



PRINCIPAL COMMUNITY VISITOR

# Annual Report

DISABILITY SERVICES 2015-2016



THE SOUTH AUSTRALIAN  
**COMMUNITY  
VISITOR SCHEME**



Front cover artwork **Storm over Darling** by Jason Cutler, Mental Health Consumer

*This painting represents a seasonal storm brewing over the otherwise parched Darling River.*

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Hon. Leesa Vlahos, MP  
Minister for Mental Health and Substance Abuse  
Minister for Disability

Dear Minister

In accordance with Regulation 6(2) of the Disability Services (Community Visitor Scheme) Regulations 2013, it gives me great pleasure to submit to you the Annual Report of the Principal Community Visitor 2015-2016 for presentation to Parliament.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2016, in compliance with the Act and the Department of Premier and Cabinet Circular (PCO13) on Annual Reporting Requirements.

Yours sincerely

A handwritten signature in black ink, appearing to read "Maurice Corcoran".

**Maurice Corcoran AM**  
Principal Community Visitor

30 September 2016

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Artwork by Dennis from Minda.

Dennis has been involved in the East End Art sessions for 16 years. Mark Warren is currently mentoring artists in East End and has these reflections of Dennis.

*"I have worked with Dennis for the past five years and in all that time Dennis has had a fascination for using cows as his subject matter when making works of art. His annual trip to the Royal Adelaide Show viewing the animals seems to refuel his imagination and his creative inspiration to make more works of cows. His excitement and joy creating his cow art is endless and long moo it continue."*

Dennis loves to create his cows in two dimensional form using acrylic on canvas and the artwork reflects on the life of Minda at Brighton over the years when cows wandered on the fields at Brighton.

# 1. Introduction

## 1.1 A Message from the Principal Community Visitor

It is with great pride I present this report, which represents the work of the South Australian Community Visitor Scheme (CVS) for 2015 -16. I do so 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 Annual Report of the Principal Community Visitor (PCV), it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

Our Community Visitors are the backbone of the Scheme and, once again have made an exceptional contribution to the CVS throughout this year. They have an extensive range of experience, skills and abilities they bring to the role and work as a collective. As one of our experienced Community Visitors said recently; they “*applied for a job as a Community Visitor and found a community*”. From my perspective, it genuinely feels like a community in the true sense of the word, a community of like-minded, passionate people committed to safeguarding the rights of people living with a mental illness or disability.

The South Australian Government announced the expansion through the 2012 State Budget, and committed \$2.3 million over four years for the establishment of Disability CVS. It provides a visiting, advocacy and inspection service to people living in Disability Accommodation Services, Supported Residential Facilities (SRFs) and more recently, those attending Day Options Programs.

It covers a target population of approximately 2,500 individuals living either in large congregate settings such as Highgate Park, in group homes or in small clusters where individuals live in units alongside others. There are a further potential 907 individuals living in SRFs. Disability CVS has continued to focus on ensuring that the rights, inclusion and participation of people with a disability are being upheld and that our visits are supportive and empower individuals to speak up.

The expansion into Day Options is already proving to be valuable as the CVS is able to obtain further information and intelligence about individuals’ accommodation support from another angle. In some instances, individuals feel more comfortable discussing issues of concern about their accommodation support while they are at Day Options and visa-versa. However, visits to Day Options Programs really only commenced in earnest in the 2016-17 financial year and will be reported on accordingly in next year’s report.

The development of the expanded CVS, has ensured that its location allows for direct, clear, open and transparent reporting methods with the Minister for Mental Health and Substance Abuse and the Minister for Disability.

The legislative framework, namely the *Disability Services (Community Visitor Scheme) Regulations 2013*, have been in place now for three years but are not as effective or as robust as the legislative provisions that are contained in the *SA Mental Health Act, 2009*. This is because they do not provide the same coercive powers to visit facilities without notice but this has not impacted on the CVS in fulfilling its role and I am pleased to report that we have not been prevented from visiting any facility.

In this current reporting period, we have been able to increase the number of visits to enable us to get to nearly all the Government and non-Government managed accommodation services. This work has been undertaken with the guidance of the CVS Advisory Committee and high level engagement and consultation with a range of stakeholders such as accommodation managers and senior managers in government, non-government organisations (NGOs) and private sectors. The CVS has maintained good communication with services in planning and negotiating visits and any follow up required.

When the Scheme expanded into disability accommodation, there was recognition by the previous Minister for Disability, the Hon. Tony Piccolo, that SA Government needed to demonstrate openness by commencing visits into Disability SA facilities that are part of Government services. As the PCV, I also felt it was important to try to prioritise visits to those individuals who were the most vulnerable or most at risk and included those with an intellectual disability, who had little or no means of communicating and had minimal or no family involvement. It was important to prioritise the visits to these people in the first instance and similar criteria has since been used for undertaking visits into NGOs where we have been able to check on their well-being and that they are being supported to achieve their full potential whatever that may be.

The CVS expansion is significant and continues to require considerable planning and organising to schedule visits and

## 1. INTRODUCTION

inspections to the 516 accommodation settings, 87 respite centres and 25 Supported Residential Facilities (SRFs) in South Australia.

I want to acknowledge and thank our Community Visitors (CVs) who have been undertaking visits and inspections to disability accommodation, SRFs and Day Options Programs. We now have 51 Community Visitors in the Scheme and I remain incredibly impressed by the calibre and breadth of skills and experience of the Community Visitor team. During 2015-16, CVs contributed a total of 1,890 hours undertaking Disability visits. The hourly calculation for all visits includes time spent on visits, follow up, travel and writing the reports which equates to an average of 158 hours per month.

We make no apology for having a vigorous screening process for appointing Community Visitors as this is a factor that leads to maintaining such a high standard. Sixteen (16) applicants were recommended for appointment during this reporting period, representing 53.33% of viable applicants. Compared with 2014-15, there was a 3.33% increase in the number of viable applicants going through to appointment.

To those individuals attending Day Options Programs, or living in disability accommodation and SRFs who have welcomed us into their facility or home-space and have spoken to Community Visitors, I say a very big thank you. For the people and families who have raised issues with us and trusted us to follow up and advocate on their behalf, I especially want to acknowledge you as this takes considerable courage, especially when individuals are quite vulnerable due to their specific circumstances.

It would be remiss of me not to acknowledge the staff in accommodation settings who have helped Community Visitors in their orientation to the various facilities and on many occasions, assisted or facilitated communication between our Community Visitors and residents. The challenge of being able to communicate with residents who have little or no verbal communication abilities was a concern of ours but it soon became apparent that objective, sharp observations at the houses between staff and residents would inform us at a range of levels.

I have been able to report to the Minister and senior managers that in general, we have been very impressed with the quality of care provided. Importantly, when we have identified concerns and issues from our visits and raised these with senior managers, the responses from them have been very accepting and positive changes have followed as a means to address our concerns. In a number of instances where we held concerns from initial visits, we then followed up with unannounced visits to determine whether the services had addressed our earlier concerns.

Lastly, to the various staff who have had the opportunity to work in the CVS office in the past year and have negotiated and coordinated these visit arrangements with a range of stakeholders to better enable Community Visitors and myself to undertake our respective roles, thank you. As a coordination and monitoring team, I believe we have made significant progress in the way in which all individual issues raised is tracked and followed up with the respective organisations. It keeps the services and ourselves focused on the resolution of issues and which ultimately results in better outcomes for services users, those we are all here to serve and support.

**Maurice Corcoran AM**



## 1.2 The Context of Disability Services

The establishment of a Disability Community Visitor Scheme (CVS) formed part of the Government's 2012-13 State Budget commitment to protect the rights and wellbeing of people with disabilities who live in disability accommodation or in Supported Residential Facilities (SRFs) in South Australia. This extended the original role of the CVS which was to visit mental health treatment centres. Further expansion to the role of the CVS will occur in the next reporting period, as Community Visitors will commence undertaking visits to Day Options Programs and mental health rehabilitation units and community mental health programs.

Disability affects many Australians. In a population of approximately 24 million people, over 4 million or 16%, report as having a disability resulting from a health condition. 19% of men, and 18% of women have a disability and 43% of people over 55 years of age have one or more disabilities. 2.2 million Australians of working age (15-64 years) have a disability, whilst people with a disability are twice as likely to be in the bottom 20% of gross household incomes.<sup>1</sup>

People with disabilities continue to face significant barriers to being able to participate in everyday life in Australia. These issues have been identified at a national level by reports such as *'Shut Out: The Experience of People with Disabilities and Their Families'*<sup>2</sup> and strategies introduced to improve the quality of life for these people. The aim is to break down some of the barriers so that people with disabilities can be a part of their local community, contributing and growing through involvement in meaningful valued activities, and participating in a network of relationships characterised by acceptance, belonging and love<sup>3</sup>.

As *'Shut Out'* highlights, most people who have a disability have been discriminated against based on their disability and have experienced a general lack of acceptance and exclusion from the community and there is a growing recognition that we need to address this discrimination and exclusion. The Australian and South Australian Governments, as signatories to the United Nations convention on the Rights of Persons with a Disability recognise the need to do this. There has been significant progress at an international, national and state level to develop legislative frameworks and both policy, programs and strategies to better address the needs of those with a disability.

As recently as forty years ago, many people with a severe disability were usually kept quite separate from society in large institutions and attended 'special education' settings. Some of these are still in existence but have much fewer residents. The growth of the Disability Rights Movement has meant that there have been many changes in the understanding of persons with disabilities and there has been a significant shift towards deinstitutionalisation and a 'rights based' approach to disability.

The *Disability Services Act* passed by the Commonwealth in 1986, embraced the conceptual shift from disability being seen as an individualised 'medical problem' to a social problem and the failure of society to adapt and accommodate to the various needs of people with disabilities. This view has increasingly underpinned policy and legislative changes as society is moving from a welfare-based model to a rights based system. Clear and recent examples of this are the United Nations Convention on the Rights of Persons with a Disability, the National Disability Strategy and the National Disability Insurance Scheme.

One of the fundamental rights of members of society is the right to accommodation, which is safe, stable and secure. People with a disability who have high support needs face a number of challenges and risks associated with living in community accommodation; many are reliant on staff for all their personal care.

The expansion of the CVS into disability is an important strategy to independently monitor and report on how individuals are being supported in these accommodation settings and Day Options Programs and how they are supported to reach their full potential, whatever that may be.

1 Australian Bureau of Statistics, Survey of Disability, Ageing and Carers 2012.

2 Shut Out: The Experience of People with Disabilities and their Families in Australia. National Disability Strategy Consultation Report prepared by the National People with Disabilities and Carer Council 2009

3 Ibid

## 1. INTRODUCTION

### 1.3 Data Caveat

This report contains an analysis and presentation of data regarding the South Australian Community Visitor Scheme throughout the 2015-16 reporting period of operation.

Where possible explanatory narrative has been added but interpretation must be informed by context.

### 1.4 Annual Reporting Requirements

The 2015-16 Annual Reporting requirements of the South Australian Department of the Premier and Cabinet outlines the requirements for the content of South Australian Government Annual Reports, within the statutory obligations of any relevant Acts.

Section 12(1) of the *Public Sector Act, 2009* requires that all public sector agencies make an annual report to that agency's Minister. Section 12(3) provides that a public sector agency that is also under another statutory obligation to make an annual report may incorporate those reports.

Accordingly, information regarding the finances, service agreements and workforce of the CVS are contained in the Department for Communities and Social Inclusion Report 2015-16.



The Community Visitors and office staff in attendance at a morning tea at old Parliament House with then Minister Piccolo in recognition of their service and to celebrate International Day of Disability, 3 December.

## 2. Executive Summary

### 2.1 Highlights and Achievements

A highlight of this year's visits and inspections has been the ongoing expansion of the Scheme with nearly all South Australia's group homes now visited. The average number of visits conducted each month has increased by 66% in 2014-15 and a further 45% this reporting period. It has been a significant task establishing relationships with management and staff of the non-government sector, building confidence and respect for the role the CVS can play for the residents they support, and managing any apprehension and anxiety that services may have about how identified poor practice would be managed by the scheme and be reported on.

The CVS also consolidated its communication and interactions with owners and managers of Supported Residential Facilities (SRFs) and continued to build a positive working relationship, demonstrated by the CVS' participation in the Association's Strategic Planning Day in May.

In March this year, an SRF and Day Options Coordinator was appointed and commenced the groundwork for visitation and inspection of Day Options Programs to formally commence in 2016-17. The Department for Communities and Social Inclusion, in partnership with the CVS, organised and facilitated an Information Forum for registered Day Options Program providers in May and consulted them on an implementation strategy and assessment prompt sheet which was piloted in two preliminary visits during June.

It has been great to read through the CVS visit reports and observe the obvious enjoyment and insight that our Community Visitors have obtained from our visits and inspections of disability accommodation, SRFs and Day Options Programs. As a group of Visitors, there is a real sense of feeling privileged and honoured to be able to go out and meet with a whole range of individuals who have a range of quite significant challenges, but who are just getting on with their lives and making the most of opportunities to participate and have a go! CVs get this unique opportunity to meet so many interesting individuals and get a 'snap-shot' into their lives and how service staff are supporting them to reach their full potential.

*"It was a joy to visit both these houses and to see firsthand the results of the professionalism, nurturing and genuine caring of the staff have had on the lives of the residents. The importance of consistency of contact is respected and the results are clear- two houses where people are relaxed, free to make personal choices and be respected. It is a huge 'hats off' to the staff. Thank you"*

*"Staff at this residence have established a truly client centred model of care, highlighting individual choice and independence. Staff are attentive and responsive to changing needs of the ladies as they age. The affection of the staff for the ladies was obvious, and reciprocated, and the overall feeling of the visit was one of a happy, settled house with contented residents. It was a joy to visit"*

### 2.2 Recognition of Community Visitors

Another highlight during this reporting period 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 our key outcomes of monthly inspections and associated reports at a very high level. A number of them have relayed to the office how much they appreciate being involved, with examples of their feedback below.

*"Before I started working with CVS, I lacked motivation, questioned my ability/self-worth, had a sense of loss of identity, and I wondered if I would ever be happy again. Since I have been visiting facilities and report writing, I have regained such a sense of meaning, achievement and purpose, and identity in my life"*

*"I really appreciate you forwarding the feedback from our visit. It is nice to know that issues we raise from visits are being addressed and hopefully our visits are making some impact on these people's lives for the better"*

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

## 2. EXECUTIVE SUMMARY

### 2.3 Governance and Strategic Influence

The PCV regularly meets with the Minister providing opportunity to discuss the disability visitation program and the strategic issues being progressed. The meetings also provide the ability to alert the Minister in regards to any emerging issues. With Minister Vlahos now holding both the portfolios of Disabilities and Mental Health and Substance Abuse, there is increased opportunity to discuss and progress issues around comorbidity.

