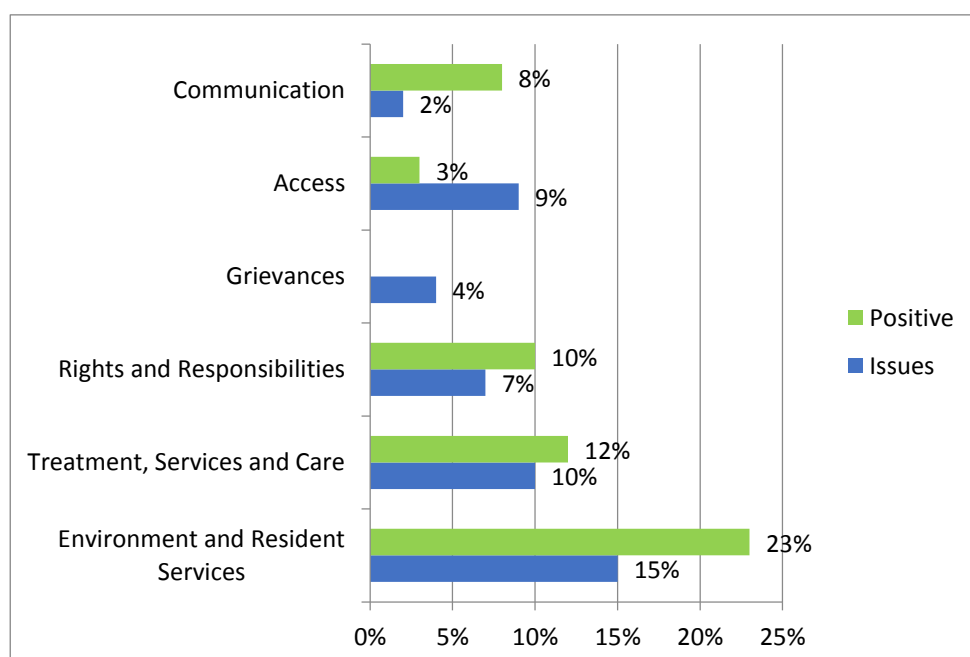


Figure 4.1.2 – Level 1 – percentage of positive and negative comments

The most reported Level 1 classification was *Environment and Residence Services* with the majority of the comments being positive. This was closely followed by *Treatment, Services and Care*, with an even split between positive comments and issues raised, predominantly within the classification of *Activities and structured programs*.

In contrast, the Level 1 classification *Grievances* reported the smallest number of responses, with even distribution across the Level 2 classifications.

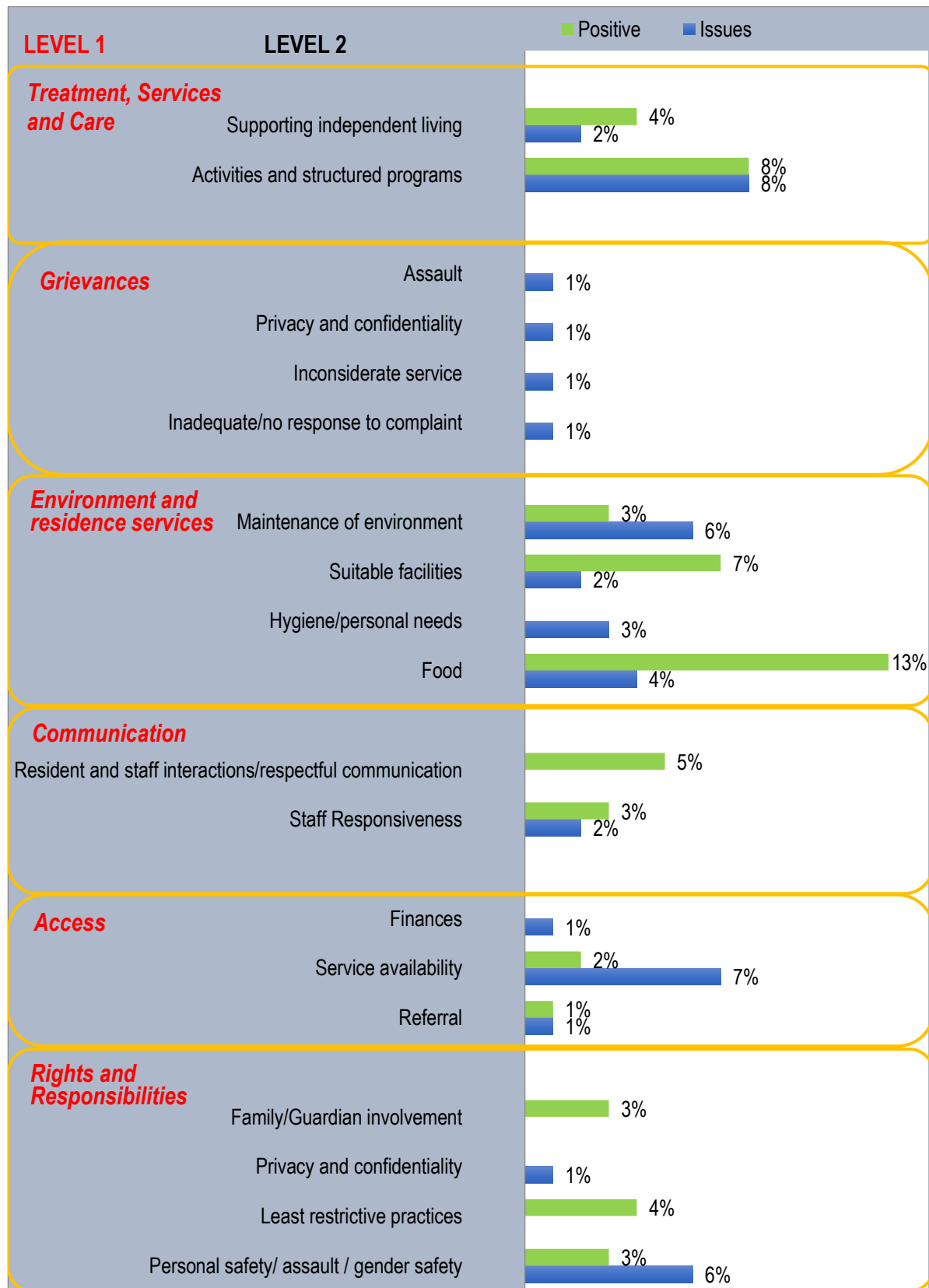


Figure 4.1.3 – Level 2 – percentage of positive comments and issues raised

## 4.2 Treatment services and care

The Level 1 classification of *Treatment Services and Care*, was most strongly represented in the area of *Activities and Structured Program*, with close to a 50% split with regard positive comments and issues.

The other level 2 classification represented is *Supporting independent living*, with both positive comments and issues expressed.

It is clear from reports that there are certainly SRFs endeavouring to promote various activity options for the residents and create 'specific use' spaces within the facilities.

In most instances, SRFs do not arrange for regular on-site activities to be provided. However, more often residents are linked into activities and opportunities for community connection through external organisations such as various non-government organisations (NGOs) and the local government Regional SRF Programs.

Some examples from reports include:

*All residents are allocated 3 hours per week with a staff member for individual activities. Not all residents use all of the time available.*

*Whilst few activities are provided by the facility, access is facilitated to recreation programs provided by the council and care packages for 1:1 support from NGOs*

However, there is equal representation in the reports of residents sitting around with no obvious engagement. The CVS recognises that while this may well reflect an individual's choice it can also be representative of a general disengagement, sense of loneliness or indeed the impact of a particular diagnosis or medication.

*The atmosphere seemed low with residents pacing and bored. Residents said they have asked for activities however had been told it is not the responsibility of the centre to provide these. In discussion with the residents, it was mentioned numerous times that there was a lack of activities within the SRF. They volunteered that table tennis table, cards, pool table etc would be great. At the time of the visit the activities observed were watching TV, sitting outside smoking, drinking coffee, and making plans to go to the pub.*

*There is a distinct lack of stimulation other than a television room that is too small to cater for all of the residents at one time*

The impact of the NDIS has continued to be reflected in the sector during this reporting period (see section 4.8). Of particular relevance to this discussion is the impact on psycho/social programs currently being provided through the local government regional SRF programs and NGOs, funding for which will cease by June 2018.

Additionally concerns continue to be expressed for the future of some allied health services that are currently funded by Disability SA and provided by DOH.

The classification of *Supporting independent living* received both positive and negative comments and is strongly influenced by the attitude of the managers as demonstrated by the comments below:

*Any support towards independent housing would need to be driven by external agencies. A number of the residents had previously been housing trust tenants, but had found this difficult to maintain due to various episodes of illness.*

*The manager has put time into enabling five residents to attend work on a regular basis.*

*However, the manager stated that the remaining residents lack motivation / inclination to achieve greater independence.....and also considers that many of the residents lack capacity, skills or willingness to extend their living situation and independence beyond their current environment and circumstances*

*Most residents in this facility are independent enough to come and go as they please and three work at Bedford*

## 4.3 Grievances

The level 2 classifications of *Inadequate response to complaint*, *Inconsiderate service*, *Privacy and Confidentiality* and *Assault* sit within Level 1 – Grievances – and are equally represented.

While the number of reports within this classification is very small, as was the case last year, themes are reflected in other sections of this report. Of note, most of the grievances reported were by SRF staff. This does not of course imply that residents have no grievances. Rather, due to the small sample, CVS considers that other classifications can be regarded as incorporating grievances that have been identified by residents, CVs or others.

Examples of comments include:

*The majority of the visit was spent in supporting management with the eviction of a resident.*

*An incident was discussed by the manager whereby a resident was admitted to the RAH; after 3 weeks of inpatient care within MHS he was discharged back to the SRF with a change of medication which included the addition of a depot medication but there were no drugs accompanying him or discharge/ medication summary.*

## 4.4 Environment and residence services

As previously noted, this was the most reported Level 1 classification and within that the Level 2 classification *Food* featured most prominently

The importance of providing nutritious food within SRFs has become well recognised over recent years, as it is widely acknowledged that SRF residents as a population group, face an array of complex health issues, including premature ageing. Progression of this focus has been aided by the involvement of allied health professionals providing a variety of health services and promoting health messages. This is evidenced by research such as that previously mentioned, regarding the impact of diabetes and obesity on SRF residents who are also living with a mental health diagnosis.<sup>7</sup>

Additionally, organisations providing various social programs have also moved across to healthy options when planning activities and events.

Supporting this is the priority given to nutrition in the *Supported Residential Facilities Regulations 2009*, and its reflection in the audit process undertaken by local government licensing authorities.