The PCV in addition meets with senior executive within Government and the NGO sector to similarly review current and emerging strategic themes as contained in the Annual Report and the CVS issues tracking document with the intent of influencing policy and service practice in ameliorating the barriers and challenges faced by those receiving services.

### 2.4 Tracking and Resolution of Issues

The CVS has implemented a comprehensive means of processing information and issues that are identified during visits. These quite often require follow up, further research and analysis. All reports are submitted electronically by Community Visitors via an online reporting tool. The tool allows for accurate and comprehensive data collection and analysis of the matters arising during visits. During this reporting period, the CVS has raised and monitored a total of 148 issues/concerns with disability and SRF providers and achieved positive outcomes for the residents in most incidences. At the time of writing this report, 35 remain outstanding/awaiting an outcome.

Full reports are provided to CEOs and senior staff following completion of visits to the homes they support. The CVS has met with a number of organisations and attended organisation's management meetings to present a review of visits to their accommodation and to seek feedback on the organisation's perspective of the CVS visitation program to their accommodation. It has been a good opportunity to answer any questions they have in relation to the CVS reports or any aspect of the Community Visitor Scheme. Constructive feedback has been received at all of these meetings.

Issues of significance or issues identified as systemic are documented on an Issues Register for further research and action. The Issues Register is tabled at the CVS Advisory Committee where there are robust and well-informed discussions about how best to advance these issues. This has influenced the many successful outcomes that the CVS has already achieved.

### 2.5 Visits

End of the 2015-16 financial year summary of visitations undertaken:

Service Definition	Total Services	Total Places	2013-14 Visits	2014-15 Visits	2015-16 Visits
Large Residential/Institution (>20 places)—24-hr care	8	477	4	4	1
Small Residential/Institution (7-20 places)—24hr care	2	8	0	0	2
Hostels — Generally not 24-hour Care	2	8	0	0	0
Group Homes (usually <7 places)	452	1463	50	254	390
Centre-Based Respite/Respite Homes	87		18	18	1
Supported Residential Facilities (SRFs)	25	907	1	14	26
<b>TOTAL</b>	<b>577</b>	<b>2892</b>	<b>73</b>	<b>290</b>	<b>420</b>

Table 2.5.1 Summary of 2015-16 CVS Disability Visits.

In summary, the CVS has conducted 420 visits this year. Combined with the last two years of visits, the CVS has visited a total of 783 homes/accommodation sites since the Scheme commenced disability accommodation visits. Over this past year, the CVS has visited 253 homes/accommodation sites for a second time.



The CVS has now visited all of the non-government organisation (NGO) run homes.

The CVS has visited a number of homes in regional areas including Murray Bridge, Strathalbyn, Victor Harbor, Port Pirie, Yorke Peninsula, Port Augusta, Whyalla, Berri, Loxton, Renmark, Mt Gambier and Millicent.

In 2014-15, there was an average of 24 houses visited a month, rising to an average of 35 in 2015-16. For the CVS to achieve its target of two visits each year to all disability accommodation, SRFs and Day Options Programs, there will be requirement for a further increase to 70 visits per month in 2016-17.

Having worked through the initial apprehension surrounding the inclusion of SRF visitation, it is pleasing to note the significant progress that has been achieved over the past 12 months, with all facilities being visited and some now visited twice.

## 2.6 Summary of Report Outcomes & Themes

From the reports received during this reporting period, the vast majority comprised positive comments. Notably more positive outcomes/comments were identified in the areas of *Rights and Responsibilities*, *Communication*, *Environment & Residence Services and Treatment*, *Services and Care*.

Of these areas, the majority of positive observations were of the *Treatment, Services and Care* provided to residents where activities and structured programs were being provided and residents were being given the assistance they require to enjoy a fulfilling life. Observations also found clear indications that residents were being supported to live as independently as possible.

Most of the facilities visited were assessed as suitable with food provisions being of a high standard.

Observations also found clear indications that residents were being treated in as 'least restrictive' way as possible and with dignity and respect.

Interaction and respectful communication amongst staff and residents was another area where the majority of comments provided were of a positive nature. However, the CVS is aware that recruiting and retaining staff is an area where organisations will continue to be challenged, especially with the rapid expansion of the sector through the implementation of the NDIS. This could potentially affect the interaction and communication between staff and residents as there will be periods of adjustment as staff orientate and build competence in meeting the support needs of residents.

Another area of concern is *Maintenance of the Environment* where a number of reports provided negative comments and there is evidence that the design, function, accessibility and condition of a house impacts on the quality of care provided to residents.

A further area of concern is the absence of *Care Plans/Individual Support Plans* in many houses or that they are old and no longer align with the assessed capacity of the individuals and their specific needs and goals.

In terms of the SRFs, the most reported category was *Environment and Residence Services* with the majority of the comments being positive. In contrast, the issue category of *Grievances* reported the smallest number of responses, and related to inadequate complaint responses. The category of *Rights and Responsibilities* generated a greater rate of issues of concern than positive comments, and most strongly represented in the area of personal safety.

A more detailed summary of the reporting outcomes and themes has been provided in Sections 6 and 7 of this report.

### 2.7 Recommendations

#### Disability Accommodation Services

##### Activities & Structured Programs

1. That CVs 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.

##### Suitable Facilities, Maintenance and Transport

2. 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.
3. 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.

##### Respectful Communication

4. 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.
5. The CVS to highlight the above observations and continue to report these to Senior Management in DCSI and the relevant NGO managers.
6. The CVS to highlight the importance of staff recruitment, training and consistency through the ongoing benefits of being able to acknowledge, reward and retain quality staff.
7. The CVS to highlight the importance of retaining the specialist disability programs to ensure ongoing training and support for new and current staff in the management of residents with complex needs and behaviours.

##### Supporting Independent Living

8. CVs to continue to monitor the level of encouragement and support by staff to assist residents in developing independent living skills.
9. CVs continue to monitor and report on activities residents wish to undertake but are unable to afford to do so.
10. The CVS continue to check and report on concerns raised regarding the cost of utilities and how costs are shared within accommodation settings.

##### Food Preparation and Provision

11. 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.

##### Care Planning

12. That CVs continue to monitor and report on Lifestyle/Person Centred Plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
13. That CVs enquire into the implementation of the plans and seek out evidence that the Plan is being implemented and regularly reviewed.

##### Gender Safety of Residents and Protective Behaviours

14. That CVs check with residents who require a support worker for personal support, that they are receiving that support from a worker whose gender is one that they prefer.
15. The CVS continues to monitor gender safety and protective behaviours of both residents and staff.

### **Clients with Disabilities Such as Intellectual Disability, Brain Injury or Autism in Acute Mental Health Units Especially in Forensic Care**

16. That the independent review report into forensic care be released to the public together with the Government's response.
17. That all patients with dual-disability be linked to a key worker with expertise in this area who establishes a detailed Case Plan.
18. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
19. That individual case planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.

### **Medication and Restrictive Practices**

20. The CVS continue to check resident's medication charts and report unusual behaviours (including the appearance of excessive drowsiness) to the PCV.
21. The CVS to continue to monitor progress of the Chemical Restraint Project and agreed actions from the planning session.
22. 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.

### **Delays in Responding to Requests for Provision of Equipment by ASSIST**

23. The CVS continues to monitor, report and follow up any individual delays in the provision of equipment or services.

## **Supported Residential Facilities**

### **SRF Governance Structure**

24. That the CVS canvas the most appropriate forum through which to address concerns related to the 'whole of government' changes currently impacting the SRF sector.

### **Premature Discharge of SRF Residents from Hospital**

25. 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.

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

26. The CVS continue to strengthen its relationship with local government Environmental Health Officers, recognising the critical role they have within the SRF sector.
27. The CVS promotes establishment of an MOU between the CVS and Environment Health Officers with respect to sharing of information relating to issues raised within the SRF sector.

### **NDIS, Aged Care Reform and Transforming Health**

28. The CVS continue to promote to key stakeholders the specific support requirements of individuals with complex needs and co-morbidities to access NDIS and My Aged Care Portal, ensuring the needs of this group are being represented within the decision making and change process currently being implemented.
29. That consideration be given to assessing how best to accommodate the transition of the SRF sector to the NDIS, recognising the multiple and complex needs of this population group and their high rate of dual-diagnosis.

### **Review of the *Supported Residential Facilities Act, 1992* (the Act)**

30. The CVS continues to advocate for a review of the *Supported Residential Facilities Act, 1992* which reflects the complex and specific requirements of this population group and provides for genuine enforcement by those bodies assigned licencing and regulation responsibilities.

## 3. Supporting Legislation and Policy

### 3.1 United Nations Convention on the Rights of People with Disabilities

The Australian and the South Australian governments have 'signed up' to uphold the rights of people with a disability and ensure there is legislative and policy reform to address any form of discrimination. Australia has ratified the United Nations Convention on the Rights of People with Disabilities (UNCRPWD) and has signed the Optional Protocol, which ensures that Australians with disabilities have rights and avenues to lodge complaints.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Under the UNCRPWD, discrimination on the basis of disability '*means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination*'.

The Convention aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The UNCRPWD sets out clear obligations that governments must undertake in order to address rights and remove discriminatory legislation, policies and practices to develop appropriate services. The obligations include:

- a. To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention;
- b. To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- c. To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programs;
- d. To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention; and
- e. To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise.

### 3.2 National Legislation and Policies

#### **The Disability Services Act, 1986**

The *Disability Services Act* was passed in 1986 with the aim of providing a coordinated approach to assisting people with disability to obtain and maintain their full potential whatever that may be. The Act provides a legislative and funding framework for a range of disability services, including accommodation services and provides a set of guiding standards for the delivery of quality services known as the *Disability Services Standards* – revised in 2013.

There are six standards which providers of employment, advocacy services and rehabilitation programs funded under the Act, are required to observe. Each standard is intended to address the same three basic elements of rights for people, outcomes for people and standards for service. There are forty 'Indicators of Practice' which are applied when assessing whether a standard has been observed.

#### **Disability Discrimination Act, 1992**

The *Disability Discrimination Act* (DDA) provides protection for everyone in Australia against discrimination based on a broad definition of disability. The DDA was enacted in 1992 and makes it unlawful to discriminate against people in the provision of mainstream services such as housing, transport, education, goods and services. It is based on an understanding that an individual has, have had, or may have in the future, a disability. It also makes it unlawful to discriminate against a person who may be an associate of a person with a disability.



#### Disability Discrimination Act Standards

The functioning of the *Disability Discrimination Act (DDA)* is supplemented by a series of Disability Standards and Guidelines, which provide more detail on rights and responsibilities about equal access and opportunity for people with a disability. Standards are legally binding regulations set by the Attorney-General under the DDA. The Australian Human Rights Commission may advise the Attorney-General on development of such standards.

Guidelines (or 'Advisory Notes') are issued by the Commission to assist persons and organisations to understand their rights and comply with their responsibilities under the DDA and accompanying Standards. Unlike the Standards themselves, they are not legally binding.

Standards and Guidelines can be made in the areas of employment, education, public transport services, access to premises, accommodation and the administration of Commonwealth laws and programs.

Complaints about discrimination and breaches of human rights can be made to the Australian Human Rights Commission and the South Australian Equal Opportunity Commission.

#### National Disability Strategy

The National Disability Strategy (the Strategy) sets out a ten-year national plan for improving life for Australians with disability, their families and carers. It draws on the findings of extensive consultation conducted in 2008-2009 by the National People with Disabilities and Carer Council and reported in *Shut Out: The Experience of People with Disabilities and their Families in Australia* (2009).

The Commonwealth, State and Territory governments have developed this Strategy in partnership under the auspice of the Council of Australian Governments (COAG). The Australian Local Government Association has assisted in the development of the Strategy and there will be a strong role for local governments in its implementation. The shared vision is for **an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens**.

The Strategy will play an important role in protecting, promoting and fulfilling the human rights of people with disability. It will help ensure that the principles underpinning the Convention are incorporated into policies and programs affecting people with disability, their families and carers. It will contribute to Australia's reporting responsibilities under the Convention<sup>4</sup>.

#### National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is the new way of providing disability support for Australians with disability, their families and carers. The NDIS will provide about 460,000 Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life.

As an insurance scheme, the NDIS takes a lifetime approach, investing in people with disability early to improve their outcomes later in life. The NDIS gives all Australians peace of mind that if their child or loved one is born with or acquires a permanent and significant disability they will get the support they need. The NDIS supports people with disability to build skills and capability so they can participate in the community and employment.

##### ***Receive Reasonable and Necessary Funded Supports***

The NDIS can pay for supports that are reasonable and necessary. This means they are related to a person's disability and are required for them to live an ordinary life and achieve their goals.

Assistance from the NDIS is not means tested and has no impact on income support such as the Disability Support Pension and Carers Allowance. The National Disability Insurance Agency (NDIA) is an independent statutory agency whose role is to implement the National Disability Insurance Scheme (NDIS).

The first stage of the National Disability Insurance Scheme in South Australia began on 1 July, 2013 for children aged 13 years and under.

By end December 2016, entry into the NDIS of children aged between 0 and 14 will be completed.

From 1 January 2017, the NDIS will begin to be available to young people aged between 15 and 17.

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<sup>4</sup> National Disability Strategy 2010-2020. An initiative of the Council of Australian Governments, 2011.

### 3. SUPPORTING LEGISLATION AND POLICY

From 1 July 2017, adults aged 18 to 64 will begin to enter the NDIS based on where they live.

Existing Commonwealth and State based supports will continue until an individual is covered by the NDIS.

The NDIS is expected to be operating state-wide for all age groups by July 2018, ultimately providing support to about 32,000 people.

The CVS is aware of this important development and continues to monitor its progress through the Advisory Committee. Regular updates are provided by the South Australian Executive Director of Disability Services, Dr David Caudrey and the Executive Director, NDIS and Service Reform, Nick Ashley.

The CVS recognises the important role it can play in influencing key principals, policy and design of the Scheme ensuring safeguards are put in place for the very many clients that we meet who would find it difficult to advocate for themselves. The CVS has taken up opportunities to attend forums and provide submissions in relation to the NDIS Quality and Safeguarding Framework consultation paper.

#### 3.3 South Australian Legislation and Policies

##### Legislation that Established the Community Visitor Scheme (CVS)

Part 8 Division 2 of the *Mental Health Act, 2009* establishes a CVS in South Australia which aims to provide further protection to the rights of people with a mental illness who are admitted to treatment centres in South Australia.

CVs who have been appointed under the *Mental Health Act* can have functions conferred on them by that Act or any other Act (Section 51(1) (d)) hence the basis for the functions conferred by the *Disability Services (Community Visitor Scheme) Regulations, 2013*.

The Regulations give CVs functions in respect of supported residential facilities and disability accommodation facilities – and this is compatible with the purposes of the *Mental Health Act*. The maintenance of appropriate standards and the meeting of objectives in both types of premises are clearly of paramount importance to the welfare and mental health of residents.

Regulation 4(1) sets out the functions of CVs. These include the ability to visit disability accommodation premises and make inquiries into matters including the appropriateness and standard of the premises. Many of these premises are run by non-government service providers. Under the Regulations, these service providers need to be advised of and give their permission for such visits and inquiries to take place. However, the Department also developed a clause to go into funding and service agreements with NGOs to ensure their compliance with the CVS visits and inspections.

##### The South Australian Strategic Plan (SASP)

The Plan guides individuals, community organisations, governments and businesses to secure the wellbeing of all South Australians. The SASP contains our community's visions and goals - its 100 measurable targets reflect the state's priorities.

The Disability Community Visitor Scheme contributes directly and indirectly to the following targets set out within the SASP:

- Target 11: Housing for People with Disabilities** - Increase the number of people with a disability in stable, supported community accommodation to 7,000 by 2020.
- Target 23: Social Participation** - Assist people to deal with all forms of illness and to live a satisfying life where they can contribute to their community.
- Target 24: Volunteering** – Maintain a high level of formal and informal volunteering in South Australia at 70% participation or higher.
- Target 25: Support for People with a Disability** - Triple the number of people with a disability who are able to access self-managed funding by 2016.
- Target 50: People with Disability** - Increase by 10% the number of people with a disability employed in South Australia by 2020.
- Target 86:** To improve **psychological wellbeing** in South Australia.

#### **The Disability Services Act, 1993 (DSA)**

The DSA underpins provision of disability services in South Australia and sets out the current funding, research and provision of disability services in accordance with certain principles and objectives.

As previously stated, the CVS was originally established pursuant to Sections 50 - 54 of the *Mental Health Act, 2009*. The *Disability Services (Community Visitor Scheme) Regulations, 2013* (CVS Regulations) extended the role of the CVS into Disability Services and commenced operation in May 2013. These new Regulations are to be read in conjunction with Sections 50 – 54 of the *Mental Health Act, 2009* [Appendix 1 and 2].

#### **Amendments to the DSA**

A review of the DSA was undertaken culminating in the ***Disability (Rights, Protection and Inclusion) Act, 2013*** which amends the DSA. The amendments required Disability Services Providers to have safeguarding policies addressing issues including restrictive practices, supported decision making and complaints policies. The amendments also contain a definition of what constitutes victimisation. Breach of any of the provisions results in a fine of up to \$10,000. This, in part, involves implementation of the recommendations contained in the disability blueprint *Strong Voices: A Blueprint to Enhance Life and Claim the Rights of People with Disability in South Australia 2010 –2020*, which was released in October 2011.

The ***Statutes Amendment (Assessment of relevant history) Act, 2013*** has commenced operation together with the *Disability Services (Assessment of relevant history) Regulations, 2013*. In the context of Disability Services, the amendments to the DSA contain provisions dealing with the checking and screening of persons who wish to work with vulnerable persons. This safeguard is to ensure that persons who may pose a risk to the safety and welfare of people with a disability, are prevented from applying for positions to work with people with a disability.

#### **Review of the Mental Health Act, 2009**

A review of the *Mental Health Act* was conducted and a report was produced and tabled in Parliament on 1 July, 2015. The role of the Community Visitor Scheme was examined as part of the review and the following recommendations were made relevant to the CVS:

- » The Principal Community Visitor should have the capacity to conduct visits and inspections of facilities alone;
- » The Principal Community Visitor may delegate a power or function of the Principal Community Visitor to another Community Visitor;
- » Community-based services and facilities should be included in the scope of the Community Visitor Scheme; and
- » That the limit of two terms for people appointed to the position of Community Visitor or Principal Community Visitor be removed.

As such, the amendments were presented in the *Mental Health (Review) Amendment Bill, 2016* and were approved by the House of Assembly and the Legislative Council during the 2015-2016 financial year. It is anticipated that the approved amendments will come into effect during the first half of 2017.

#### **The Supported Residential Facilities Act, 1992 (the Act) and The Supported Residential Facilities Regulations, 2009**

The *Supported Residential Facilities Act, 1992* and the *Supported Residential Facilities Regulations, 2009* underpin provision of services to those individuals residing in accommodation licensed under the Act, which identifies its primary objectives as being:

- (a) To establish standards for the provision of personal care services in supported residential facilities in this State; and
- (b) To recognise and protect the rights of persons who reside in supported residential facilities; and
- (c) To ensure that a resident or prospective resident of a supported residential facility has ready access to information about the scope, quality and cost of care within the facility; and
- (d) To regulate the responsibilities of service providers in supported residential facilities; and
- (e) To ensure accountability in relation to supported residential facilities.

The Act identifies a range of principles which must be applied in relation to the management and administration of

### 3. SUPPORTING LEGISLATION AND POLICY

supported residential facilities, including:

- » Provision of high quality care based on informed choice; receipt of reasonable levels of nutrition, comfort and shelter in a home-like and safe environment;
- » Treating residents with dignity and respect and a reasonable level of privacy;
- » Ensuring residents' independence and freedom of choice with regards friendships with people of either sex, religious and cultural customs and pursuit of activities of interest (as long as they do not unreasonably impinge upon the rights of others; and
- » Provision for residents to manage their own affairs wherever possible, without exploitation of their financial or other assets.

#### Policy Developments – Access to the Justice System

The Select Committee on '*Access to and Interaction with the SA Justice System for People with Disabilities*', was tabled in Parliament on 25 July, 2013. The PCV was a member of the Steering Group that was established by the Attorney General's Department to provide advice on the Strategy. The Report established the Disability Justice Plan 2014-2017, with the purpose of making the criminal justice system more accessible and responsive to the needs of people with disability.

In June 2014, the Government launched the 'Disability Justice Plan' and associated guidelines '*Supporting Vulnerable Witnesses in the Giving of Evidence: Guidelines for Securing Best Evidence for Investigative Interviewers Working with Vulnerable Witnesses*'.

A key action of the Plan was the establishment of a specialist communication assistance scheme to support people with disability and children in their contact with the criminal justice system. This new scheme known as the Communication Partner Service, is to assist people with complex communication needs, to provide an accurate and coherent account of their experiences in police interviews and court proceedings.

The Communication Partner Service will provide independent, trained volunteer personnel to facilitate communication between vulnerable victims, suspects, witnesses and defendants with complex communication needs in and out of court. Uniting Communities has been selected to partner with the Government in the delivery of the new Communication Partner Service.

In addition, *The Statutes Amendment (Vulnerable Witnesses) Bill, 2015* was introduced into Parliament on 6 May, 2015 to improve the position of vulnerable parties, namely children and persons with a cognitive impairment, within the criminal justice system, both in and out of court. The Bill extends to victims, witnesses, suspects and defendants.

The Bill builds on previous changes to the law. The Bill and the recent addition of Section 51 to the *Criminal Law Consolidation Act, 1935* are both part of the wider Disability Justice Plan. All of these measures aim to ensure that people with disability, whether as victims, witnesses, suspects or defendants, are better served by the justice system.



## 4. Strategic Partnerships

### 4.1 Minister for Disabilities

In accordance with Regulation 6(1) of the Regulations, the PCV is required to report on an annual basis to the Minister on the work of the Community Visitors. The PCV also meets with the Minister providing opportunity to discuss the disability accommodation visitation program, the highlights and issues of concern. The meetings also provide the ability to have open and transparent discussions regarding the independent visits and inspections of disability accommodation and SRFs. With Minister Vlahos now holding both the portfolios of Disabilities and Mental Health and Substance Abuse, there is opportunity to discuss and progress issues around comorbidity.

### 4.2 Minister for Communities and Social Inclusion

The Minister responsible for SRFs is the Minister for Communities and Social Inclusion however, the PCV relays all issues of concern or highlights within SRFs through the Minister for Disability. The vast majority of the residents within SRFs have either a mental illness, disability or dual-disability and therefore, it feels appropriate to relay this to the Minister in the first instance.

### 4.3 Chief Executive, Department for Communities and Social Inclusion

During this reporting period, the PCV met with the Chief Executive, Ms. Joslene Mazel on a regular three monthly basis. These meetings provided opportunity to inform the Chief Executive of the work being done by the CVS, the general positive nature of the visits and issues that have arisen. When issues have been raised with the Department, the Chief Executive has been most considerate and responsive. The PCV looks forward to continuing the quarterly meetings with the new Chief Executive, Mr. Tony Harrison.

### 4.4 Executive Director, Disability SA

The Executive Director of Disability SA, Dr David Caudrey has continued to be very involved in the progressive development of the Community Visitor Scheme through his membership on the CVS Advisory Committee. Regular meetings have also been held between the PCV and Dr Caudrey, as the Minister's delegate to highlight the work of the CVS and any high level issues that arise. Dr Caudrey has been an important and valued 'sounding-board' for providing strategic advice and has been extremely responsive in progressing issues that have been raised with him.

### 4.5 Senior Practitioner

The Senior Practitioner, Professor Richard Bruggemann has been crucial in monitoring standards of practice, especially restrictive practices that are being used across the service system. The CVS has consulted with the Senior Practitioner on issues relating to restraints and seclusions of residents and/or practices that challenge the duty of care of service providers versus dignity of risk to residents. Protocols for communication between the CVS and the Senior Practitioner have been established.

Professor Bruggemann has also provided training on restrictive practice to the Community Visitors and has become a regular presenter on the topic at the Community Visitors two-day orientation program. Professor Bruggemann co-authored the 2013 'Review of the Day Options Program', which has informed progression of the Day Options visitation and inspection components of the Scheme.

### 4.6 Executive Director, Disability and Domiciliary Care Services

The PCV continued to provide reports of visits to the Executive Director Disability and Domiciliary Care Services, Ms. Lynn Young. In addition, the PCV has written to Ms. Young on a range of issues during this reporting period and would like to acknowledge her positive and constructive responses in achieving resolution to these issues.

### 4.7 Other Senior Staff in Disability Services

The PCV has provided copies of visit reports to senior staff within Disability Services and has either telephoned or written to them when there were issues that required their input. Quarterly meetings have also now been arranged to discuss any outstanding issues from visit reports. The PCV would like to acknowledge their constructive responses when issues have been brought to their attention.

## 4. STRATEGIC PARTNERSHIPS

### 4.8 Staff of Disability Accommodation, SRFs and Day Options Providers

The CVS acknowledges the many staff who are responsible for the day-to-day care and support of residents including the program coordinators, managers and house staff. They have all been very responsive to facilitating visits and the CVS acknowledges their assistance through the provision of resident's profile information and providing introductions and stimulating conversations with residents during visits.

### 4.9 The Community Visitor Scheme Advisory Committee

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

The CVS Advisory Committee meets bi-monthly. The Committee's membership reflects the three service streams of Mental Health, Disability Accommodation and SRFs and has representation from both the government and non-government services. Detailed committee membership is provided in Section 9.4.

An important function of the Advisory Committee is to discuss items listed on the 'Issues Register', which are either of a significant, systemic or strategic nature that have been reported through Community Visitor reports or the CVS office. The Committee provides an opportunity for vigorous discussion and the development of recommendations on how best to resolve/progress issues. Outcomes may include suggestions on who/where to refer the matter, recommendation of further research or the development of discussion papers which can be a reference by committee members to lobby and progress issues through their respective channels.

The Terms of Reference for the Advisory Committee are available on the CVS webpage on [www.sa.gov.au/cvs](http://www.sa.gov.au/cvs)

### 4.10 The Office of the Public Advocate (OPA) and Health and Community Services Complaints Commissioner (HCSCC)

The CVS has jointly developed a Memorandum of Agreement with the Health and Community Services Complaints Commission (HCSCC) and the Office of the Public Advocate (OPA) in relation to its role in the Mental Health and Disability Services context. The Agreements provide the framework for communication between the respective offices and the CVS, and provide a process for referring matters or clients.

The CVS continued to work closely with both the OPA and the HCSCC and would like to acknowledge the ongoing collaboration on both systemic issues such as gender safety but also on individual cases where we have been contacted regarding complaints against services and where the CVS may refer to either agency for investigation. To Anne Gale and Steve Tully, our sincere thanks

### 4.11 Non-Government Organisations (NGOs) Sector

The CVS has, during this reporting period, established strong working relationships with senior executive and staff of the state's NGOs who provide support to those with a disability who live in residential care. This includes Anglicare SA Inc., Baptist Care (SA) Inc., Barossa Enterprises Inc., Calvary Home Care Services, Catholic Family Services (Centacare), Community Accommodation & Respite Agency Inc. (CARA), Community Living Australia (previously Community Lifestyles Inc. and Community Living and Support Services Inc.), Community Living Options Inc., Disability Living Inc., EBL Disability Services Inc., Eureka Care Communities (previously Sorento Care Ltd), Hills Community Options Inc., KinCare Healthcare Services, Life Without Barriers Inc., Lifestyle Assistance & Accommodation Service Inc., Lighthouse Disability (previously Leveda Inc.), Lutheran Disability Services, Mary MacKillop Care Pty Ltd, Minda Inc., NEXTT (previously Sorento Care Ltd), Orana Inc., Riverland Respite and Recreation Service Inc. and The Paraplegic & Quadriplegic Association of SA Inc.

The PCV and Disability CVS Coordinator have attended a number of meetings with senior staff and operational staff who are responsible for the day-to-day management of the residential facilities. These meetings have proved useful in discussing visit procedures and processes and exploring ways to work collaboratively to ensure that we get the most out of visits and inspections to their facilities and involve them in the process of identifying priorities for our visits.

The CVS has continued to work with operational staff on a daily basis when organising visits to their facilities and would like to acknowledge all their assistance in planning visits and providing information in advance to enable the CVs to be prepared. This might include information on when to visit and when the residents will be home, their level of communication and/or comprehension and interests.

Summary reports have been provided to managers of organisations on completion of visits to their accommodation sites and have included meetings to review how the visits went, respond to questions and explore in more detail the issues, both positive and negative, that were raised.

### 4.12 Supported Residential Facility (SRF) Sector

The CVS has continued its positive working relationship with SRF Association in South Australia, with the President being a member of the CVS Advisory Committee. The PCV and SRF Coordinator were invited to attend the SRF Association Strategic Planning Day in May, which provided an opportunity to explore achievements and challenges impacting on the sector such as the NDIS rollout. Proprietors recognise this has significant implications for the sector with the focus on individualised funding and changing models of accommodation. The PCV was able to report on Access 2 Place, a new disability housing organisation which provides individual housing options for people with a disability and to discuss models of housing that the NDIA are likely to support.

The CVS recognises the work of the SRF Association in strengthening its sector and promoting training and skill development to its members. To this end, the CVS welcomes the recent development of the Supported Residential Facilities Association Strategic Plan 2016 – 2019. The commencement of an SRF & Day Options Coordinator in March has supported the relationship building across these two sectors, both with government and non-government stakeholders. Attendance at regular regional SRF network meetings for example, has assisted in identifying issues of concern and providing a forum for service providers to discuss issues of mutual concern. In addition, the CVS recognises that termination of the SRF Advisory Group in 2014, has significantly impacted on the sector's capacity to operate from a coordinated and inclusive base of governance.