Further, as the majority of SRFs do not involve residents in food purchase and preparation, choice with regard menu options for example and provision for specific dietary needs take on additional significance. Additionally, given that some SRFs serve dinner early, flexibility regarding supper would also enhance a sense of choice and take into account the dietary requirements of certain health conditions such as diabetes.

Some SRFs have created edible gardens, which is a very positive initiative as it also provides additional activity options for residents to participate in. Most comments about the food were favourable, though the need for improvement in some SRFs was also noted in reports. Comments received included:

*All the residents that were spoken with indicated that the food was good. Although no menu plan was evident there was a blackboard in the dining room listing the day's meals. The cook was in the kitchen preparing the evening meal and has been at the site for over 15 years. There was evidence of consideration to meal variations for those with diabetes*

*The facility prides itself on a large kitchen, with staff providing only fresh foods, with no pre-prepared foods. A dietician assists in advising staff on food planning. Whilst menus were not discussed directly during this visit, the residents we spoke with all said they were comfortable and enjoyed the food.*

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<sup>7</sup> *Dietetic and educational interventions improve clinical outcomes of diabetic and obese clients with mental impairment* - Nutrition & Dietetics 2017; 74: 236 – 242 – Kerri HUNT and Kathy STILLER

There have however been some issues noted regarding food. Some residents have indicated that the menu plan does not always coincide with what is served. The early commencement of meals in some SRFs has also been identified as an issue.

Level 2 classifications *Maintenance of Environment and Suitable Facilities* were also represented strongly in this section.

A key focus of the CVS visit is to ensure that standards are being maintained, in terms of both accommodation and quality of the care and support services being provided. In general this area has received positive feedback during the reporting period. However, there are still some settings that are not providing a level of accommodation and care that is considered optimum.

The CVS recognises that in some instances, an SRF licensee does not own the actual premises, which can influence responsiveness or otherwise to identified maintenance issues. However, as with other sector stakeholders, the CVS would assert that the *Supported Residential Facilities Act 1992* (the Act) can make enforcement of requirements difficult.

Excerpts from reports reflect this contrast:

*The general ambience and temperature of the facility was good. The internal and external areas of the premises were clean and tidy. House layout and accessibility were satisfactory*

*As previously noted the extensive back area is currently covered with weeds with little protection from the elements or places to sit. The interior is dark and while common areas and corridors are tidy the décor is tired and not homely.*

It is noted that a number of SRFs that changed hands late in the preceding reporting period, have continued to consolidate the positive changes being undertaken. The Level 2 classification representing the most issues only was that of *Hygiene /and personal needs*. SRFs provide low level support which includes prompting residents when needed to undertake personal care routines. Various physical and mental health conditions experienced by residents can impact their capacity for self-care.

The following comments are representative of such observations:

*The CVs were concerned that the focus on the physical requirements also needed to take into consideration the daily needs of the residents and to ensure that those who needed prompts and reminders for washing, toileting and general self-care are not overlooked*

*Discussion with manager regarding personal hygiene needs after observing some of the clients' manner or dress and appearance. Manager stated that clients were encouraged to take more care of their personal needs and responsibility for themselves regarding regular washing etc.*

*Residents were dressed appropriately, although some of the clothes appeared to be ill fitting and had food stains and a general unwashed body odour was evident.*

## 4.5 Communication

The Level 2 classifications of *Staff Responsiveness* and *Resident and staff interactions/respectful communication* are considered concurrently within the context of this report.

The CVS recognises that the attitude and engagement of SRF staff has a significant impact on how the facility operates and the overall atmosphere. This is something that CVs are particularly mindful of when visiting and comments received throughout this reporting period were generally positive. All responses in relation to *Resident and staff interactions/respectful communication* were positive. *Staff responsiveness* registered both positive and negative comments.

*The feeling at this SRF is warm and friendly. The culture is of one BIG family. The staff provide an excellent atmosphere.*

*A general group meeting is held regularly to assist in keeping residents informed, together with regular personal contact with staff.*



*Residents were listened to and not dismissed or ignored during the visit. Residents were free to interrupt at any time and welcome to share comments and requests*

*The CV is unsure whether interpreter services and culturally appropriate services might be of value to this particular woman who did seem quite linguistically isolated.*

## 4.6 Rights and responsibilities

The level 2 classification of *Personal safety/assault/ gender safety* maintained the same level of issues as last year. However, there were also examples of positive actions taken to address potential areas of concern.

The DCSI SRF Intake and Support Service (SRFI&SS) and its Single Entry Point (SEP) process plays an important role in mitigating potential problems with regard personal safety. However, given the size of many of the SRFs, the challenges of managing a congregate site, populated by many more people than would normally live together are evident.

Comments received on this issue included:

*The procedures regarding dealing with difficult residents needs addressing. There may need to be parameters set on who can be referred to the facility. Certainly it would be prudent to have some sort of screening process*

*Staff commented about alcohol and substance use by residents (sniffing lighter fluid was specifically mentioned). Previous attempts have been made to seek outside help (eg Rehab) but this has been unsuccessful. Staff noted alcohol and substance use can be associated with increased aggression and residents returning to the facility under the influence need to be managed carefully.*

*Most rooms could not be locked which is a concern that has been raised previously especially if residents have valuables in their room.*

Level 2 classification, *Least restrictive practices*, registered as positive because they were not observed other than as safety precautions, such as detailed in the following example:

*There are no restrictive practices. However, ingress through the front door is restricted. Residents are free to leave the residence through the front door but they need to ring the bell to enter the premises. This least restrictive practice was put in place to protect the residents and the staff from uninvited people or intruders.*

Level 2 classification, *Family and guardian involvement* was reflected through positive comments in the reports, including the following:

*Individual plans up to date & reviewed regularly with family involvement.*

*Residents and their family have input in into their individual plans which are updated as required or at least annually. Consumer meetings are held once a month and when required*

It is pleasing to note the involvement of family in the identified examples. However, the CVS is cognisant of the fact that a significant proportion of SRF residents do not have regular or ongoing contact with family.

Though small in representation, the Level 2 classification of *Privacy and confidentiality* is important to acknowledge. As previously mentioned, the congregate nature of SRF accommodation generates some specific challenges. Those include how to ensure that residents' right to privacy and confidentiality are achieved. The comment below demonstrates this:

*It was also noted that there did not appear to be any private spaces for residents to utilise for quiet time or private meetings or conversations.*

## 4.7 Access

The most frequently reported level 2 classification was that of *Service availability*, although *Referral and finances* also had minor representation.

This can manifest in different ways and be the culmination of many factors including health and psycho/social considerations, financial limitations and frequently a sense of disengagement from the general community. This can result in difficulties for a resident attempting to access various resources and opportunities.

The uncertainty raised by NDIS was also a theme that featured strongly within the classification of Access. Report comments demonstrating this range of themes include:

*These residents, as well as many others, are concerned that they may lose their home as a result of (NDIS), particularly as many have undiagnosed mental health issues. Staff and management are attempting to remain abreast of changes and developments of the NDIS in order to alleviate any fears and anxiety.*

*Staff reported that they did not receive support from the Community Mental Health services. They believed clients would benefit from specialized follow ups and perhaps from educational groups to tackle alcohol and smoking habits. All the care, support and treatment is in the hands of the management. It has been difficult sometimes to get medication reviewed during admission process of new residents*

It is relevant to note that the theme of Access is also reflected positively in other sections of this report, as per the following comment describing residents' participation in activities provided by local government and non-government organisations:

*Programs are also offered by Life Links, run by Holdfast Bay Council, and Anglicare. The council provides a bus and various activities including bus trips, walking events, coffee mornings, lawn bowls, and Super Saturdays, which involves activities such as movies and dinner. Anglicare also provides programs including Men's Breakfasts and other social activities.*

## 4.8 Issues impacting the SRF sector

The 2016-17 reporting period has been a time of significant challenge for the SRF sector. The 2015-16 report referred to a number of strategic and operational issues impacting the sector, which remain relevant for this reporting period. The CVS has enacted the recommendations contained in last year's annual report and continues to advocate and promote the issues through appropriate channels.

### 4.8.1 NDIS and Aged Care Reform and Transforming Health

The concurrent system wide changes have continued to be the primary area of impact for the SRF sector and a major source of concern for sector service providers.

There has been considerable confusion as to the proposed NDIA assessment process and its suitability for this client group. CVS and other stakeholders have advocated for providing specific consideration and support to SRF residents to ensure that they are able to access the assessment process. Of particular concern is that of those SRF residents not currently in receipt of any additional support package are particularly at risk of 'falling through the gaps'. Additionally, support services provided by SRFs can 'camouflage' the support needs an individual has, resulting in a lack of personal insight as to the true extent of their support requirements and underlying issues.

SRF residents over the age of 65 are required to access the *My Aged Care* portal for aged care services. Feedback from health providers suggests that this has proved difficult. There is still uncertainty surrounding the continuation of allied health services that SRF residents currently access.

Concerns have been raised that some SRF residents may be moved across to aged care prematurely, thereby enabling SRFs to 'cherry pick' residents with lower support requirements. A key challenge for the sector is managing and highlighting the issue of premature aging across this population group

The SRF Association has been proactive in promoting sector concerns. It has sought information and clarification regarding the transition process and opportunities to discuss consideration of alternative accommodation models, inclusive of SRFs.



The CVS has continued to advocate for the wellbeing of SRF residents throughout this transition process. Correspondence detailing concerns has been provided to Minister Bettison and CVS acted as a conduit in providing opportunity for the three regional SRF networks to meet with the SA regional manager NDIA.

### **Recommendation**

1. That the CVS will continue to advocate for the specific support requirements of SRF residents throughout this transition process and refer any identified issues of concern to the appropriate forum.

### **4.8.2 Local government regional SRF social programs**

The CVS acknowledges that the majority of activities accessed by SRF residents are through the three regional local government SRF social programs.

Funding underpinning these programs – along with a number of other local government programs – will cease as of 1/7/2018. The programs have been a valued and respected presence in the SRF sector for well over a decade, providing significant opportunities for socialisation and community connection and reducing isolation.

Devolving these programs will dramatically reduce available opportunities for SRF residents. However, a number of the councils have committed to incorporating some level of SRF service provision within their established programs in an effort to redress this issue wherever possible.

### **4.8.3 Role of Environmental Health Officers**

The CVS provided two recommendations in the 2015-16 Disability Annual Report involving the strengthening of collaborative working relationships with local government Environmental Health Officers (EHOs), in keeping with the complementary nature of the two distinct roles.