## 5. Functions of the Community Visitor Scheme

### 5.1 Community Visitor Functions

The functions of Community Visitors in the context of Disability Services are set out in Regulation 4(1). They are:

- » To conduct visits to and inspections of supported accommodation, group homes and SRFs to ensure compliance with standards; to refer any matters of concern relating to the organisation and delivery of disability accommodation and SRF services in South Australia or the care, treatment or rights of individuals to the Minister; and
- » 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.

Regulation 4(2) sets out the rights that Community Visitors can exercise in their performance of these functions. They may enter disability accommodation premises at any reasonable time and, while on the premises, may;

- » Meet with a resident;
- » With the permission of the manager of the premises — inspect the premises or any equipment on the premises;
- » Request any person to produce documents or records; and
- » Examine documents or records produced and request to take extracts from, or make copies of any of them.

Section 52(1) of the *Mental Health Act* provides the PCV has the following additional functions in relation to mental health and these functions also apply in the area of disability services by virtue of the definition of PCV contained in the Regulations:

- » To oversee and coordinate the performance of the Community Visitors functions;
- » To advise and assist other Community Visitors in the performance of their functions; and
- » Reporting to the Minister for Disabilities regarding the performance of the Community Visitor functions.

### 5.2 Visits and Inspections

During this reporting period, the Scheme has focused on visiting the 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 time.

Out of the 420 visits and inspections to disability accommodation conducted this reporting period, 264 were to NGO supported accommodation. Combined with last year's visits, the CVS has now visited a total of 783 homes/accommodation sites since the Scheme commenced in disability accommodation.

The CVS has also visited a number of homes in regional areas including Murray Bridge, Strathalbyn, Victor Harbor, Port Pirie, Yorke Peninsula, Port Augusta, Whyalla, Berri, Loxton, Renmark, Mt Gambier and Millicent. The ability of the CVS to get out to regional residential facilities has been supported by the supply of an appropriately modified vehicle suitable for the PCV to drive.

With the ongoing increase in the number of Community Visitors recruited, the average number of houses visited a month has significantly increased from 24 last year, to 35 in 2015-16. For the CVS to achieve its target of two visits each year to all disability accommodation, SRFs and Day Options Programs, there will be requirement for a further increase to 70 visits per month in 2016-17.



### 5.3 Requested Visits

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. If a request is made to a manager of, or a person in a position of authority at, disability accommodation premises, that person must advise the CVS office of the request within 2 working days.

There were 19 Disability and SRF requested visits/advocacy requests in the reporting period. An example of a typical case the CVS acted on is outlined below.

#### Security at a Respite Facility

An incident occurred at respite accommodation where two children with intellectual disabilities and autism left the house while staff were busy providing personal care to a third child. The two children were able to get outside of the yard through a gate which was supposed to be locked and got onto the nearby road. Both children lacked any road sense and were at high-risk when unsupervised on the road. The Disability SA Feedback and Incident Review Team requested a CVS visit to the house as an independent third party review.

The CVS undertook an unannounced visit and was pleased to be able to report back to Disability SA, that the service had initiated a number of protocols and practices and was providing sound, positive services and that the risk noted previously was now being appropriately addressed.

### 5.4 Advocacy

Community Visitors undertake an advocacy role in referring matters of concern and provide information and assistance to support and empower patients/residents, to make a complaint or express their concerns about any aspect of support and care being provided. However, the CVS is not a complaints resolution body nor an investigation unit. Examples of advocacy undertaken in this reporting period are presented in Section 6 of this Report.

### 5.5 Education

The Scheme has attended parent group meetings; in conjunction with Disability SA, hosted a CVS Information Forum for registered providers of Day Options Programs and provided updates to NGO Service Managers and Disability Service Regional Managers.

### 5.6 Policy, Strategy and Clinical Practice Development

A significant and important role the CVS plays is its contribution to Policy, Strategy and enquiries 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;
- » Parliament of SA Social Development Committee Inquiry into Comorbidity;
- » SA Transforming Health Strategy;
- » 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.
































## 6. Disability Outcomes and Themes

### 6.1 Conducting Visits

Three years of conducting visits to disability accommodation has confirmed a visitation program that comprises of two afternoon visits usually commencing at 3:30pm followed by the second at approximately 4:45pm. This appears to best suit the needs of the residents, the service and the CVs. This normally ensures residents are home from work, Day Options Programs, study etc. and the second visit is completed by 5:45pm, before residents head out to any evening activities.

Prior to a visit, CVs are provided with some basic information on the house (contact name and number) and basic profiles of residents, especially in relation to their level of communication and comprehension. This information is extremely valuable to the CVs in preparing for the visit and in completing their post visit report. Prior to each visit, houses and residents are provided information about the Scheme, the purpose of the visit and the names of the CVs who they can meet with.

On receiving some invaluable feedback from a parent of a young person with an intellectual disability living in supported accommodation, the CVS worked in partnership with the parent, in developing a low literacy handout about the CVS and a visit. This is now provided to all services, house staff and Day Options Programs prior to the visit to assist staff in promoting and informing residents with an intellectual disability about the visit. Positive feedback has been received from the services and family members indicating this to be a valuable resource and one we are pleased to be able to offer.

	.....		Some people are		coming to visit		you in your home		on		.....
Insert picture of person										Insert name of day	
											
Their names are		.....		and		.....		They want to find out		how you feel about	
			the help you get from		the support staff.		Their job is to make sure		everything is okay with		
living in your home											
			your activities		the people you live with		and your tablets.		You can		tell them about the
your house	your food										
			scared,		angry,		or bored;		your dreams and		your goals.
things that make you happy,											
											They want to make sure you feel safe.

Produced by Jayne Lehmann in consultation with the PCV.

Visits commence with a meeting with the House Manager, providing information about the house, its residents and staff. This may include highlighting communication and safety issues if relevant. This is followed by a tour of the facility and introductions to residents who are willing to chat and could include discussions on daily routines, personal support provided and individual support or lifestyle plans that are in place and being implemented.

On completion of the visit, where possible, the CVs will provide the senior staff at the facility with informal verbal feedback about any issues of concern raised during the visits or any positive observations. CVs are also required to provide a formal written report on the visit to the Principal Community Visitor (PCV). The facility is expected to make every effort to address any issue(s) raised in the report promptly or at the least, present a plan/strategy they are implementing in resolving the issue.

If an issue(s) cannot be resolved at the facility level, the PCV will refer the matter to senior management of the service or another appropriate body to resolve.

The responses from disability accommodation management to visitation requests have been positive, as has their response to issues or concerns arising from visits.

*"We appreciate the work the CVS does around providing feedback to our organisation and I would like to thank you all for providing us with your report."*

*"I just wanted to send you some feedback from the CVS visit to one of our services. One of the resident's home was a lady named X, who has lived there for a number of years. X is in a wheelchair and has an intellectual disability and often becomes stressed with visitors to the house. Whilst the CVs were visiting, X did not have any signs of being stressed. Part way through the visit, X indicated towards the CVs and signed 'friends'. It was really lovely and it was a very clear sign that X understood what the CVs were there for. This was the first time I had met one of the CVs and the second time I had met the other but I felt this was indicative of all of my interactions with Visitors. This is a very positive Scheme. Thanks to everyone"*



(Above) Photo of X with CVs

If the CVs have reason to believe there is a serious issue, the CV is required to:

- » Report the issue to the PCV immediately;
- » Take reasonable steps to preserve any evidence relating to the issue;
- » Await further directions from the PCV;
- » If the PCV has reason to believe that there is a serious issue or an offence has been committed, inform the Department immediately; and
- » The PCV is required to follow up with the senior management within two weeks.

The *Disability Services (Community Visitor Scheme) Regulations, 2013* (the Regulations), made under the *Disability Services Act, 1993* provide for Community Visitors to refer matters of concern in relation to the organisation or delivery of disability services in South Australia to the Minister for Disabilities (Clause 4(1)(b)) or the Minister's delegate.

## 6. DISABILITY OUTCOMES AND THEMES

A protocol for the referral of matters of concern to the Minister for Disabilities by CVs has been developed. The purpose of this protocol is 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 Regulations.

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 Public Advocate and the Health and Community Services Complaints Commissioner.

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 strategies where there are common issues.

### 6.2 Quantitative Data on Visits

Data acquisition from the CV reports to the PCV throughout the 2015-16 period, has demonstrated a number of trends that are further explored through this Section.

Figure 6.2.1 and 6.2.2 to follow relate to the number of issues or positive comments raised. Of the total 774 reported comments during this reporting period, it is pleasing to note that 612 (79%) 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.

Further, it is important to note the total number of comments raised over the last reporting period has significantly increased. This is as a result of the new online reporting tool that has been in operation during this 12-month period. The tool requires the CVs to assess, rate and comment on all aspects of care delivery.

2013-14 Total	2014-15 Total	2015-16 Total	2015-16 (Positive)	2015-16 (Issues)
123	196	774	612	162

Figure 6.2.1- 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; and
- » Treatment, Services and Care

Figure 6.2.2 highlights that there were notably more positive observations made relative to negative issues identified in the areas of Communication, Rights and Responsibilities, Treatment, Services and Care, and Environment and Residence Services.



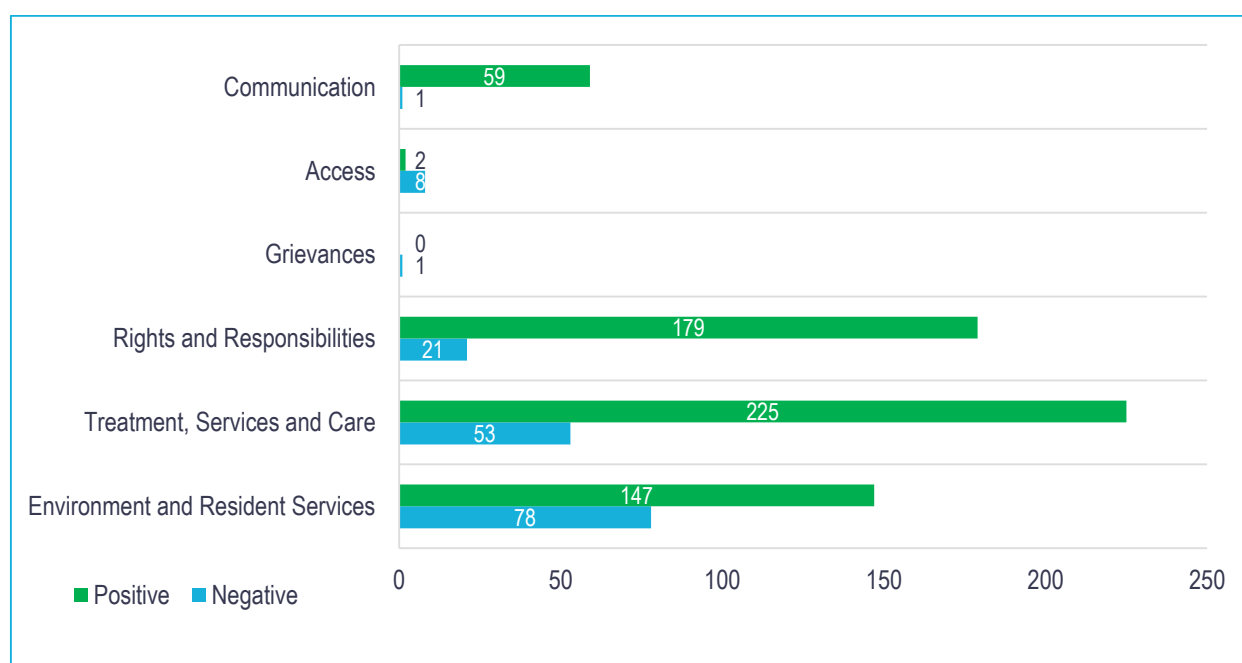


Figure 6.2.2 - Number of Positive and Negative Comments by Level 1 Categories.

The vast majority of positive observations were in relation to the *Treatment, Services and Care* provided to residents with the provision of activities and structured programs being highlighted and staff noted to be giving residents the assistance they require to enjoy a fulfilling life. Observations also found clear indications that residents were being supported to live as independently as possible and that residents were being treated in as least restrictive way as possible and were being treated with dignity and respect.

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

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

Examples of positive observations include:

*The resident greeted CVs at the door and welcomed us into his home. He enjoys attending a cooking program at the school on Friday mornings and works 5 days a week at Barkuma. He became very excited when CVs asked him about his time in Melbourne where he visited his parents recently and flying on his own.*

*The residents seemed to get on well and both were full of stories about their holidays and outings. One described as quite shy until she got to know people was very open with us from the beginning, being keen to tell us about and show us photos of her recent holiday in the snow, show us her room, and some of her art. Both residents expressed great comfort with their care. One had recently come from another residence and had also recently become engaged. Both do some chores, go to work, one of them catching 2 buses, and they go on outings, classes, have hobbies, etc. - active lives!*

*In the short time that the residents have been living at the facility, they have gained independence and living skills which have impressed family and staff.*

*Residents are encouraged to help with household chores such as washing and folding, cooking, dishes, making tea and coffee, making their beds and tidying rooms. Staff encourage the resident's to be involved in the household duties to foster their independence. CVs were pleased with the standard of care the residents receive in this residence. Staff encourage independence and are invested in their wellbeing. The residents were proud to show us around their house, which felt like a family home. The staff and service provider should be commended with the standard of care they are providing.*

*Residents choose their weekly menus and some go with staff for weekly food shopping. Staff encourage healthy food options. A staff member commented that with healthy food options, resident X has reached a healthy weight, after having been overweight for many years.*

## 6. DISABILITY OUTCOMES AND THEMES

*All the residents had been in the accommodation for some time and all spoke highly of the care and support they received. It was so heartening to see residents and staff interacting so easily and in very positive and affirming ways.*

*Restrictive practices, if ever used or required, are only practiced if absolutely necessary and with carer/guardian knowledge, understanding and written consent.*

Figure 6.2.3 shows that the Level 1 Categories most commonly reported during 2015-16 was *Treatment, Services and Care*, and provides comparative data for the last three reporting periods.

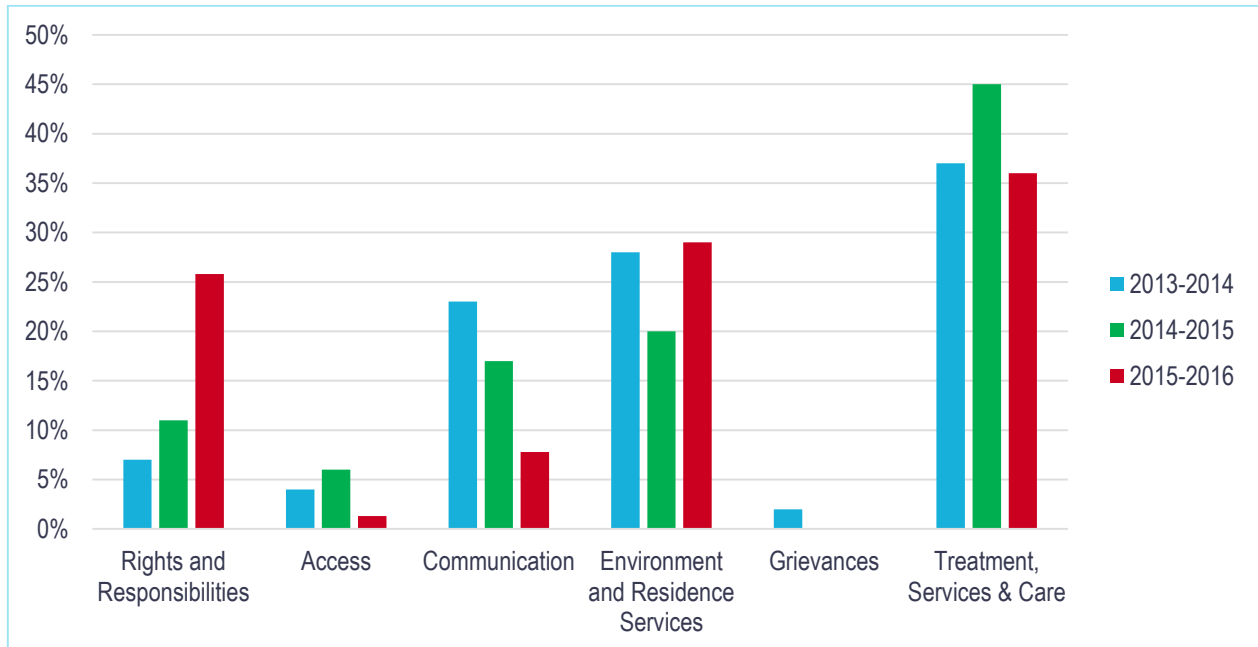


Figure 6.2.3 – Comparison of issues/comments by Category 1 for the 2013-14, 2014-15 and 2015-16 reporting periods  
[Percentage of total issues raised].

Figure 6.2.4 provides a summary of issues reported during the 2015-16 reporting period by both Level 1 and Level 2 Classification. As noted earlier, the positive reports outweigh the issues raised, in this reporting period 79% - 21%.

The most positive Level 2 classified observations were *Activities and Structured Programs, Suitable Facilities, and Dignity and Respect*.

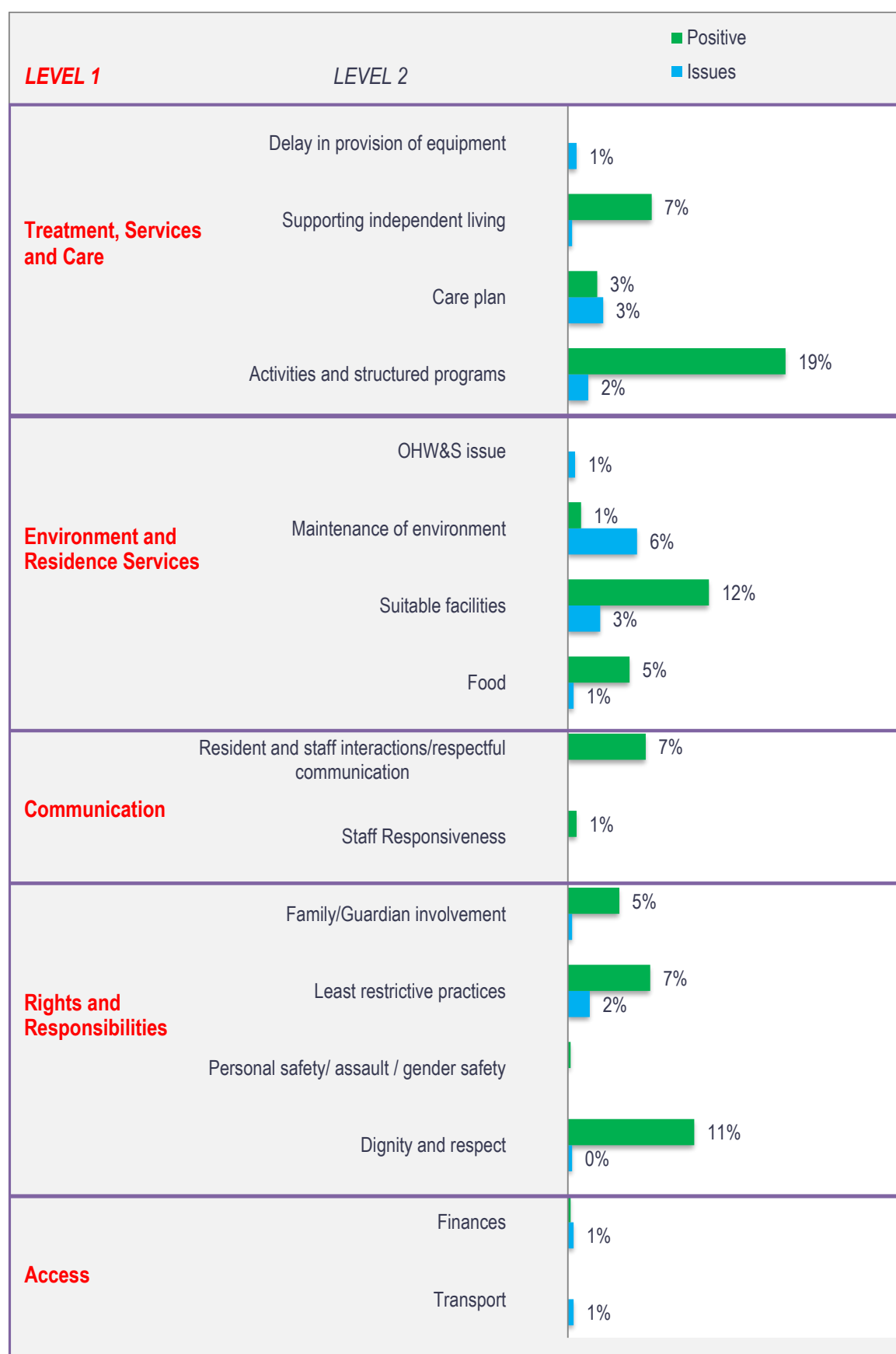


Figure 6.2.4 – Classification Level 2 issues and positive comments as a percentage of the total issues/positive comments raised during 2015-16 reporting period.

## 6. DISABILITY OUTCOMES AND THEMES

### 6.3 Activities & Structured Programs

116 (19%) of the total comments provided during the reporting period were positive in relation to activities and structured programs and, in general terms, the sector appears to be performing well in this area.

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 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, however, as is explored further in this report, some residents had limited opportunities especially holidays. Some residents are working, some attend Day Options Programs 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.

Concerns with Day Options Programs has again been raised in a number of reports and it is pleasing to report the CVS has just commenced visiting these programs to review their quality of care. It should be noted however, the PCV has followed up individual issues as they have arisen. It is anticipated that visiting people both in their residential setting and Day Options Program will provide greater opportunity for them to open up about issues they may have. It will also enable the CVS to assess how effectively their care is coordinated through the cross correlation of information.

Several innovative activities were identified. Below are some examples and positive excerpts from visit reports:

*A resident expressed his needs and activities very well, and CVs spoke to him in his own self set up workshop in the back yard. He expressed satisfaction with work, care and Day Options.*

*One resident showed us all around his house and garden and talked to us about his music (drum kit especially evident but also bongo drums), his dancing (quick demonstration too!), the chickens (now gone) and the rabbits that were coming soon once the hen house had been 'rabbit proofed'. Both residents explained that the rabbits would be purchased with money one earned by collecting recyclable bottles from around the neighbourhood.*

*All the residents were looking forward in going to Port Elliot for a 3-day holiday at the organisations' beach house that is rented to residents.*

*Resident X attends a Day Activity Program 5 days a week at X Day Options Program. The staff member showed CVs the daily program which has exciting and stimulating activities.*

*The men no longer attend Day Options due to their high support needs, they get better care at home. The staff all appeared to enjoy working with these residents and focused on their abilities and positive aspects of the individuals which was pleasing. They believed that the residents would not get the same level of care and support at a Day Options Program and the cost of this was also significant.*

3 (2%) of the total comments provided were noted as 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:

*CVs observations at the time of the visit were that while the residents are engaged in various activities, they could possibly be encouraged to be more involved in community activity. Residents reported spending a lot of time watching TV although, CVs reported they may not have been provided with all information relating to this.*

The Service Provider responded stating that "only one resident was being supervised and supported 24 hrs/day. Residents in the other units come and go as they wish and are very engaged with the team that supervise them. The supporting team will suggest further activities they may be interested in pursuing within the local community but the final decision is in the individual's and that of the next of kin".

*While not a major issue, resident X, who seemed fit and animated, and particularly enjoyed indoor bowling, told us that he did not have any daytime options. X expressed interest in volunteering work with bowling. The CVs gained the impression that resident X seemed to need more meaningful weekly daytime activities.*

The CVS is still awaiting a response from the Service Provider and will continue to follow up.



*Only basic care was provided and the residents appeared very disconnected and fragile (CVs feel some activities or stimulation to engage the residents is needed). CVs noted the staff intend to start taking the residents out on short drives and gradually increase the length of time out, as at the present time, outings tend to cause the residents stress by the change of routine and unfamiliar places.*

The Service Provider responded in agreement that the residents living at this home do have challenging and complex support needs. *"We continue to provide them with opportunities for engagement and activity, but they often choose not to participate. There is an activity schedule in place (copy attached), and various sensory items available in the home. We are working with staff to encourage them to more actively engage with the residents and to document what works and doesn't work."*

### Recommendation

1. 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.

## 6.4 Suitable Facilities, Maintenance & Transport

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:

- » 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?
- » 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 Visitors?
- » Are residents' 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?
- » If maintenance is required, how efficiently are requests met?

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 (new Access 2 Place developments as example). 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.

73 (12%) 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.

Excerpts from visit reports:

*The apartment has a bedroom and a bathroom well equipped and spacious enough to accommodate wheelchairs. The living area is similarly spacious and ideal for moving about in a wheelchair. The kitchen has been constructed at an appropriate height, and appliances such as the cook-top have access underneath to allow wheelchair access.*

*One bedroom has been set up as a photography studio, the other as a bedroom/office. Resident X does not use a bed but prefers to sleep in a large reclining armchair. The office has a computer and equipment for editing photographs and videos. The CVs were impressed with the resident's set-up.*

5 (3%) of the comments provided were noted as issues of concern. Excerpts from visit reports and responses received to issues raised:

*With regards to the large outside area, it was highlighted by staff that the shin-high brick border between the lawn and garden was a tripping/falling hazard particularly for one of the residents who liked to spend time under the tree. His balance is not good and to get to the shade of the tree he has to navigate the small wall into a ditch like area which places him at significant risk of injury from falling.*

## 6. DISABILITY OUTCOMES AND THEMES

*Staff commented that there was a need for a latch on the door to the kitchen area which could be used during meal preparation times only as there are hot surfaces and sharp objects around during preparation and cooking. Presently there is a door but residents are free to wander in which is a risk to themselves and staff.*

Within the same month of raising this issue with the Service Provider, a work request had been submitted and advice from trades people to remedy the shin-high border situation had been sought. Significant renovations had occurred by adding a wall and door and a latch was about to be added for use only when cooking.

*The bathroom has some corrosion on the walls as a result of salt-damp and rusting metal around the hand-basin which could be a risk to residents if they accidentally scraped themselves against this.*

Within a short time of this issue being raised with the Service Provider, the CVS was informed the bathroom had since been repaired.

*The complete omission of a bathroom hand basin and tapware in unit 2/9, having been removed some 6-weeks prior, requiring the residents to use the shower or kitchen sink in which to wash, clean their teeth and shave is quite unsatisfactory.*

*The extensive failure of the ceiling in the bedrooms of unit 2/9 is unsatisfactory. The ceiling in the westerly bedroom is particularly poor, with the easterly bedroom having a lesser level of decay/although mould still being of concern. The ceilings show evidence of heat and/or moisture damage, with peeling paint and considerable areas of mould being present.*

*The residents and the care worker expressed concerns regarding the high temperature levels found in the 2/9 unit for much of the year; the residents and worker having not used the heater for over 12 months. The high temperatures have led to the extensive use of the air conditioning (often being switched on by the care worker well prior to the residents coming home).*

*The rear garden to both units was quite unkempt and overgrown and is in need of significant trimming and re-establishment.*

The response from the Service Provider to the issues raised was again timely with confirmation that Housing SA had been further contacted regarding repairs and a staff member's mobile number provided to assist with future entry to the house. A roof plumber had been ordered by Housing SA to attend to inspect and arrange repair. The residents were budgeting for some outside blinds and a Housing SA roof inspector was requested to report on the roof insulation situation. Enquiries had been made with the gardeners as to why backyards were not being included in the maintenance schedule.

In relation to transport, some support staff commented that the lack of an allocated vehicle impedes their delivery of service. In general, most houses have a vehicle that they can transport residents in and those that do not, have raised it as a concern and that it has impeded them in providing a complete service.

In instances when this was raised as a concern, the Disability Coordinator followed up with the service concerned and was often advised opportunities were available for use of a share-vehicle, fleet vehicle &/or taxi vouchers.

### Recommendations

2. 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.
3. 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.

## 6.5 Respectful Communication and Interaction

Observations of resident and staff interactions/respectful communication was another key component of all visits and inspections and it is pleasing to report the majority of comments provided in reports were positive (7% of total comments). The sector is continuing to perform well in this area and staff should be commended on these observations made by the CVSs.

Hand in hand with respectful communication and high levels of interaction is dignity and respect and the majority of comments provided by CVSs were positive (11% of total comments).

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

*Staff are involved with resident's needs and they have a good understanding of resident's gestures as a communication tool.*

*The residents all require high levels of care and attention due to the nature of their disability. The staff were observed to be kind and respectful towards each resident.*

*The staff at both of these houses are exceptional and the relationships they have with their residents are warm, caring and respectful. This was reflected in the comfort levels of the men and the women in residence.*

*It was completely obvious that the staff member knew the individuals and their particular idiosyncrasies in relation to meeting and talking with new and different people. She was respectful, taking into account some of the resident's reluctance to meet CVs.*

*Staff are very involved with the residents, showing a demonstrated understanding of their needs and personalities. The staff have clearly built positive relationships with their residents, which is reflected in the positive atmosphere in the units.*

*Staff at this residence have established a truly client centred model of care, highlighting individual choice and independence. Staff are attentive and responsive to changing needs of the ladies as they age. The affection of the staff for the ladies was obvious, and reciprocated, and the overall feeling of the visit was one of a happy, settled house with contented residents. It was a joy to visit.*

While not a specific classification, observations in relation to staffing continued to be a significant issue raised in reports during the reporting period. This is not surprising given that staffing is the largest component of any business in the provision of supported residential care. Report comments reflected both a positive and negative perspective. In general, CV observations of staff were extremely positive with examples of positive comments provided in many reports.