This continues to be viewed as a priority by the CVS and has progressed strongly during the current reporting period. Arrangements were finalised at the end of this reporting period for the CVS to host a *CVS and Local government SRF Forum* in early August 2017. This Forum will consider the varied components of the roles performed by local government and the CVS and protocols for the sharing of information when responding to issues that are raised within the SRF sector.

### **Recommendation**

2. That the CVS continue to strengthen its relationship with local government Environmental Health Officers, recognising the critical role they have within the SRF sector.

### **4.8.4 Boarding Houses**

SRF residents are widely recognised as a particularly vulnerable and disadvantaged population group, reflecting a variety of complex needs requiring a range of support services. The majority of residents present with a primary mental health or disability diagnosis. However, dual diagnosis and complex co-morbidities are frequently evidenced including health conditions reflective of premature ageing. A high proportion of SRF residents do not have a key support worker or active engagement with family.

Implementation of the NDIS has the potential to significantly impact the SRF sector in terms of the non- congregate accommodation model that is favoured by NDIA. There is concern that the predicted closure of multiple SRFs will displace a growing number of people - who already meet the definition of tertiary homelessness – into unregulated boarding houses/rooming houses

In April 2017 Shelter SA released its report *'The End of the Road – Rooming Housing in South Australia'*, highlighting the issues and high level risks for those individuals residing within this accommodation model.

The similarity of residents utilising these two accommodation models was acknowledged, with the difference being that SRFs were regulated under legislation to provide low level support while boarding houses were unregulated. There is no formal register of boarding houses.

*'The report identifies that the profile of rooming house residents is predominantly one of complexity and vulnerability...other characteristics of residents include that they are more likely to live with psychiatric and behavioural*

issues, social isolation and poor access to community supports and high levels of general health care needs with repeated admissions to acute care health facilities’.<sup>8</sup>

As a result, Minister Bettison has convened a Round Table discussion, which was held on 3 July 2017, to discuss the concerns and recommendations raised in the report.

The CVS 2015-16 Disability Annual Report contained a recommendation to review the *Supported Residential Facilities Act, 1992* (the Act). However, it is now recognised that ideally any review of the Act should be undertaken from a broader perspective that incorporates consideration of Boarding Houses and accommodation of vulnerable and complex client groups. (see section 4.8.5)

The CVS recognises that increased intersection between the SRF sector and others, such as the homelessness sector for example, is both likely and appropriate.

### **Recommendation**

3. That the CVS continue to participate in the Boarding Houses Round Table discussion process
4. That the CVS continue to participate in cross sector opportunities with regard addressing the accommodation needs of vulnerable population groups

### **4.8.5 Review of relevant legislation - the Supported Residential Facilities Act, 1992 (the Act)**

The CVS 2015 – 16 Disability Annual Report identified the difficulties posed by the *Supported Residential Facilities Act, 1992* (the Act) for licencing authorities due to its vague definitions and scope of interpretation.

A recommendation of that report called for a review of the Act. This was supported by the Co-Morbidity Inquiry of 2016, undertaken by the Social Development Committee of the South Australian parliament, in which Recommendation 28 states, ‘It is recommended that the *Supported Residential Facilities Act, 1992* be amended to include adequate provisions for co-morbidity to ensure appropriate accommodation and support is provided.’<sup>9</sup>

The government’s response was to support this recommendation in principle. However, it further added, ‘As with the *Disability Services Act, 1993*, a review of the *Supported Residential Facilities Act, 1992* is planned to coincide with full implementation of the NDIS in South Australia’

The CVS asserts however, that with the release of the Shelter SA report, consideration needs to be given to both review of current relevant legislation and the development of new legislation that encompasses both SRFs and boarding houses within consideration of the accommodation requirements of vulnerable population groups.

Further, the Shelter SA report identifies the limitations of the current *Residential Tenancies Act (1995)* ‘This legislation...is outdated and does not reflect the requirements of the current resident population, particularly those living with high and complex accommodation, health and/or mental health needs’<sup>10</sup>.

### **Recommendation**

5. That the CVS continue to promote review and creation of legislation that incorporates regulation of SRFs and Boarding Houses.

### **4.8.6 Premature discharge of SRF residents from hospital**

This issue was raised in the 2015 – 16 reporting period and health workers and SRF managers continue to identify this as a concern. Examples have been provided to the CVS of occasions when residents have been discharged from hospital without appropriate documentation and the SRF does not have capacity to manage the particular medical requirements.

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<sup>8</sup> Shelter SA ‘*The End of the Road – Rooming Housing in South Australia*’

<sup>9</sup> *Co-morbidity Inquiry of 2016* undertaken by the Social Development Committee of the South Australian Parliament

<sup>10</sup> Shelter SA ‘*The End of the Road – Rooming Housing in South Australia*’

SRFs are licenced to provide low level support requirements and it has been reported that the systemic changes being implemented across the health system have reduced the potential length of stay that is available within the hospital setting.

#### **Recommendation**

6. That the CVS, through its Advisory Group, promote and raise awareness of the issue of SRF residents being discharged from hospital without appropriate care provisions being available at the SRF.

## 5. Day Options programs outcomes and themes

Inclusion of Day Options programs within the scope of the Disability Community Visitor Scheme (CVS) was clearly identified as a key priority in the 2014-15 Annual report. Issues of concern had been raised within the disability sector itself and featured in Community Visitor reports.

Day Options programs were subsequently included in the Scheme in 2016 pursuant to the *Disability Services (Community Visitor Scheme) Regulations, 2013 (the CVS regulations)* with an SRF and Day Options Coordinator being employed in March 2016.

Additionally, the Contracting and Sector Liaison Department of DCSI, ensured that host agreements with registered Day Options program providers contained a clause – section 26.3 – 26.6 – requiring the organisations to accommodate CVS visits within a stated range of provisions.

Day Options programs as we know them today commenced in 1997 and target school leavers from 18 years of age with an intellectual disability who have moderate to very high support needs and require an alternative to paid employment.

The guiding principle has been that Day Options programs will focus on development and learning with the stated aims being to achieve increased opportunities to participate and be included in the community, expanded social experiences and interests, and the development of prevocational skills, where possible, with a view to transition to paid employment. These stated outcomes would indicate that participants are expected to have opportunities to develop skills and achieve goals.<sup>11</sup>

The number of participants accessing services has increased significantly, while the number of participants exiting the program is low.

Visits to Day Options programs formally commenced in July 2016. A number of organisations providing Day Options programs are already familiar with the CVS through visits to their disability accommodation. For others, it has been their first contact with the Scheme.

Overall the response had been positive, with providers identifying the CVS visits as a valuable resource for both the individual clients and the providers themselves.

When considering inclusion of Day Options programs within the Scheme, the anticipated benefits were:

- increased observation on the quality of care provision to people with disabilities
- opportunity to engage with individuals in a neutral environment which may give them more confidence to disclose issues of concern about their treatment especially if of a serious nature
- conduction of visits to and inspections of an environment where people with disabilities spend a considerable proportion of their day to ensure they are in receipt of quality care in the least restrictive manner
- ensure the delivery of activities that provide opportunity for further enhancement of each individual's capacity rather than provision of a pseudo 'sitting' service, and
- opportunity to engage and advocate for residents, to promote the proper resolution of issues relating to the care, treatment or control of residents, including issues raised by a guardian, medical agent, relative, carer, or friend of a resident or any person who is providing support to a resident.

Review of the Community Visitor reports and feedback from agencies would suggest that the first year of operation has certainly progressed these aims.

The CVS currently has 21 organisations on its data system, providing Day Options programs across 70 sites. The programs vary widely with respect to number of clients, clients' support requirements, programs on offer and the sites themselves. Of the programs visited by the CVS, 56 are located in the metropolitan area while 14 are regionally based. The CVS is mindful of the fact that NDIS will change how Day Options programs are delivered, given the provision of individual packages as opposed to the historical government block funding. As with disability accommodation, it is

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<sup>11</sup> Review of the Day Options Program Disability SA Department for Communities and Social Inclusion SA May 2013 Lumin Collaborative

impossible for CVS to accurately anticipate now to what degree NDIS will impact the number of programs CVS will be required to visit (see section 5.7).

The Community Visitors (CVs) have embraced visits to the Day Options programs and appreciated the inherent opportunity to gain further insight into the disability sector.

Once the Day Options component had been operational for a little over six months, the CVS hosted a *Day Options Workshop* for CVs, on 16 March 2017. The workshop included presentations by the Department for Communities and Social Inclusion (DCSI) on the history of the Day Options Program and the anticipated changes relating to NDIS Reform. The Senior Practitioner DCSI, Professor Richard Bruggemann, also presented on the initial concept of the Day Options Program, with specific reference to the 'all day away from home' model currently employed and the commitment or otherwise of organisations to individualise and extend clients' opportunities.

The Day Options component of the Scheme is now well established and has ensured a more comprehensive service provision to the disability sector.

## 5.1 Visit statistics

During 2016-17, the CVS conducted 89 visits to 57 Day Options programs. The CVS originally aimed to undertake six monthly visits to each site. However, various considerations impacted scheduling and frequency of visits including for example timing of CVS regional visits and allowance for school holidays and visit commitments of other components of the Scheme.

Further, in review of the first 12 months of operation, it was evident that some settings do not perhaps require twice yearly visits. However, any reduction in potential service provision is likely to be absorbed by additional providers registering with the NDIS.

As previously noted, CVs have embraced this new area of visitation and during this reporting period, contributed 267 hours to Day Options visits.

The online reporting tool enables the CVs to record issues of concern or positive comments that they observe during visits. Of the 252 comments received during the reporting period, 82 % (N=207) were positive and 18% (N=45) were issues presented in Figure 5.1.1

2015-16 Total Visits	2016-17 Total Visits	2016-17 (Positive Comments)	2016-17 (Issues)
125	252	207	45

Figure 5.1.1 - details the comparative number of positive comments and issues raised during the 2016-17 reporting period

Once CVS reports are submitted, comments are assessed using a two tiered classification system to categorise issues that are raised and ensure consistent reporting (see Appendix 6).

The first tier, Level 1, is comprised of six themes, while Level 2 provides more detailed classifications within each Level 1 theme.

The most reported Level 1 classification was *Treatment services and care*, with the majority of comments being positive, reflected in the Level 2 classifications of *Activities and Structured programs and supporting independent living*.

This was closely followed by Level 1 classification *Environment and residence services*, also reporting predominantly positive comments, primarily in the area of *Suitable facilities*.

Level 1 classification *Rights and responsibilities* was represented most strongly in the area of *Family/Guardian involvement*, with all comments being positive. The classification of *Least restrictive practice* also featured strongly, again with comments being positive.

In contrast, the Level 1 classification of *Access* recorded the most issues, the majority of which were represented in the Level 2 classifications of *Transport and service availability*.

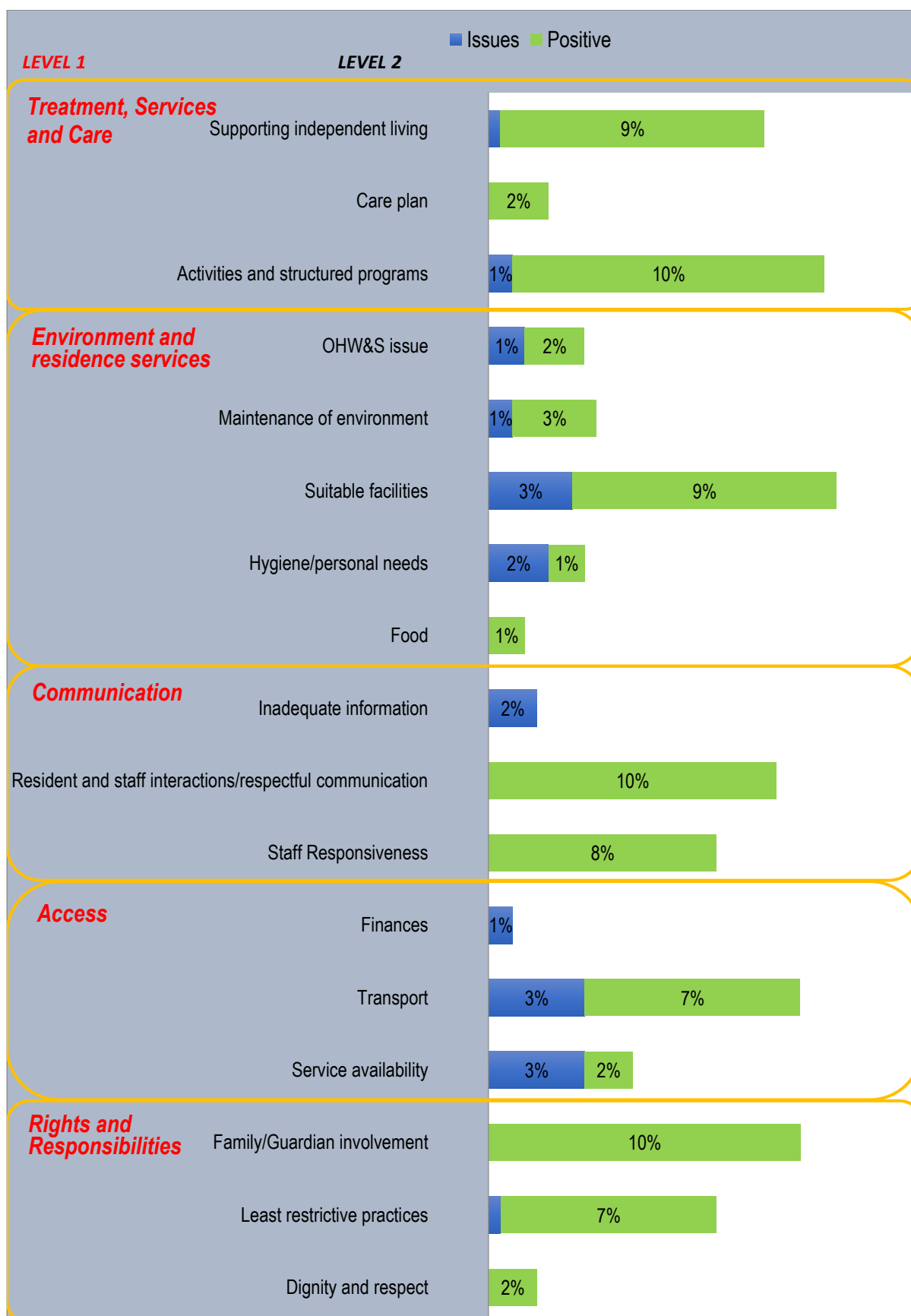


Figure 5.1.2 - Level 2 – percentage of positive comments and issues raised



## 5.2 Treatment services and care

The Level 1 classification of *Treatment services and care*, was most strongly represented in the area of *Activities and structured programs*.

In some respects this result is perhaps not surprising given that a key focus of Day Options programs is activities, delivered both on-site and in the community.

It was clear from the CV reports that organisations are endeavouring to provide activities that are responsive and individualised with regard clients' interests and capacity. The majority of organisations have also established specific spaces, particularly 'quiet rooms' where clients are able to enjoy some space and time out from a busy environment.

Reports have revealed some very innovative and entrepreneurial initiatives providing clients with enhanced opportunity for community engagement and contribution and supporting independence and skill development.

One particularly pleasing aspect reflected in reports is that CVs are able to share their observations of various activities with other programs during their visits.

The classification of *Supporting independent living* also featured strongly and is closely aligned with the variety of programs and activities being provided:

*The Team Leader is currently changing the individual client goals from strictly activity based to community living goals (e.g. extending the clients' public transport or needing to communicate with a shop attendant).*

*Another outings example involves visits to the Coonalpyn Snail Farm. This 'care farm' concept was originally set up as a program where dementia patients assist with the breeding, feeding and harvesting of snails which are sold to the gourmet food market. The program is being extended to the disability sector and the program has received a grant from the snail farm which covers the cost of transporting the clients to and from the farm.*

*One of the specialities of the cooking program is the development of their own Muesli Bar, which is not only cooked but packaged as if a commercial product and distributed to a Strathalbyn school through a breakfast program. The breakfast program is sponsored by the local IGA, covering the cost of ingredients.*

*There is also a beauty salon which is available for all clients, including those from other sites. The beauty salon looks very professional, with all the equipment you would expect from any beauty salon. Services such as hair shampoo and cut, manicures and make up are available for clients at an affordable price.*

*Clients assist with the management of the horses and take them for walks in the local area. The house also assists with wildlife rescue services, and clients are involved with preparing meals, feeding and cleaning up after orphaned joeys.*

Care plans were represented positively in reports, with comments identifying the involvement of family as well as initiatives being undertaken by some organisations to more specifically develop values and goals as a means of providing greater focus on skill development. Other organisations are also moving towards the creation of behaviour support plans in keeping with the focus on least restrictive practice.

Some of the issues noted in reports related to age appropriate activities and staff having relevant training to enable utilisation of specific communication skills particularly in the engagement of non-verbal clients:

*On this day the activity was painting ornamental flower pots. The process was for the staff to do the work whilst talking to the participant about what was happening. Staff were clearly doing their best but it was difficult to identify any level of engagement from the participants. Energy levels of participants were low but as we had observed changes in initial responses, we wondered whether incorporating these folk into a group with more active people would provide better and more varied stimulation.*

It is difficult for the CVS to anticipate what impact the NDIS will have on the delivery of Day Options programs, both in terms of current and new service providers.

Staff are aware that particular government funded activities will cease. One example is a regular music event called 'Sound Waves', which is very popular with clients across a range of sites. Staff have expressed concern that access to

music and other creative options will possibly be more limited under NDIS, areas of activity regarded as particularly valuable to many in this client group.

### 5.3 Environment and residence services

As previously noted, *Environment and Residence Services* was the second most reported Level 1 classification, with the majority of comments being positive, reflected in the Level 2 classification of *Suitable Facilities*.

This is an interesting outcome. Many of the sites are not 'built for purpose', but rather regular houses that have been converted to accommodate the requirements of Day Options programs. However, what has been evident in the reports is that in most circumstances modifications have enhanced opportunities available to clients.

*There is good access and the house layout is good. There is a relaxation room, art room, a good size kitchen and a big family room at the back with big doors to the backyard with wheelchair access.*

*There are plans to utilise the shed as an additional program area which would be very beneficial.*

*The Community Centre is very suitable for the day option program. It is clean, tidy, open and easily accessible. It is well equipped with resources for personal care and entertainment. The surrounding grounds are well maintained and there are a number of areas that can easily accommodate outdoor activities for the group.*

However, issues relating to the suitability of facilities were represented in comments such as the following:

*The house is quite small and accessibility either entry/exit and room to room was observed to be difficult for two of the clients using wheelchairs. Entry is more accessible through the back door, the front does not have a ramp so wheelchair access is awkward and requires assistance. The clients using wheelchairs and walkers were unable to move with ease or without support/assistance due to the lack of space and number of people crowded into a small space.*

*There is only one toilet available for clients to use and the sensory room is no longer in use because of the need to accommodate a large number of clients into the facility. The front entrance to the facility as well as other areas within the building do not provide easy wheel chair access.*

This section also registered issues in the classifications of *Hygiene and Personal needs* and *OHWS*. Clients attending Day Options programs have a range of support requirements up to and including full support for personal care. While the clear majority of settings were ensuring adequate staffing levels and facilities to properly meet these needs, when this issue was raised in reports concerns expressed about privacy provision in some settings as well as clients not being provided with an appropriate level of personal care. Comments below illustrate such concerns:

*A notable exception was toilet access. Significantly (and somewhat disturbingly) only two clients can access the ablution area. The rest of the clients, presumably, soil their under-garments until they return to their accommodation. One client was distinctly odorous. Clients are present in the room for approximately 6+ hours and have travel time to and from the Centre. This means that for 4 of the residents, their toilet needs are not attended to for many hours.*

*An area of most concern was a second toilet area within the original laundry room, adjacent to the outside back veranda/deck area. This area was distinctly unpleasant with a strong smell of urine. There were mops and cleaning equipment standing in the laundry troughs and it was a cold and unpleasant area for carrying out personal care of any kind.*

Individual issues of concern are followed up with the organisation. Additionally, as a result of these findings, the CVS amended its reporting tool to contain specific questions regarding toileting provision, particularly for those clients requiring total support for personal care.

A key point that has become evident through visiting Day Options programs is the importance of communication between the accommodation sites and the programs when seeking to ensure the most appropriate and comprehensive care for the clients.

*OHWS* has most commonly been commented on with regard fire safety, particularly in light of the fact that the majority of settings were not 'built for purpose'. The CVS is not suggesting that required codes are not being complied with. However, the nature of the programs coupled with the numbers of people utilising the facilities whom live with physical disabilities inherently makes this a focus area.