Some examples of comments provided and feedback received are noted below:

*It should be taken into consideration to keep such high-care demanding residents together with the present staffing or management plan.*

The Service Provider agreed with the feedback provided by the CVs and informed the CVS they are doing their best to retain the current staffing arrangements at this house.

*The resident is not willing to exercise despite attempts by staff to involve him in healthy activities due to his diabetes.*

Feedback from the Service Provider indicated that due to a change in staffing at the house, the resident is now far more engaged and exercising.

### Recommendations

4. 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.
5. The CVS to highlight the above observations and continue to report these to Senior Management in DCSI and the relevant NGO managers.
6. The CVS to highlight the importance of staff recruitment, training and consistency through the ongoing benefits of being able to acknowledge, reward and retain quality staff.
7. The CVS to highlight the importance of retaining the specialist disability programs to ensure ongoing training and support for new and current staff in the management of residents with complex needs and behaviours.

### 6.6 Supporting Independent Living

With the ongoing transition to the NDIS, CV reports are indicating there is progressive improvement in client centred care and purchaser choice. However, an emerging issue in many reports is that residents are expressing a desire to undertake further activities but with the increasing costs of doing so, there is a potential that participation will be reduced. Also highlighted in reports is the concern regarding the cost of utilities and how proportional cost sharing should occur when staff have an office/bedroom within the residence.

Of the 43 (7%) positive comments reported, below are excerpts from visit reports:

*One resident had quite a messy house but not dirty, staff are supporting him to be more independent and how to keep house. They are letting this resident learn and make his own decisions about the level of tidiness and trying not to impose their values, some refer to this as Reality Therapy!*

*Residents are encouraged to assist and carry out household tasks such as cooking, cleaning and washing. There is a kettle which will boil enough water for one hot drink, which allows resident X to make her own cup of tea by reducing the risk of injury.*

*All four residents seem to be strongly encouraged to enjoy independence. They all work and are able to travel to and from work independently. Three of the residents also do their own banking and shopping etc. One resident is very independent and travels alone to a range of activities as well as his work. Family members are closely and regularly involved with each resident and know the staff member well too.*

Although the majority of comments provided by CVs were of a positive nature, there were a few comments where encouragement and support in this area is still required. For example:

*Increasing costs of activities/holidays (all have Companion Card) as sign of times and has potential to reduce overall participation.*

The CVS raised this concern with the Service Provider and have been informed that whilst the Service has developed a policy in relation to holidays taken by people supported in their service, activities continue to be undertaken by residents and supported by staff. Examples were provided. Connections with families are supported and individual activities are undertaken. Costs of entry into venues is offset by using the companion card where possible.

The PCV has suggested to a range of organisations and individual residents that they may be able to obtain funding for holidays through the Wyatt Trust who have accessible holiday units available and financial grants for holidays or vocational training - <http://wyatt.org.au/small-grants/>

#### Achieving the Right Mix of Residents

Finding suitable placements for 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. An example being

*A major area of concern noted and later discussed by the CVs is whether there is a detrimental impact of resident X's challenging behaviours on resident Y as they spend a lot of time together, including week-ends. We did have a conversation with staff about the possibility of separating X and Y at week-ends to give each a break but the major difficulty is having enough staff/funding available. CVs felt the service does need to recognise the importance of Y having quality space and time without X.*

The Service Provider's response was in support of the above comment by CVs. They hope the opportunity of different living arrangements will be possible when NDIS is rolled out as it is certainly something the service is advocating for.

#### Recommendations

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.
10. The CVs continue to check and report on concerns raised regarding the cost of utilities and how costs are shared within accommodation settings.



## 6.7 Food Preparation & Provision

Another area reported on at all visits and inspections relates to the provision of food, the preparation of meals and how much involvement residents have in choosing the menu. Questions asked by CVs highlight whether residents were happy with their food and if there was a menu plan that residents had been consulted on that reflects their preferences, their dietary requirements and that they are being encouraged to make healthy choices.

Although 'food' has not been seen to be of great concern, restrictive practices often apply in this area (locked fridges, etc.) and this can impact on other residents within the same house.

It is reported that healthy food choices are evident in most accommodation settings however, there have been examples 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.

The CVS has collaborated with other agencies and attended 'healthy eating forums' over this reporting period and intends to continue monitoring this area.

### Recommendation

11. 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.



Sculptures by John (SRF Resident)

### 6.8 Care Planning

The regular investigation by CVs as to whether 'Lifestyle/Person Centred Plans' are in place revealed that most houses complied (3% of all positive comments). Their absence in many houses however (3% of all negative comments) is of concern and in these situations it was immediately raised with the relative service provider. Most notably, the CVS found that in many instances, Lifestyle Plans were not available within Disability and Domiciliary Care houses due to either having been archived or not updated for quite a period of time. Staff stated they were advised to archive current Plans and await training and support in the implementation of new Person Centred Plans. 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.

Last year's Annual Report highlighted that the creation and implementation of Individual Support Plans required considerable improvement and the CVS Advisory Committee confirmed that monitoring of Plans needed to be a priority activity for the CVS during 2016. As a result, a two-month focus of our visits on these plans was organised and implemented in consultation with the Ministers delegate, Dr David Caudrey and the Senior Practitioner, Professor Richard Bruggemann. All service providers were informed of the intent to focus into enquiring into the status of Plans for each resident as part of visits during the months of May and June. Findings from this review will be forwarded to each service provider and reported to the CVS Advisory Committee and Minister in due course.

Below is an example of the questions asked and brief summary of the findings.

- » Do residents have a current Plan?
- » How frequently are the Plans reviewed?
- » Did any resident you spoke to report not being consulted and involved in the development of their Plan?
- » Did any of the residents report that their family/carer/supporter had not been included in their Plan?

Throughout the focus' months, a total of 49 houses/cluster sites were visited, 70% being various NGOs and 30% being Disability & Domiciliary Care Services. These houses were accommodating to a total of 195.

Of the 49 reports received, it was found:

- » 39 (80%) of the houses had current Plans;
- » 23 were reviewed annually, 17 as needed, 5 on a quarterly basis and 4 (was not discussed);
- » Of the residents spoken to, all reported they had been involved in the development of their Plan; and
- » 4 residents reported that their family/supporter had not been included in their Plan.

There remains confusion across the sector regarding terminology and interpretation. Some services refer to the Plans as Individual Support Plans; others refer to them as Lifestyle Plans/Person Centred Plans. This in turn could lead to implications in the data sourced. Some organisations have presented at visits weekly activity schedules lacking any personal goals or aspirations.

Positive excerpts from visit reports:

*Person Centred Plans were very thorough and extensive and it was emphasised that staff were required to familiarise themselves with client's details and folder contents before commencing work with them.*

*The Care Plans are all up to date and were available for inspection on visit. One was examined in detail and content was comprehensive and relevant to resident.*

*As we were instructed to take particular note of Plans, we did so/and/or discussed Plans with the Manager. The Plan for resident J is currently under review, because of her declining health. Similarly, the Plan for resident T is being reviewed, because of her increased vitality. Other Plans were in place, and regularly reviewed. The Manager was creating forms for reviewing existing Plans, extracting KPIs within a succinct Action Plan for each individual. We were satisfied that the facility is complying with the intent of the legislation.*

*The Person Centred Plans for all 5 residents were checked and had been updated within the last year. Corresponding with the Plans, each person then had an action plan for the staff to implement the associated goals identified in the Plan. A third step is that every 3 months these Plans are then audited by staff to ensure progress/steps have been taken and further adjustments that may need to be incorporated to achieve the PCP goals.*

The CVS have identified houses that have no Plans in place, are outdated or are not a Care Plan. Negative excerpts from visit reports:

*A staff member advised CVs, that GP Management Plans are updated 6 monthly, and Care Plans should be reviewed every 12 months. A check of the files however, showed that Care Plans had not been updated recently (since 2012 in one case).*

*An inspection of resident files found that they were dated between 2011 and 2013. There were no current Plans available to view. Some files were also incomplete (required documents missing). Staff member said that since the organisation had withdrawn clerical support from this house and others (about 2 years ago) the 'paperwork' other than financial records to his knowledge, was simply not being attended to.*

*CVs noted that Personal Care Plans needed updating as it was at least 2 years since last done.*

*Documentation was available but was not clearly up to date on hard copies. Staff allowed us to view a hard copy & computer copy of a Plan for resident. This was old and staff discussed with us that staffing is tight and that the Plans are reviewed but may not be kept up to date on file or system.*

The CVS is aware one of the first steps of the NDIS as it is rolled out is where 'Planners' meet with individuals with a disability and family members where appropriate, and prepare an Individual Plan. The PCV has expressed concerns to both the Minister's delegate, Dr Caudrey but also the Chief Executive and Minister Vlahos that accommodation services do not have individual Plans in place for all residents and they should have.

As shown above and elsewhere, 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 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.

These are just examples of important elements that could be within an individual's Plan and services not doing well in this area have given a range of excuses for why they are not in place or outdated. They include comments like; *"We simply don't have time; they are not our responsibility; that is going to happen when the NDIS comes along; these are in Health Care Plans; and we have had resistance from residents"*.

### Recommendations

12. That CVs continue to monitor and report on Lifestyle/Person Centred Plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
13. That CVs enquire into the implementation of Plans and seek evidence that the Plans are being implemented and regularly reviewed.

### 6.9 Gender Safety of Residents and Protective Behaviours

The issue of resident safety remains a key area of interest and is regularly a point of discussion at the CVS Advisory Committee meetings. The CVS took the opportunity to provide input into the Senate enquiry into Violence, Abuse and Neglect Against People with Disability in Institutional and Residential Settings.

The CVS continues to monitor gender safety at all visits drawing attention to situations and environments which could potentially expose individuals to risk. The CVS has been prompting the department to release a policy position on individual's rights to request the gender of staff of their choice. An example:

*After concerns were expressed by two CVs who did an initial visit to a house, the CVS decided it would be best to do an unannounced visit. When the initial visit took place, a number of the female residents were screaming and yelling loudly for much of the time and CVs left the house worried about what was behind the screaming and what the impact was on the residents and staff alike. There were questions asked at the visit about how personal care of the women was managed given that there were only two staff on duty at the time and both were male.*

*At the unannounced visit, there was not the same level of screaming but there was little, if any, activities occurring with the residents and CVs left concerned about the fact that there were two men caring and providing intimate personal care for 5 women who had little, if any, communication skills.*

Immediately following the unannounced visit, the PCV contacted the service provider and expressed his concerns regarding the support being provided by the staff at this residence. He was informed that in future, it will be noted on the staff list, the gender of the staff member that is required for each house. All Managers in the area had also been advised to, where possible, roster a male and female to each site on an ongoing basis. Shift Supervisors had been advised if a staff member was to ring in sick, they are to specifically seek a same gender replacement.

#### Recommendations

14. That CVs check with residents who require a support worker for personal support, that they are receiving that support from a worker whose gender is one that they prefer.
15. That the CVS continues to monitor gender safety and protective behaviours of both residents and staff.

### 6.10 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 five 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 statuses, 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.



It is important to understand what a forensic client is within mental health services and how that is determined. Section 269C of the *Criminal Law Consolidation Act, 1935* (CLCA) provides that a person is mentally incompetent to commit an offence if, at the time of the offence, the person was suffering a mental impairment and in consequence of that mental impairment, the defendant:

- » Did not know the nature and quality of the conduct; or
- » Did not know the conduct was wrong; or
- » Was unable to control the conduct.

Section 269A of the Act defines 'mental impairment' as including a mental illness, an intellectual disability, or a disability or impairment of the mind resulting from senility.

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 approximately 10 staff which was 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 services that was conducted during the 2014-2015 reporting period. 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 PCV has expressed a view to the Minister that it is extremely important that this report is released to the public and that everyone has the opportunity to see what has been recommended as a means of improving forensic care in SA. The Minister has informed the PCV the reason for the delay in releasing this report is largely due to the Government wanting to be able release their response to the report and the work to prepare this response has been considerable.

### Recommendations

16. That the independent review report into forensic care be released to the public together with the Government's response.
17. That all patients with dual-disability be linked to a key worker with expertise in this area who establishes a detailed Case Plan.
18. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
19. That Individual Case Planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.

## 6. DISABILITY OUTCOMES AND THEMES

### 6.11 Medication and 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 is whether each resident has a Care Plan and a Medication Chart which should include the type and amount of medication that is prescribed and administered. During the training and induction of CVs, they are instructed about the importance of monitoring restrictive practices and this includes medication specifically prescribed to manage behaviour.

CVs are also instructed to be mindful that where residents may appear 'very drowsy', they need to make enquiries about the level of medication and/or sedation that the resident is on. In such instances they are also instructed to seek copies of the medication chart and this may result in the CVS obtaining a request for a medication review.

The CVS Advisory Committee received a presentation on a Chemical Restraint Project being undertaken by Doctor Maria Tomasic and her team to look at the extent of chemical restraint being used in Disability Services with an aim to reduce this.

In response to issues raised through the presentation and recommendations contained in the 2014-15 CVS Annual Report, the CVS facilitated a planning session with intention to achieve the following

- » Give clarity as to where discussions between the state of SA and the NDIA in relation to:
  - » Strategies being developed to ensure disability clients with a co-occurring mental illness will have access to specialist psychiatric care and to ensure these specialist services will be available in the state; and
  - » Strategies being developed to ensure chemical restraint is not used in place of addressing underlining reasons for behaviours of concern.

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 the Intellectual Disability (ID)/Dual-Disability (DD) population and how this can be improved given rates of mental illness are significantly higher in this population;
- » Give understanding to the level of assessment that has been undertaken and funding allocation for this anticipated increased service demand and to assess and redress the situation some disability clients post institutional care are now in;
- » Give clarity to the current funding distribution for these specialist services; and
- » Have a plan of action including key drivers to progress these important issues.

The CVS Advisory Committee continues to monitor progress on the agreed actions from the planning session.

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:

*Residents all seemed content with their home and staff seemed very aware of ensuring the least restrictive environment - even though they had some practices in place that had been approved by SACAT.*

*The kitchen was locked because one of the residents has an eating disorder and other residents have behaviours that could be of danger to themselves and others if able to access the stove etc. in the kitchen. The front door was also locked to prevent some of the residents from wandering off into possibly dangerous situations. Staff member showed CVs the paperwork associated with obtaining permission from SACAT.*

*CVs inspected all appropriate paperwork regarding restrictive practices which included secured premises and hormonal manipulation.*

*As part of resident X's challenging behaviour, she wants and demands food and water a lot of the time. Staff do not have restricted practises in place. They do the best to try and encourage her to not for example, drink as much. She has very dangerous low sodium levels as a result of drinking too much water. She has been hospitalised 3 times recently as a result of this and a host of other medical issues. Staff reported resident Y gets aggressive and can get violent if her wants are not met. Staff do the best they can under the circumstances.*

*There was P.R.N. that was dispensed for behaviour problems but this was all documented, authorised and explained and all the paper work was up to date and reviewed regularly*

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 required the CVS follow up and restitution by the service provider:

*The major issue was the staff's lack of awareness/appreciation/understanding of restrictive practices and procedures. The paperwork that was seen during the visit regarding restraint was out of date and requiring an up to date review. It may however be that there are up to date reviews and documentation had been completed and were available but staff could not access them on request which in itself is an issue.*

The CVS has now been informed the Service Provider is trialling a new staff induction folder that will be translated across to all services. Within the folders is a section that indicates where the Client Record and Support Plan folders are kept at each house. When this is finalised and circulated to each area, the CVS will be informed. Furthermore, restraint documents relating to each individual resident have now been sent to each consenting officer for updating and will be sent to the house when signed and completed.