*The design of the facility and its unfriendly layout for wheelchair access make it a potential hazard if a fire did occur.*

It is pleasing to note through reports that Day Options programs address this issue through practicing emergency evacuations with their clients and the development of PEEP plans, as referenced in the comment below:

*As an aspect of continuous improvement, the on-duty team leader advised that he would like to consider personal emergency and evacuation plans (PEEPs) for every person with a disability requiring assistance to evacuate.*

## 5.4 Communication

The level 2 classifications of *Resident and staff interactions/respectful communication* and *Staff responsiveness* represented the clear majority of comments, all of which were positive. A small number of issues were noted in the classification *Inadequate information*.

The reports consistently presented positive feedback with regard staff and client inter-relationships, commenting on the professional and respectful way in which staff related with the clients. Supporting this in some instances was the low turnover of staff which enabled an understanding of individual clients to be established over time and a sense of trust and safety to be generated for the clients. Individualised responsiveness was much more likely to be the result of this kind of environment.

It was also apparent from reports that some organisations created different program structures over different days to better meet the varied needs of the clients. Further, some larger organisations with multiple sites had a different focus at different sites. This addresses various considerations such as age range, gender balance, support requirements and individuals' interests and capacity.

*The participants had a range of skills in this program, some were physically able to do many of the tasks independently, others could do with direct assistance while others were happy to observe but were included in conversations and repeated invitations to get involved. The staff worked really well together and their supportive mentoring and encouragement to participants was great to witness.*

*One staff member is learning Vietnamese in her own time and at her own cost and this is helping all staff talk with a regular Vietnamese client*

*They have a weekly schedule of activities, individual plans made after consultation with clients and carers, a Family Liaison Committee, open days for potential future clients, newsletters, a Facebook page and website, and written diaries, which go home with each client*

The classification of *Inadequate information* contained issues only. All of these were brought forward by staff with regard communication processes between the accommodation site and the Day Options program.

All clients have a communications book that travels with them between their accommodation site, and/or their family and the program. As its title suggests, it contains relevant information regarding the client such as health considerations, behavioural and emotional concerns, etc. When used as intended it ensures that clients are best positioned to receive seamless, informed and consistent support.

However, staff have highlighted that this does not always occur which can create health and behavioural issues demonstrated by the following comment:

*Staff spoke about a recent fall and miscommunication contributed to this adverse event. Apparently, the accommodation support staff did not communicate via the Participant Profile document or any other method that the client must not be left unattended whilst on the toilet and that the client needs a gluten free diet.*

*If the service is not aware as to a client's requirements, it can be difficult to support them adequately. An example cited related to a client who has a tendency to abscond. After an incident, parents mentioned that it had occurred in the past however they had not disclosed it because they were concerned their son would not be accepted. Had the organisation been aware, from the outset they would have arranged for funding to support him by having two staff present at all times for activities with which he was involved.*

## 5.5 Rights and responsibilities

The Level 2 classifications with primary representation in this section are *Least restrictive practice* and *Family /Guardian involvement and Dignity and respect* with all but one comment being positive.

*Least restrictive practice* was the primary classification represented. There appeared to be very genuine efforts being made to address this issue and find the least restrictive practice in any given situation. Some organisations had moved more towards a 'behavioural management' protocol and employing diversional strategies.

A number of practices raised in reports were identified to be 'therapeutic or safety practices' rather than restrictive in and of themselves. Reports indicated that relevant documentation was in place when necessary.

Examples of comments relating to this classification are provided below:

*The only restrictive practice we were informed of was that one client had gloves put on her hands during her travels in Access Cabs. It was explained that the client was anxious during travel and tended to scratch herself. There were clear instructions to remove the gloves upon arrival.*

*CVs spoke with staff about restrictive practices. Their approach is to support clients so they recognise their own feelings of things going wrong or "yucky feelings", and take themselves off to a quiet room ... for whatever time they require. One client has a tendency to scratch herself and the organisation has a letter and mittens provided by parents. Staff prefer measures such as clothing with long sleeves and other diversionary methods to avert the use of mittens. Two other clients have a tendency to wander into the car park area and doors are locked when they are in a certain area to prevent them from doing so. There is an electronic gate at the driveway entrance which is usually closed and locked to prevent clients from wandering (and to prevent others from coming onto the property).*

One agency noted that they had been working with Professor Richard Bruggeman, the Senior Practitioner Department for Communities and Social Inclusion (DCSI) to clarify and confirm any issues in the finalisation of their restrictive practice policy and procedure.

It was clear from reports that the involvement of family and guardians is prioritised across Day Options programs. There were multiple examples of family events, the participation of family in the creation of care plans and activity plans and clear communication pathways in place between the programs and families. This is demonstrated by the following comments:

*The CVs met a consumer's mother and she spoke very highly of all the staff, carers and consumers, explaining that her son had flourished and gained confidence since attending. She explained families were encouraged to be involved and that staff were very accessible if required. Her son was socialising and expressing himself with other consumers and loved the activities and had formed friendships. She emphasised that continuity of staff was vital to her son's success.*

*The activities program is well developed and involves the participants and their respective families and/ or carers in decisions of what to attend*

## 5.6 Access

Transport received most comments in this section. While the majority were positive, some issues were also raised. Service availability also featured with a mix of positive comments and concerns.

Most of the comments relating to transport were positive. Particularly with regards larger organisations, vans/ buses were readily available both for transport of clients to and from the program and for community based activities. When this is not the case the range of activities available to clients is limited and alternative arrangements need to be made by the individuals for transport to and from the program.

Another issue related to transport pertains to the length of time that some clients travel to and from the program they attend. Depending on the number of pickups along the way, some clients could be travelling for an hour or more to get to the program. This is not seen as ideal particularly when considered in light of the additional level of personal support some clients require.



The following comments refer to this range of considerations:

*The Centre has its own dedicated vehicles (mini buses) which are used for outings and activities transporting clients as required, with some pickups and drop offs each day. Others clients are dropped off by their parent or guardian.*

*There are vacancies at the Community Options Centre but the obstacle for some parents is considered to be the lack of transport to and from the Centre. Currently taxis are the main means of transport as the Centre does not have access to vehicles*

*This is regarded as a fortnightly 'centre-based service' as they do not have access to a vehicle (clients transported to and from by taxi/bus arranged by family/accommodation provider), Access to a vehicle (requires two vans and extra staff) would allow joining in with other centres' outings to provide socialisation opportunities.*

Service availability was also represented within this Level 1 classification. Transport - as demonstrated in previous examples - and the NDIS were identified as having the main impact on service availability. On occasion finances were mentioned as also influencing access to services, primarily thought the additional costs that might be incurred through the activity itself or the costs associated with the required additional staff. However, as was also noted, collaboration between organisations could also potentially increase opportunities for clients.

Staff expressed concerns regarding the impact that NDIS may have on the activities currently being provided. The following comments illustrate these observations:

*There was a concern about NDIS in that it did not approve as a therapy, dancing and music when it is one of the more important activities that offer clients the opportunity to develop social skills, friendships, physical activities, meaning, manual skills through instruments playing, stress relief, positive environment for clients*

*On leaving after the visit, what seemed like a similar program for about 10 more able clients, was seen operating in the sports stadium. Collaboration may provide extended socialisation options*

*Staff reported that the funding is mainly from applying for grants and some from self-funding. Funding uncertainty relating to NDIS is one of the key challenges faced by the organisation.*

*Clients are funded from a variety of sources, and NDIS is expected to become a major factor over the next year or so*

*The organisation is being proactive and have provided their clients with an itemised quotation for the service provided. The quotation can be used as the basis of a support plan.*

## 5.7 Issues and challenges impacting Day Options programs

The CVS recognises that there are a number of issues and challenges affecting Day Options programs and these have been identified in a 'Day Options Issues Document'. As this is the first year that the Scheme has been visiting Day Options programs it is anticipated that additional issues are likely to emerge over time.

### 5.7.1 NDIS

The advent of NDIS is an unknown at this stage as to the impact it will have on Day Options programs as they currently exist. It is impossible to tell how many new providers will enter the space, how many current providers may exit and how this will effect individuals' accommodation and program choices.

This clearly has the potential to impact CVS particularly in relation to the number of visits conducted within the sector. It is conceivable that some programs will be conducted from private homes potentially with possibly only one or two clients so clarity will be required as to what in fact constitutes a Day Options program for the purpose of CVS visitation and inspections.

The *Disability Inclusion Bill 2017* and the *Disability Services (Community Visitor Scheme) Regulations 2013*, both of which recently undertook a consultation process, will influence this.

### Recommendation

1. That the CVS canvas the process by which it can best monitor the number of registered Day Options providers to which it will provide visitation and inspection.

### 5.7.2 Communication between accommodation sites and Day Options programs

Increased observation on the quality of care provision to those with disabilities was one of the initial anticipated benefits of incorporating the Day Options component of the Scheme. Provision to achieve this is supported by the Scheme's undertaking visits to both accommodation and Day Options sites.

Staff at Day Options programs have noted that on occasion accommodation sites and / or family have not provided them with comprehensive information relating to a client's behaviour or health considerations. This negatively impacts the programs' capacity to provide appropriate and informed support both for the particular individual as well as those clients already in attendance and potentially poses significant risks.

The issue of provision of out of date documentation and individual support plans has also been raised in disability accommodation reports. CVS has raised the issue with the relevant organisations and it appears that there has been some reluctance to update plans given the uncertainty of future accommodation arrangements.

This is of concern to the CVS as up to date plans are seen as an important source of information that can assist in the development of accurate and comprehensive packages under the NDIS.

Additionally, the CVS regards interagency communication as critical in ensuring awareness of any instances where clients either arrive at Day Options or at their accommodation in a soiled state.

#### Recommendation

2. That the CVS continue to promote the importance of accurate shared client information between Day Option programs and disability accommodation.

### 5.7.3 Least restrictive practice

Any restrictive practices noted at CVS visits are brought to the attention of the Principal Community Visitor (PCV), with the organisation being contacted to clarify the circumstances and ascertain that appropriate documentation is in place.

However, more consistently, CVS reports have noted that the focus has moved towards behaviour support plans as a way of managing challenging situations and generating an inclusive and proactive approach. Certainly there appears to be a widespread and genuine intention across Day Option programs to move away from the use of restrictive practices.

Requirements for the establishment of behaviour support plans are underpinned by *The Restrictive Practices Reference Guide for the South Australian Disability Services Sector* which was recently launched by the Senior Practitioner DCSI, Professor Richard Bruggemann.

The CVS recognises the importance of this document in providing clear and concise direction in the reduction of the use of restrictive practices.

#### Recommendation

3. That the CVS continue to champion the reduction and removal of restrictive practices and promote the development of behaviour support plans within Day Options programs.

### 5.7.4 Current Day Options model

The current Day Options model is based on clients travelling to a particular site where they spend the day with varying numbers of other people and attend community based activities.

Historically, individuals were only able to attend Day Options or supported employment. This inherently limited the potential for a person to generate opportunities that were individualised and skill enhancing. Further most would attend the same Day Options program each day. It has been interesting to learn that there are more individuals combining different activities throughout the week including work and attending different Day Options programs depending on the activities.

While the CVS has seen many examples of dedicated and professional staff and innovative programs in its first year of visits and inspections, the current model does not reflect how most people live and raises the question of how this may change with the advent of NDIS.



Can opportunities be created whereby individuals are able to spend time both at home and in the community participating in pursuits of their choosing and thereby reflecting a more accurate life rhythm?

#### **Recommendation**

4. That the CVS promote the development of Day Options models that are readily individualised and provide for opportunities that occur both at home and in the community, thereby more accurately reflecting a natural life rhythm.

#### **5.7.5 Transport**

The CVS recognises that transport is an important consideration within Day Options programs from a number of perspectives. Adequate transport options are necessary to ensure access to community activities and the drop off and pick up of clients. Larger organisations usually have sufficient transport arrangements while smaller organisations find this more challenging. Limited transport can impact an organisation's capacity to include additional clients as well as the range of activities that can be offered.

Concerns have been raised by organisations in particular with regard NDIS and the lack of certainty as to how transport costs will be met when incorporating a range of individualised packages. Uncertainty has also been expressed with regard continuation of the current SA Transport Subsidy Scheme (SATSS) past July 2019 for example, as this currently provides additional transport assistance.

The CVS is also aware that some clients travel for long periods of time to attend a Day Options program. This is largely dependent on how many people are being picked up and where a person is located within that itinerary. While some organisations have stated that they aim to not have anyone travelling for longer than an hour that is still a long time particularly when considered that it occurs on a daily basis. This can be further complicated if a client has high level personal care support requirements.

#### **Recommendation**

5. That the CVS continue to monitor this issue and advocate for the importance of adequate transport provision within the NDIS

#### **5.7.6 Hygiene and personal care requirements**

Clients attending Day Options programs have a range of support requirements up to and including full support for personal care. The CVS regards this as a priority area and has made amendments to the reporting process to ensure its specific consideration at every visit.

Organisations are required to have appropriate resources for clients needing full personal care support. Further, it is critical that both the Day Options program and disability accommodation maintain awareness of any instances of clients being left soiled and unattended.

Awareness of the impact of extended transport time on clients requiring full personal support needs to be maintained by organisations.

#### **Recommendation**

6. That the CVS continue to monitor and promote this as a priority area.

## 6. Workforce

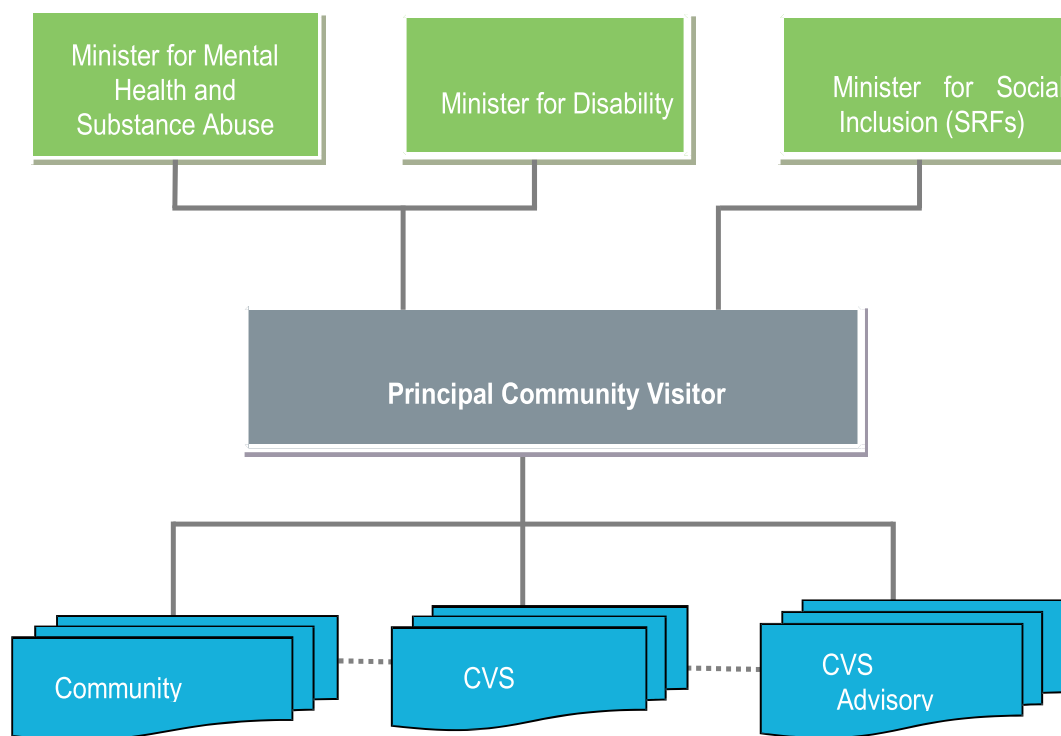
### 6.1 Governance of the Community Visitor Scheme

The Principal Community Visitor (PCV) and Community Visitors are independent statutory appointments by the Governor of South Australia. The PCV reports to the Minister for Mental Health and Substance Abuse on matters related to the Scheme's functions under the *Mental Health Act, 2009*; the Minister for Disability on matters related to the Scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations, 2013* and the Minister for Social Inclusion on matters relating to Supported Residential Facilities.

Amalgamation of the Ministerial portfolios of Disability and Mental Health and Substance Abuse under Minister Vlahos created a unique opportunity to discuss and progress Comorbidity issues.

The independence of the CVS is integral to the program, enabling patients/residents, carers and family members to speak with individuals who are not associated with the provision of support and services.

An Advisory Committee provides strategic advice and support to the PCV, monitors and evaluates the CVS, and contributes to strategic networks and relationships.



Effective 1 July 2014, the Community Visitor Scheme is auspiced by the Department for Community and Social Inclusion (DCSI) for administrative purposes only.

## 6.2 Staff of the Community Visitor Scheme

Following is a list of paid staff members who worked either full or part time in the Community Visitor Scheme Office during the 2016-17 reporting period:

<b>Principal Community Visitor</b>	Mr Maurice Corcoran AM
<b>CVS Manager</b>	Mr John Alderdice
<b>Mental Health CVS Coordinator</b>	Ms Connie Migliore
<b>Disability CVS Coordinator</b>	Ms Michelle Egel
<b>SRF CVS Coordinator</b>	Ms Karen Messent
<b>Recruitment and Training Officer</b>	Ms Leanne Rana
<b>Project Support Officer</b>	Ms Rondelle Oster
<b>Administration Officer</b>	Ms Lisa Margrie & Mr Micah Mango

## 6.3 Advisory Committee

The members of the Advisory Committee during 2016-2017 were:

Ms Anne Burgess	Chairperson – The CVS Advisory Committee
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Niki Vincent	Equal Opportunity Commissioner/Public Advocate
Ms Anne Gale	Public Advocate
Mr Steve Tully	Health and Community Services Complaints Commissioner
David Christley	Interim SA Mental Health Commission

### Mental Health Representatives:

Dr Aaron Groves	Chief Psychiatrist and Director Mental Health Policy
Ms Carol Turnbull	Private Mental Health Services Representative
Mr Ben Sunstrom	Manager, Legislation and Policy – Office of Chief Psychiatrist
Mr Jason Cutler	Consumer Representative
Ms Julia McMillan	Carer Representative
Ms Joan Cunningham	Community Visitor Representative
Ms Marianne Dahl	Community Visitor Representative (Proxy)

### Disability Representatives:

Mr David Caudrey	Executive Director, Disability SA
Mr Richard Bruggemann	Senior Practitioner, Disability SA
Ms Sandra Wallis	Government Disability Accommodation Representative
Ms Narelle Jeffery	Non-Government Disability Accommodation Representative
Mr Geoff O'Connell/Kris Maroney	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Ms Ann Rymill	Disability Community Visitor Representative

## 7. Conclusion

The Community Visitor Scheme has again been successful in achieving its objectives. While it was able to meet its legislative requirement to visit all treatment centres once per month and managed to visit all SRFs and Day Options operating within the State, the recruitment of sufficient volunteer community visitors to achieve the target of visiting every disability group home (over 600) twice per year has not been reached thus far.

Our improved more robust process of tracking and following up every issue raised in reports has delivered many positive outcomes for individuals and their families. There has already been improvement in some of the more long term systemic issues such as outdated lifestyle/person centred plans and it is anticipated with the ongoing transitioning to the NDIS this will continue to improve.

There have been significant learnings gained by the CVS from the Oakden enquiry and especially the ICAC investigation that examined how and when the CVS escalated issues of concern to Ministers or senior officers within the Northern Adelaide Local Health Network (NALHN). This has also highlighted the importance of our monitoring of issues raised through visits and it has been an area that I am very proud to say has been significantly improved over the past 2 years through our internal and external processes that communicates issues to service providers and seeks responses.

We have also increased the number of unannounced visits we do to facilities where there has been concerns flagged or even where CVs had a 'gut-feeling' that something was not right.

### 7.1 Future steps of the South Australia Community Visitor Scheme

The new *Mental Health (Review) Amendment Bill, 2015* has been enacted and plans are already in place to commence visits to Mental Health Community Centres and Mental Health Rehabilitation Centres in South Australia. These visits will be done in addition to the existing visits and inspections of all Mental Health Treatment Centres.

Implementation of the NDIS is having a significant impact across all the service streams. From a mental health perspective the delayed intake of those with psycho social disabilities until 2018 will create challenges during these transitional years and it will be incumbent on the CVS to refer issues of concern to the appropriate committees, forums or meetings. As example, the challenges of finding discharge options already identified in this report will be further exacerbated should roll out of the NDIS accommodation model result in closure of SRFs.

### 7.2 Community Visitor workforce

The targeted recruitment of community visitors in regional areas has continued with mixed results. The Riverland is now well serviced with 4 visitors in that region. Over the 12 months, recruitment in the Whyalla and Mt Gambier regions has gone through both positive and challenging periods. As indicated above, the capacity to build the number of active community visitors above the 50 mark has proved challenging and therefore further strategies to build the workforce will need to be considered. The CVS will continue its endeavouring to recruit Community Visitors from an indigenous background.