*Resident J appeared to have restricted access from one room of her residence. A note on the door stated "Staff Only". It is assumed that maybe the fridge or food could be in this room as a staff member indicated the residents tend to have unsafe eating habits.*

Documentation was not sighted at this visit but CVs noted this will need to be followed up at the next visit to this residence.

### Recommendations

20. The CVs continue to check resident's medication charts and report unusual behaviours (including the appearance of excessive drowsiness) to the PCV.
21. The CVS to continue to monitor progress of the Chemical Restraint Project and agreed actions from the planning session.
22. 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.

## 6.12 Delays in Provision of Equipment by ASSIST

While the waiting period for assessments and prescriptions for equipment and services (e.g. physiotherapy, psychology) being provided by ASSIST has again significantly reduced since the last reporting period, several individuals are still required to wait longer than is clinically satisfactory.

Excerpts from visit reports and outcomes from follow ups with Service Providers:

*There are a few ongoing equipment issues, which are impeding on the health and wellbeing of the Client's. Client WJ has been on the waiting list of ASSIST North Equipment program prior to 2014, waiting for a new shower chair. The chair that is currently utilised presents a high risk of harm, and staff are concerned that if an accident was to occur, it would be while they are still waiting for a new shower chair to arrive.*

*Client W is also still waiting for ASSIST North to fix her chair, as it is run down and needs adjustments made as she has lost weight and now slides down into the tray top.*

*Client J is currently waiting for a seatbelt to be fitted to his brand new wheelchair, which has been sitting unused for months. Staff are having a very difficult time trying to get the seatbelt fitted for J, which is incredibly frustrating as it is limiting the activities that J is able to participate in, in the community. The new wheelchair will allow 1 staff member to transport J safely and quickly by themselves, rather than having to coordinate assistance from a volunteer. The new chair is also far more comfortable for J, and it is extremely disappointing that he is still unable to use it.*

The CVS informed Lynn Young, Executive Director of Disability and Domiciliary Care Services of the above issues and within a reasonable timeframe a response was received. "Further funds had been released which addressed the issues for client WJ & W. The issue surrounding client J's concerns was being further looked into."

## 6. DISABILITY OUTCOMES AND THEMES

*One resident has a wheelchair that still has not been modified to suit her, despite OT assessor, staff and mother frequent requests - reason given funding - none available and need to wait for NDIS. Uncomfortable, spends 18 hours per day in chair; has not caused pressure areas. Shower chair - dangerous in terms of positioning safely.*

The CVS referred this matter to Lynn Young and again, within a reasonably short time a response was received. "Access to additional funds had been sourced and the residents' needs would be attended to ASAP".

### Recommendation

23. The CVS continues to monitor, report and follow up any individual delays in the provision of equipment or services.

### 6.13 Advocacy Assistance

As mentioned in the previous section, a key element of the Community Visitors role is to provide support and advocacy in referring matters of concern and promoting the proper resolution of issues. Below are just a few examples of effective advocacy that achieved positive outcomes for clients.

#### Dignity and Respect

*Resident X reported that he was having issues regarding toileting in that as he is immobilised in a 'princess chair' and if he needs the toilet, he must call a staff member. Sometimes the response is not immediate and on one occasion he was told to just toilet in his adult diaper. This is of course unacceptable in terms of nursing practice and respect for resident X's dignity and when CVs heard this from resident X, they suggested that this needed to be reported and investigated. Resident X agreed to CVs reporting to senior staff. Resident X's issue regarding toileting was reported at the time to the Senior Nurse, who documented the details and contracted to follow the matter up.*

It is pleasing to report the PCV was contacted the following Monday and was informed that a senior member of staff had interviewed resident X and they had identified the staff person who had responded inappropriately. They had counselled that individual and would ensure this was on the staff meeting agenda so that all staff were made aware of the issue. They were organising a physiotherapist and occupational therapist review to ascertain whether resident X could now be provided a new wheelchair that he can push around making him more independent and less reliant on staff assistance.

#### Poor Condition of a Resident

The PCV was contacted by an independent advocate seriously concerned for a resident living in disability supported accommodation whose health was rapidly deteriorating, with significant concerns regarding the residents current weight and feeding.

The PCV undertook a visit and in response contacted senior management within Disability SA expressing his concern, and was informed a formal investigation would occur and the PCV would be kept updated. An assessment was undertaken and a Treatment Plan implemented. In addition, an independent assessment by an occupational therapist regarding his capacity to use communication devices was undertaken. The Disability Services Director and Senior Practitioner became involved and met with the resident's advocate(s). The PCV continues to receive regular updates concerning the resident's improved health and wellbeing.

#### Management of Finances

A resident whose finances were being managed by the Public Trustee, contacted the CVS concerned that the amount of savings in his account did not match his calculations and requested a meeting with the Public Trustee. The CVS contacted the Public Trustee who confirmed that the resident's finances were being managed according to his budget. As this was the first time the Public Trustee had been made aware of his concerns, the resident was invited to contact his Case Manager to discuss his concerns.

## 7. 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 considerations (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 are 25 ‘pension only’ SRFs in South Australia, the majority of which are privately owned and operated. Of these, 23 are located within the metropolitan area of 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 7.1 – List of SRFs by location and NDIS region).

Local Government is responsible for the auditing and licensing requirements of SRFs. However, the Eastern Health Authority undertakes these responsibilities on behalf 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 (refer to Section 3.3 of this report for additional detail regarding legislative requirements).

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 wants 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 for those individuals who have accessed the SEP.

The SRFI&SS team also undertake assessments of residents who may require additional psycho-social and or health support to enhance the person’s tenancy, reduce social isolation and link 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 aging clearly and consistently identified. A recent Literature Review – *The Health of The Vulnerable, Disadvantaged People Living in Supported Residential Facilities* - undertaken by Ms. Di Pilcheck is testament to this.<sup>6</sup>

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5 Specific program information provided by the SRF Intake and Support Service (SRFI&SS) – Exceptional Needs Unit (ENU) Department for Communities and Social Inclusion (DCSI)

6 Literature Review – *The Health of the Vulnerable, Disadvantaged People Living in Supported Residential Facilities* - Independent Study by Diane Pinchbeck SRF Health Access Team SA Health



## 7. SRF OUTCOMES AND THEMES

The gender breakdown indicates that the majority of SRF residents are male at 71%, while 29% are female. The majority of residents (69%) are aged between 40-64 years, 3.7% are aged under 25 years and 8.1% are aged over 65 years. The reported primary disability type is listed as psychiatric at 44%, 8% physical/neurological disability and 12.6% Intellectual/Acquired Brain Injury/Autism Spectrum.<sup>7</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.

During this reporting period, Amaroo Lodge in Whyalla closed, and three metropolitan SRFs - Glenelg House, Russell House and St Michael's (now known as Ocean Grove Myrtle Bank) - transferred their license. The Scheme has been pleased to see that these transfers have resulted in significant improvements to the services being provided to SRF residents.

These changes combined with three other closures since the CVS commenced visits in 2014, highlights the changing landscape.



Sculptures by John (SRF Resident)

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<sup>7</sup> Data for 2015-16 provided by the SRF Intake and Support Service (SRFI&SS) – Exceptional Needs Unit (ENU) Department for Communities and Social Inclusion (DCSI)

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	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
Amaroo Lodge	Hawdon Street WHYALLA NORRIE SA 5608 (Closed May 2016)	Eyre Western
Lambert Lodge	87 Gray Street MOUNT GAMBIER SA 5290	Limestone
Southern Fleurieu Silver Circle	55 Victoria Street VICTOR HARBOUR SA 5211	Fleurieu & KI

Figure 7.1 - Supported Residential Facilities (SRFs) by location and NDIS region

## 7. SRF OUTCOMES AND THEMES

### 7.1 Summary of How Visits and Inspections Are Conducted

Visitation and inspection of SRFs was included in the Scheme's 2014 expansion to incorporate disability. As previously noted in Section 3 of this Report, a number of stakeholders initially challenged the Scheme's involvement with the SRF sector, which hindered the anticipated rate of engagement.

However, once resolved the Scheme commenced the process of building relationships and undertaking visits within the SRF sector.

The employment of an SRF and Day Options Coordinator in March, has ensured the consolidation and further development of the SRF component of the Scheme.

The CVS is funded to provide visitation and inspections to the 25 'pension only' SRFs located across the State.

In keeping with the visit and inspection protocols established by the Scheme, visits to SRFs are undertaken by two CVs. The Coordinator provides the CVs with a copy of the previous visit's report, which gives context and highlights any areas that may benefit from follow-up. CVs are asked to report to the manager or identified staff person on arrival and sign the visitors book provided, as per the *Supported Residential Facilities Regulations, 2009*.

The times at which visits take place vary, with experience demonstrating that on average visits tend to be approximately 1.5 hours. CVs are provided with an 'SRF Prompt Sheet' (see Appendix 4), which identifies areas to focus on during a visit.

The size of SRFs and the residents' demographic can entail the involvement of and visits by multiple service providers. Aware of the potential sense of intrusion experienced by the residents, CVs undertake visits mindful of the fact they are entering peoples' home. Our experience however, is that overwhelmingly, residents have appreciated the opportunity to meet and speak with the CVs, especially as the Scheme is becoming better known amongst residents within the sector.

On completion of the visit, the CVs are encouraged to raise any issues of concern or positive observations with the manager. A report is then prepared and submitted through the online reporting system to the SRF and Day Options Coordinator for review. Issues of concern are raised with the Principal Community Visitor (PCV) with significant or recurring issues placed on the CVS Issues Register, which is presented at Advisory Committee meetings for consideration and recommended action.

A copy of the report is provided to the SRF manager, as well as general feedback and specific actions required to address issues identified during the visit.

### 7.2 Statistics on Visits

The CVS has progressively increased its involvement with the SRF sector over the past three years, demonstrated by Figure 2.5.1 – Summary of 2015 -16 CVS Disability Visits.

During 2015-16, the CVS conducted 26 visits to SRFs, representing an increase of 54%.

In May, the CVS reviewed its SRF visitation and inspection program with CVs who had undertaken the SRF visits. It was an opportunity for them to provide feedback and suggestions and consider future directions for this component of the Scheme. In 2016-17, the CVS will subsequently be undertaking twice-yearly visits to each SRF, with provision for a third visit as required.

CVs have embraced SRF visits and the opportunity to gain knowledge about the sector and its particular considerations and challenges. During this reporting period they have contributed 234 hours to SRF visits.

The online reporting tool enables the CVS to record issues of concern or positive comments that they observe during scheduled SRF visits. In addition, they are able to identify who made those observations.

2015 – 16 Total	2015- 16 (Issues)	2015 – 16 (Positive)
125	54	71

Figure 7.2.1. details the positive comments and issues raised during the 2015 – 16 reporting period

Of the 125 comments received during the reporting period, 57% (N= 71) were positive and 43% (N=54) were issues presented in Figure 7.2.1.

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.

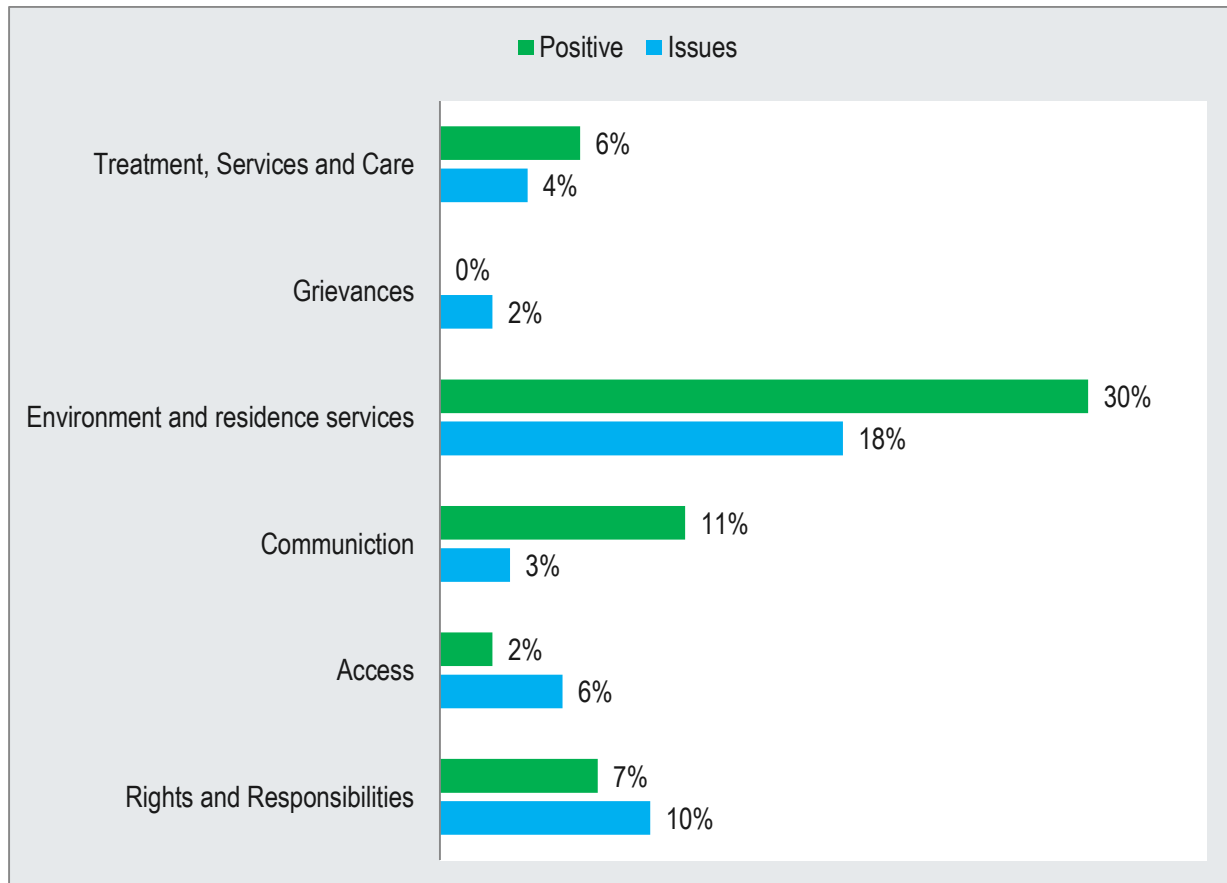


Figure 7.2.2 – Level 1 – percentage of positive and negative comments

The most reported Level 1 classification was *Environment and Residence Services* with the majority of the comments being positive. In contrast, the Level 1 classification *Grievances* reported the smallest number of responses, with all relating to a stated inadequate complaint response.