### 7.3 Development of a new CVS information management system

The Community Visitor Scheme has had in place an ITC system to provide a centralised place for the CVS to access personnel information pertinent to the management of Community Visitors and to record information about the location and regions of disability houses, Support Residential Facilities and Day Options providers, as well as information about all mental health treatment centres and community mental health providers.

During this reporting period the system has been further developed to manage the coordination and recording of visits including the matching facilities to Visitors based on their location.

### 7.4 Implementation of focus projects

During the 2015-2016 reporting period, the Community Visitor Scheme Advisory Committee commenced the process of focussing on an element of service delivery for a period of time with treatment and care plans an example of a

successful review. Preparation for these reviews provides an opportunity to deliver further training to Community Visitors and expand their knowledge of daily practices in both the disability and mental health sectors.

During the 2017-2018 reporting period, the CVS aims to implement further focus projects to investigate other issues pertinent to the disability and mental health sectors regarding themes identified in this current and previous annual reports. The focus projects will provide information regarding current practices, development areas and barriers experienced by service providers to support clients. Potential focus projects could include activity programs and gender safety.

## 7.5 Recommendations

Throughout sections 3 to 5 of this report a range of significant issues that have emerged have been discussed and attempts to arrive at a set of recommendations as a means of continuous improvement reached. These are recommendations from the Principal Community Visitor alone and do not necessarily represent views of the CVS Advisory Committee or the collective views of Community Visitors.

## 8. Glossary

Acronym	Definition
ABF	Activity Based Funding
AGD	Attorney General's Department
AMHS	Area Mental Health Services
APY	Anangu Pitjantjatjara Yankunytjatjara
ATSIMHSPAG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CBIS	Community Based Information System
CCTV	Closed Circuit Television
CEO	Chief Executive Officer
CLCA	Criminal Law Consolidation Act
COAG	Council of Australian Governments
CTO	Community Treatment Order
CV(s)	Community Visitor(s)
CVS	Community Visitor Scheme
DASSA	Drug & Alcohol Services South Australia
DCS	Department of Correctional Services
DCSI	Department for Communities and Social Inclusion
ECH	Elderly Home Care
ED(s)	Emergency Department(s)
FFT	Fitness for Trial
FO	Forensic Orders
HCSCC	Health and Community Services Complaints Commissioner
ICCs	Intermediate Care Centres
ICT	Information and Communication Technology
IHPA	Independent Hospital Pricing Authority
IT	Information Technology
ITO(s)	Involuntary Treatment Order(s)
JNH	James Nash House – Forensic Facility
KOB(C)	Kenneth O'Brien Centre
KPI	Key Performance Indicator
MHS	Mental Health Service
NALHN	Northern Adelaide Local Health Network
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NHPA	National Health Performance Authority



Acronym	Definition (cont)
NMHC	National Mental Health Commission
NRT	Nicotine Replacement Therapy
NSW	New South Wales
OACIS	Open Architecture Clinical Information System
OCP	Office of the Chief Psychiatrist
OPA	Office of Public Advocate
OT	Occupational Therapy
OHW&S	Occupational Health, Welfare and Safety
PCV	Principal Community Visitor
PECU	Psychiatric Extended Care Unit
PICU	Psychiatric Intensive Care Unit
QLD	Queensland
RSL	Returned and Service League
S269 Clients	Section 269 of the Mental Health Act, 2009
SA	South Australia
SA&NT	South Australia and Northern Territory
SASP	South Australian Strategic Plan
SICC	Southern Intermediate Care Centre
SRF	Supported Residential Facility
SSU(s)	Short Stay Unit(s)
TAFE	Technical and Further Education
TSI	Torres Strait Islander
UNCRPWD	United Nations Convention on the Rights of Persons with Disabilities
VMIAC	Victorian Mental Illness Awareness Council Australia
VSA&NT	Volunteering South Australia and Northern Territory

## 9. Appendices

### Appendix 1: Disability Services (Community Visitor Scheme) Regulations, 2013

These Regulations are to be read in conjunction with Subsection 50 – 54 of the *Mental Health Act, 2009*.

Under the *Disability Services Act, 1993*

#### 1—Short title

These regulations may be cited as the *Disability Services (Community Visitor Scheme) Regulations 2013*.

#### 2—Commencement

These regulations come into operation on the day on which they are made.

#### 3—Interpretation

In these regulations, unless the contrary intention appears—

**Act** means the *Disability Services Act, 1993*;

**Community Visitor** has the same meaning as in the *Mental Health Act, 2009*;

**Disability Accommodation Premises** means any premises at which a disability services provider is providing accommodation services to persons with disabilities;

**Principal Community Visitor** has the same meaning as in the *Mental Health Act, 2009*;

**Resident** means a person with a disability who resides at disability accommodation premises.

#### 4—Functions of Community Visitors

- (1) Community Visitors have the following functions under these regulations:
  - (a) to visit disability accommodation premises to inquire into the following matters:
    - (i) the appropriateness and standard of the premises for the accommodation of residents;
    - (ii) the adequacy of opportunities for inclusion and participation by residents in the community;
    - (iii) whether the accommodation services are being provided in accordance with the principles and objectives specified in Schedules 1 and 2 of the Act;
    - (iv) whether residents are provided with adequate information to enable them to make informed decisions about their accommodation, care and activities;
    - (v) any case of abuse or neglect, or suspected abuse or neglect, of a resident;
    - (vi) the use of restrictive interventions and compulsory treatment;
    - (vii) any failure to comply with the provisions of the Act or a performance agreement entered into between a disability services provider and the Minister;
    - (viii) any complaint made to a Community Visitor by a resident, guardian, medical agent, relative, carer or friend of a resident, or any other person providing support to a resident;
  - (b) to refer matters of concern relating to the organisation or delivery of disability services in South Australia to the Minister;
  - (c) to act as advocates for residents to promote the proper resolution of issues relating to the care, treatment or control of residents, including issues raised by a guardian, medical agent, relative, carer or friend of a resident or any person who is providing support to a resident.

- (2)A Community Visitor may, for the purposes of carrying out the functions of a Community Visitor, enter disability accommodation premises at any reasonable time and, while on the premises, may—
- (a) meet with a resident; and
  - (b) with the permission of the manager of the premises—inspect the premises or any equipment or other thing on the premises; and
  - (c) request any person to produce documents or records; and
  - (d) examine documents or records produced and request to take extracts from, or make copies of, any of them.

## **5—Requests to See Community Visitors**

- (1) A resident or a guardian, medical agent, relative, carer or friend of a resident or any person who is providing support to a resident may make a request to see a Community Visitor.
- (2) If a request is made under sub regulation (1) to a manager of, or a person in a position of authority at, disability accommodation premises that person must advise a Community Visitor of the request within two days after receipt of the request.

## **6—Reports by Community Visitors**

- (1) After a visit to disability accommodation premises, the Community Visitors must (unless one of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (2) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the Community Visitors under these regulations during the financial year ending on the preceding 30 June.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the Community Visitor's functions.
- (4) The Minister must, within six sitting days after receiving a report under this regulation, have copies of the report laid before both Houses of Parliament.

## Appendix 2: Mental Health Act, 2009 Division 2 — Community Visitor Scheme

### 51—Community Visitor's Functions

- (1) Community Visitors have the following functions:
  - (a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;
  - (ab) to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division;
  - (b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;
  - (c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;
  - (d) any other functions assigned to Community Visitors by this Act or any other Act.
- (2) The Principal Community Visitor has the following additional functions:
  - (a) to oversee and coordinate the performance of the Community Visitor's functions;
  - (b) to advise and assist other Community Visitors in the performance of their functions, including the reference of matters of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;
  - (c) to report to the Minister, as directed by the Minister, about the performance of the Community Visitor's functions;
  - (d) any other functions assigned to the Principal Community Visitor by this Act or any other Act.

### 51A—Delegation by Principal Community Visitor

- (1) The Principal Community Visitor may delegate a power or function of the Principal Community Visitor under this Act to another community visitor.
- (2) A delegation under this section—
  - (a) may be absolute or conditional; and
  - (b) does not derogate from the power of the Principal Community Visitor to act in a matter; and
  - (c) is revocable at will by the Principal Community Visitor.

### 52—Visits to and Inspection of Treatment Centres

- (1) Each treatment centre must be visited and inspected once a month by two or more Community Visitors.
- (2) two or more Community Visitors may visit a treatment centre at any time.
- (3) On a visit to a treatment centre under subsection (1), the Community Visitors must—
  - (a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and
  - (b) so far as practicable, make any necessary inquiries about the care, treatment and control of each patient detained or being treated in the centre; and
  - (c) take any other action required under the Regulations.
- (4) After any visit to a treatment centre, the Community Visitors must (unless one of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the Community Visitors think appropriate.

- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.
- (7) A Community Visitor will, for the purposes of this Division—
  - (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act, 2008*; and
  - (b) be taken to be an inspector under Part 10 of the *Health Care Act, 2008*.

## **52A—Visits to and inspection of authorised community mental health facilities**

- (1) **An authorised community mental health facility—**
  - (a) must be visited and inspected at least once in every 2 month period by 2 or more community visitors; and
  - (b) may be visited at any time by 2 or more community visitors.
- (2) However, the Principal Community Visitor may visit an authorised community mental health facility alone at any time.
- (3) On a visit to an authorised community mental health facility, a community visitor must—
  - (a) so far as practicable, inspect all parts of the facility used for or relevant to the care, treatment or control of patients; and
  - (b) take any other action required under the regulations.
- (4) After any visit to an authorised community mental health facility, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.
- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.

## **53—Requests to See Community Visitors**

- (1) A patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act may make a request to see a Community Visitor.
- (2) If such a request is made to the director of a treatment centre in which the patient is being detained or treated, the director must advise a Community Visitor of the request within two days after receipt of the request.

## **54—Reports by Principal Community Visitor**

- (1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the Community Visitors during the financial year ending on the preceding 30 June.
- (2) The Minister must, within six sitting days after receiving a report under subsection (1), have copies of the report laid before both Houses of Parliament.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the Community Visitor's functions.
- (4) Subject to subsection (5), the Minister must, within two weeks after receiving a special report, have copies of the report laid before both Houses of Parliament.
- (5) If the Minister cannot comply with subsection (4) because Parliament is not sitting, the Minister must deliver copies of the report to the President and the Speaker and the President and the Speaker must then—
  - (a) immediately cause the report to be published; and
  - (b) lay the report before their respective Houses at the earliest opportunity.
- (6) A report will, when published under subsection (5)(a), be taken for the purposes of any other Act or law to be a report of the Parliament published under the authority of the Legislative Council and the House of Assembly.

## Appendix 3: Visit and Inspection Prompt (Disability)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit disability accommodation premises to inspect premises and consult with residents, staff and relevant others to ensure that people with disabilities are receiving appropriate accommodation.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the 'Disability Services Standards'. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction of the 'Community Visitor Scheme Visit and Inspection Protocol'.

### Prompts to Observe and note at Visits and Inspections of Disability Premises

<b>Customer Service</b>	Assess the welcome to the facility and introductions to residents and staff. Personal and respectful interactions between staff and residents/CVs. Adequate and accurate information provision about resident's rights and entitlements.
<b>Environment</b>	How does the place feel e.g. warmth, private and personalised spaces for clients? Are resident's rooms and amenities reasonable e.g. sufficient space, clean, temperature controlled, with well-maintained equipment and furnishings? Are residents happy with their food and is there a menu plan that residents have been consulted on and reflects their preferences and dietary requirements? Sufficient provision for space for residents to spend time in, participate in a range of activities as well as conduct confidential conversations with Visitors. Are resident's personal care and hygiene needs being met? Is the facility designed in a manner that is accessible, allows easy movement throughout including access to bathrooms, kitchen, cooking and cupboards?
<b>Rights</b>	Do clients feel they (and their carer, family member or other supporter) are being involved in decisions about the accommodation services? Do clients feel safe and is there consideration towards gender safety? Are clients provided with access to advocacy and legal representation?
<b>Access to Information</b>	Is there sufficient information provided to residents and do they have access to appropriate assistance to be able to understand the information about services offered, the CVS and other agencies that could support or advocate for them? Do residents whose first language is other than English or who are unable to read, have sufficient access to alternative formats or supports including interpreters? Are residents or CVs provided with access to medication records, behaviour and support plans when appropriate?
<b>Activity/Entertainment Provisions</b>	Are the independence and training needs of residents being met? Are residents being assisted to obtain and maintain suitable employment? Is there provision for entertainment for residents e.g. television, exercise equipment, board and electronic games? Are activities provided at the facility e.g. music therapy, art and craft, cooking and walking groups? Have the residents been asked what outside activities they enjoy and are they provided with sufficient opportunities to take part in such activities?
<b>Treatment and Care</b>	Do residents feel engaged in their personal support plans, treatment and care? Do residents feel they are being treated in the least restrictive manner? Are there any restrictive practices e.g. people locked in their rooms, people restrained in wheelchairs, tied up, doors locked, lack of access to parts of the building, locked refrigerators, inappropriate control by staff? If there are any restrictions, is there documentation that demonstrates the appropriate processes have been followed i.e. that there had been an investigation of less-restrictive alternatives, the development of a behaviour support plan with, appropriate consents. There is a review date and considerations as to whether other people were also affected by the practices (e.g. a locked door for a person with a plan will also affect all other residents). Is there a personal support plan for each resident and if so, how frequently are they reviewed?
<b>Grievances</b>	Do residents feel they are safe to make a complaint if need be and free from any reprisals or threats to be evicted? Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?



## Appendix 4: Visit and Inspection Prompt (Supported Residential Facility)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit Supported Residential Facilities (SRFs) to inspect premises and consult with residents, staff and relevant others to ensure that the residents are receiving appropriate accommodation and services.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the *'Supported Residential Facilities Regulations, 2009'*. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction of the 'Community Visitor Scheme Visit and Inspection Protocol'.

### Prompts to observe and note at Visits and Inspections of Supported Residential Facilities

<b>Customer Service</b>	<p>Assess the welcome provided to the facility and introductions to residents and staff</p> <p>Ensure a Visitors' Book is displayed and CVs are to sign in – and out on completion of the visit</p> <p>Are there personal and respectful interactions between staff and residents/CVs?</p> <p>Was prior notification of the visit provided to residents?</p>
<b>Environment</b>	<p>What is the general atmosphere of the SRF?</p> <p>How many residents live at the SRF?</p> <p>Consider residents' rooms – are they single or shared; secure; private; clean with adequate space; a comfortable temperature with well-maintained equipment &amp; furnishings?</p> <p>Are the grounds well maintained and usable?</p> <p>Are residents consulted about the menu plan? Is it nutritious and does it reflect their preferences and dietary requirements? Do the residents have free access to water?</p> <p>Is there provision of space for residents to spend time in and participate in a range of activities as well as conduct confidential conversations with CVs or other service providers?</p> <p>Is there appropriate heating and cooling options within the SRF?</p> <p>Is there provision of sufficient bathrooms that are clean and private &amp; laundry and drying facilities?</p>
<b>Rights</b>	<p>Is there provision of accurate information regarding resident's rights and entitlements and appropriate services?</p> <p>Are residents (and when appropriate, support person) involved in decisions about their care and accommodation?</p> <p>Have residents received a copy of the SRF Prospectus and their Contract and Service Plan?</p> <p>Do residents feel safe and is the SRF mindful of gender safety?</p>
<b>Access to Information</b>	<p>Is information provided to residents about available services and how to access them? Are residents aware of the CVS and other agencies that could support or advocate for them?</p> <p>Are alternative supports made available for residents whose first language is not English, and for those residents with low literacy skills?</p> <p>Are residents or CVs provided with access to medication records and service plans when appropriate?</p>
<b>Activity/Entertainment Provisions</b>	<p>Is there entertainment provided for residents e.g. television, exercise equipment, board and electronic games?</p> <p>Are residents supported and encouraged to access and participate in activities that enhance independence and community engagement?</p> <p>Are activities provided at the SRF e.g. music therapy, art and craft, cooking and walking groups - either by the SRF or an external organisation?</p>
<b>Treatment and Care</b>	<p>Do residents feel engaged in development of their service plan? How often are they reviewed?</p> <p>Do residents feel they are being treated respectfully and in the least restrictive manner?</p> <p>Are there any restrictive practices e.g. people locked in their rooms, doors locked, lack of access to parts of the building, locked refrigerators, inappropriate control by staff?</p> <p>If there are any restrictions, is there documentation that demonstrates the appropriate processes have been followed and that there is a review date and considerations as to whether other people were also affected by the practices. (e.g. a locked door for a person)</p>
<b>Grievances</b>	<p>Do residents feel they are safe to make a complaint and free from any reprisals or threats of eviction?</p> <p>Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?</p>

## Appendix 5: Visit and Inspection Prompt (Day Options Programs)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit Day Options (DOPs) to inspect premises and consult with clients, staff and relevant others to ensure that individuals attending are receiving appropriate services.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the 'Disability Services Standards'. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction with the 'Community Visitor Scheme Visit and Inspection Protocol'.

### Prompts to Observe and note at Visits and Inspections of Disability Day Options Programs

<b>Customer Service</b>	<p>Assess the welcome to the facility and introductions to clients and staff.</p> <p>Are there personal and respectful interactions between staff and clients / CVs?</p> <p>Was prior notification of the visit provided to clients?</p>
<b>Day Options Program Profile</b>	<p>Do you have a theme or focus at your Day Options Program and if so what is it?</p> <p>What would you identify as the key challenges faced by your Day Options Program?</p> <p>What do you consider to be the opportunities and strengths provided by this Day Options Program?</p> <p>How many days a week does this program operate?</p> <p>How many clients attend? Does this vary on different days?</p> <p>Does your program have different themes on different days?</p> <p>What is the age range of your clients? Does this vary on different days? – i.e. some programs focus on particular age groups on particular days.</p> <p>Do you provide both on-site and off-site activities?</p> <p>Does your program have vacancies – or is there a waiting list?</p> <p>What is the cost per client to attend this Day Options program? Do all your clients receive funding to attend your program or are some self-funded?</p> <p>What is the staff ratio?</p> <p>How are clients transported to and from Day Options – and to other Day Options sites?</p>
<b>Environment</b>	<p>Comment on the general environment of the site.</p> <p>Is the size of the site suitable for its purpose? Can clients with wheelchairs or walkers move around easily and readily access all facilities?</p> <p>Is there appropriate heating and cooling?</p> <p>Are there any resources for activities e.g. board and electronic games, television, DVDs, 8 ball etc.?</p> <p>Is it clean and well maintained? Consider all inside areas as well as outside areas.</p> <p>Do all clients bring their own food and drinks or does the program provide this? Alternatively, do clients assist with meal preparation?</p>
<b>Personal Support</b>	<p>Of the clients attending, how many require full or partial assistance with toileting and changing? How many would require two (2) staff for personal assistance?</p> <p>Of the clients attending, how many would require full or partial assistance with drinks and food?</p> <p>What is your protocol for managing a client that becomes unwell during the day or wets and soils themselves?</p> <p>How is medication dispensing managed?</p>
<b>Treatment and Care</b>	<p>Do you have restrictive practices in place? If so, is there paperwork that outlines the need for identified restrictions? Are there any behaviour support plans in place?</p> <p>Do you have an incident reporting tool?</p> <p>Do you have a process in place to communicate back to family or house support staff about issues that arise?</p> <p>Is the program developed in consultation with clients and their families?</p>
<b>Treatment and Care</b>	<p>Do you have a complaints process/procedure? Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?</p> <p>Are clients and their families provided with information about agencies that provide support and advocacy services?</p>

## Appendix 6: CVS Issues Classification Scheme

LEVEL ONE	LEVEL TWO
<b>Rights and Responsibilities</b>	Legal Rights – i.e. Access to Advocacy and Legal Representation Dignity and Respect Personal Safety/Assault/Gender Safety Least Restrictive Practices Privacy and Confidentiality Family/Guardian Involvement
<b>Access</b>	Referral Service Availability Transport Finances Access to Records
<b>Environment and Residence Services</b>	Smoking Provisions Food Hygiene/Personal Needs Suitable Facilities Maintenance of Environment OHW&S Issues
<b>Treatment, Services and Care</b>	Activities and Structured Programs Inadequate Services Care Plan Medication Negligent Treatment Withdrawal/Denial of Services Supporting Independent Living Delay in Provision of Equipment
<b>Grievances</b>	Inadequate/No Response to Complaint Reprisal/Retaliation Inconsiderate Service Privacy and Confidentiality Assault Sexual Misconduct
<b>Communication</b>	Staff Responsiveness Resident and Staff Interactions/Respectful Communication Attitude Inadequate Information