The classification of *Rights and Responsibilities* generated a greater rate of issues than positive comments, most strongly represented in the area of personal safety.

## 7. SRF OUTCOMES AND THEMES

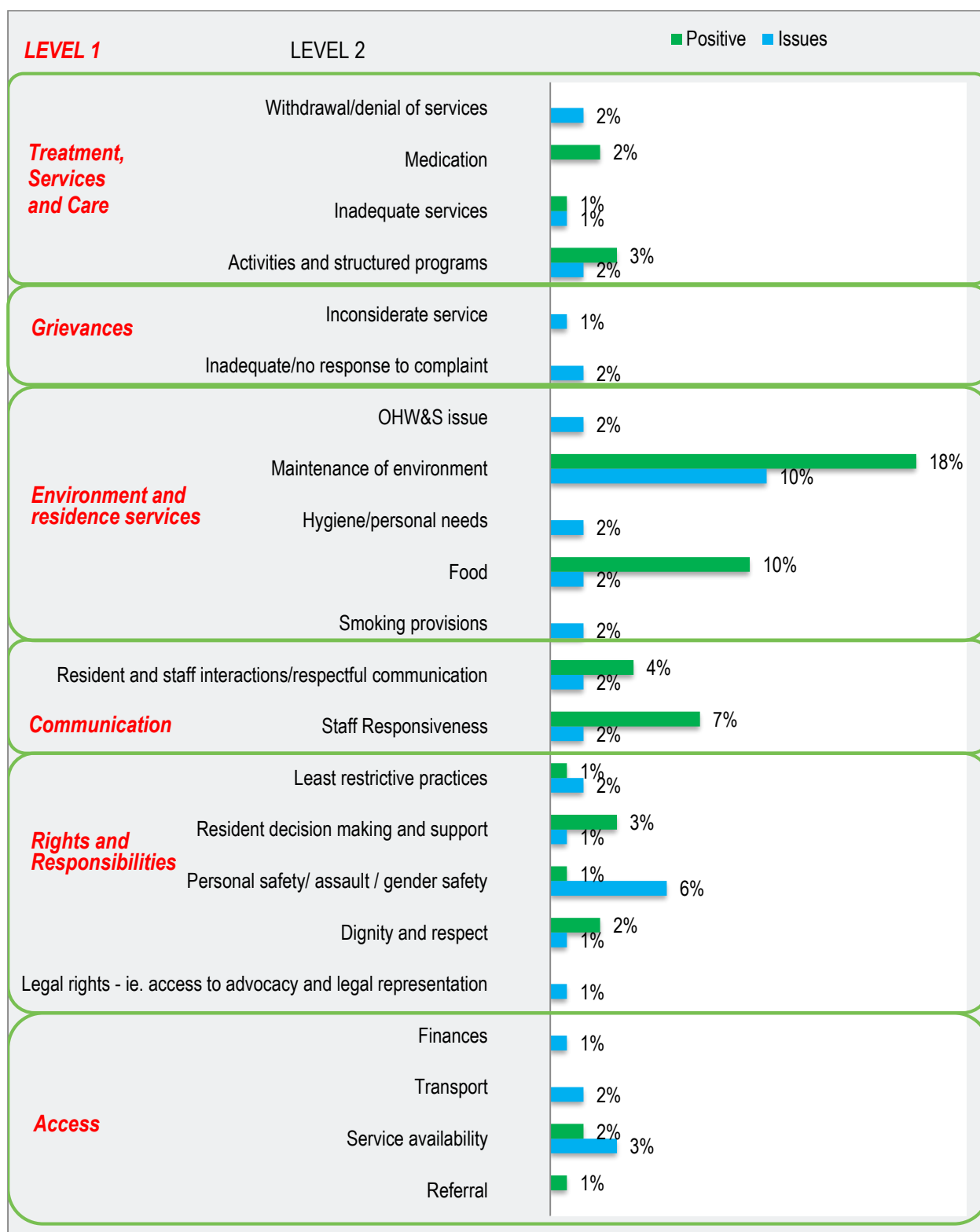


Figure 7.2.3 – Level 2 - percentage of positive comments and issues raised



### 7.3 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*, with close to a 50% split with regard positive comments and issues.

It was noticeable through the visit reports that there are certainly SRFs endeavouring to promote various activity options for the residents and create 'specific use' spaces within the facilities. Examples cited include a women's only room, a quiet space, outside spaces and a private meeting room.

In some instances, the managers arrange for regular on-site activities to be provided, for example an arts group. More often however, 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 CV reports include:

*Many residents have regular out of home activities. Some work, some have support packages for NGO workers and the Council provides a variety of recreational activities. As staff are very 'plugged in' to their residents, their needs are constantly considered.*

However, in some SRFs there are observations of residents sitting unoccupied in sitting rooms or outside the facility smoking with no obvious engagement. The CVS recognises that while at times this is due to individual choice, it can also be reflective of a general disengagement, sense of loneliness or indeed the impact of a particular diagnosis or medication.

*No activities happening at the time of the visit – most of the residents were either watching TV or sleeping on couches where there were signs stating 'no sleeping on couches - there seemed to be very little to do but watch TV and sit around outside and smoke.'*

Creating, supporting and maintaining pathways for residents' independence and engagement with the community whether in relation to social, employment or education opportunities is seen as a critically important focus for those involved in the SRF sector.

SRF residents stand to be negatively impacted by government changes to funding structures related to My Aged Care and the NDIS. In particular, funding levels previously available for provision of the psycho/social programs historically provided through the local government Regional SRF Programs and NGOs, has been significantly reduced. Particular concerns have also been expressed for the future of certain allied health services currently in receipt of disability funding.

The Level 2 classifications of *Inadequate Services* and *Withdrawal/Denial of Services* were equally represented and while not large in numbers reflect the importance of linkages and collaborative service provision across the sector. The following report excerpt reflects this:

*Many residents struggle with a range of disabilities, mental health, drug addiction and are considered to have a dual-diagnosis. The manager stated that she would appreciate closer contact and support from the local CMH team, to preserve the residents coping rather than her contacting the team when the resident was in crisis.*

*Staff worked in a collaborative agreement with the CMH team to provide a supportive, protective environment for those residents who are waiting to be transferred to a Drug and Alcohol residential facility.*

The CVS is aware that possibly up to 60% of SRF residents are not in receipt of additional support packages or accessing alternative engagement opportunities. These residents are particularly vulnerable to 'falling between the cracks' as the sector continues to be affected by broader systemic changes such as NDIS and Transforming Health.

## 7. SRF OUTCOMES AND THEMES

### 7.4 Grievances

The Level 2 classifications of *Inconsiderate Service* and *Inadequate/No Response to Complaint* sit within Level 1 - *Grievances*.

The number of reports within this classification is very small with themes reflected in other sections of this report, for example communication and collaboration with other service providers. Interestingly, of the comments reported, most were by SRF staff. Clearly, this does not mean that SRF residents have no grievances. Rather, due to the small sample, the CVS considers that for the purpose of this report, other classifications can be regarded as incorporating grievances that have been identified by residents, CVs or others.

The CVS is also mindful of the fact that there is at times a reluctance to bring issues forward - by both residents and service providers – for fear of reprisal or disadvantage. While the CVS has an important role acting as an additional safeguard within the sector, it is aware that this is strengthened through liaising with and establishing relationships and networks across the sector. The SRF and Day Options Coordinator regularly attends the three Regional SRF Network meetings and the CVS has also been invited to present at a meeting of the local government *Environmental Health Australia – SRF Special Interest Group* that meets every two months.

### 7.5 Environment and Residence Services

As noted, this was the most reported Level 1 classification and within that the Level 2 classification *Maintenance of Environment* featured most prominently.

A key focus of the CVS visit is to ensure that standards are being maintained, in terms of both the accommodation and quality of the care and support services being provided. In general, this area has received positive feedback during this reporting period. A number of SRFs have changed management resulting in measurable improvements for residents. Additionally, the SRF Association has been promoting training and best practice within the sector. 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 a number of instances, an SRF licensee does not in fact own the actual premises, which can influence responsiveness or otherwise to identified maintenance issues. However, the CVS would also assert that the inherent inadequacies of the Supported Residential Facilities Act (the Act) makes enforcement of requirements very difficult, an issue that reinforces the need for a review of the Act.

Excerpts from reports reflect this contrast:

*It was so good to see and hear of the changes that have been made to the facility and the care of the residents. The young manager is energetic and has done an enormous amount of administrative work to establish the documentation needed to ensure a high level of accountability and transparency in the delivery of genuine supported care. It was lovely to hear back from the residents just how much they appreciate these recent changes.*

*The garden was poorly maintained and needs attention to be a useful living space – the courtyard was characterised by hard surfaces, presenting a hot and rather unwelcoming character. The BBQ was in a poor state. It was concerning to note many floor level changes throughout the house and grounds restricting wheelchair access and providing multiple trip hazards.*

*The facility was very nice and clean. The residents looked very happy and the environment was comfortable with a homely feel.*

*The overwhelming impression of chatting with the residents was one of benign resignation to their circumstances and a lack of motivation/ability to problem solve this. The staff are caring and respectful but we could not help but be concerned about the people living there. It is a sad place.*

Food was the next Level 2 classification most frequently reported through CVS visits.

The importance of providing nutritious food within SRFs has gained considerable traction over the past few years as it is widely acknowledged that the SRF residents as a population group, face a complex and varied array of health issues. Progression of this focus has been aided by the involvement of allied health professionals providing a variety of health services and promoting positive health messages as well as the development of key resources, such as the *Literature Review* previously cited.

An earlier example is demonstrated by the 2010 release of the resource 'Good Nutrition – Making A Meal of it' which was developed by the Southern Adelaide Health Service, funded by the Australian Government better Health Initiative and endorsed by the Presiding Member of the SRF Advisory Committee (SRFAC).<sup>8</sup>

An additional consideration is that as the majority of facilities do not involve residents in food purchase and preparation, the process of choice with regard menu options for example, and provision for specific dietary needs takes on additional significance. Further, given that most SRFs serve dinner early, greater flexibility regarding supper and later access to tea and coffee support a greater sense of choice.

An increasing number of facilities are incorporating some form of edible gardens, which should be applauded and encouraged. Food, was well represented in CV reports. Most of the feedback about the food was positive, though the need for improvement in some SRFs was noted in reports. In some instances, the menu that was on the notice board in the kitchen did not match what was provided to residents and the CVs requested that the menu be posted out in the dining room where residents could see. When the CVS conducted a follow up visit, CVs noted that this had not been actioned and noted this within the report that was forwarded to the owner.

*The food was varied, mostly cooked from scratch and what we saw was fresh, generous and appetising. A recent innovation is serving dessert at supper time rather than straight after the main meal and it appears to be working.*

*Chooks provide fresh eggs and some fresh produce is grown in the garden. We observed the cook and one of the residents preparing the evening meal using fresh vegetables.*

*The food and menu plan for the residents are flexible and residents have the right to accept or refuse a particular meal.*

*The use of powdered milk was discussed at the previous CVS visit – this may need to be addressed again – as with previous request to post the menu in the dining room so residents know what they are having for lunch and dinner.*

## 7.6 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 attitude and engagement of SRF staff has a significant impact on how the facility operates and the overall atmosphere. CVs particularly consider this when visiting and comments received throughout this reporting period were generally positive. The CVS was pleased to note initiatives undertaken by some SRFs such as the creation of a newsletter. The variety of responses is demonstrated below:

*All interactions observed were calm, respectful and caring and the atmosphere was relaxed. It was also refreshing to note that the written notes in various parts of the facility are couched in courteous and respectful language*

*The residents maintained a friendly, respectful and positive attitude to the manger and likewise, he had a similar approach toward the residents.*

*The support worker was clearly popular whose interactions with residents were respectful and supportive. Many residents spoke well of him and felt that he was accessible should they have a problem. We did not observe any other staff/resident interaction.*

While some positive interactions were observed, there remain challenges for care providers to not fall into the adoption of institutionalised type directive support in contrast to the promotion of the more dignified self-directed care, which is the model inherent to NDIS and My Aged Care.

*Interaction between staff and residents was minimal*

*We were concerned that residents were told what to do rather than being offered a range of options to choose from, as this promotes intuitional behaviour and does not support independence.*

<sup>8</sup> SRF Advisory Committee Annual Report 2009 - 2010

## 7. SRF OUTCOMES AND THEMES

### 7.7 Rights and Responsibilities

The issue of resident safety remains a key focus of the CVS and in this reporting period was the fifth most frequently reported issue.

Various initiatives have been undertaken over the past years to assist in addressing this issue, including those relating specifically to accommodation for women, such as the Supported Social Housing Program and The Housing and Support Partnership. These initiatives were collaborative partnerships and assisted women living in SRFs into independent accommodation and particularly focused on those considered to be at risk.

The DCSI SRF Intake and Support Service (SRFI&SS) and its SRF 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 usually live together are evident.

Comments on this issue have included:

*The lack of locks on bedroom doors is a matter of concern, especially when there has been past incidences of a male resident entering women's rooms and taking his clothes off.*

*A female resident with a visual disability stated that she felt unsafe, as she stated that there were many aggressive male residents. She copes by always having her door locked and when at the dining table, she sits with her back against the wall so that she can see who is coming. She prefers to sit alone and stated that at any time there could be an angry outburst and 'at times it feels like a prison'.*

*A group of young male's bullying behaviours toward other residents for cigarettes and being unreasonable towards staff.*

*There is an inbuilt tension between maintaining awareness of individuals' dignity and respect and taking measures to reduce intimidating behaviour. This is reflected in the following comment from a CV report.*

*There are numerous cameras in the facility, which are monitored from the manager's office. The camera has been installed to reduce the incidence of intimidation and the borrowing of cigarettes. The residents are aware of these cameras. One resident reported that he felt like they were being watched all the time.*

Resident decision making and support was primarily highlighted with specific reference to the establishment of Care and Support Plans. This is an issue that has been discussed at the SRF Regional Network meetings, noting the importance of having a relevant and detailed plan in place to enable seamless support for an individual between service providers. This ideally involves all of those involved in the care and wellbeing of the resident, not least of all the residents themselves.

The CVS was able to participate in the discussion about the importance of 'Care and Support' or 'Service Plans' at the SRF Association Planning Day in May. The CVS was able to discuss the model utilised by Mental Health and reinforce the benefit of undertaking this task when someone is well and the importance of keeping it updated. This was well received by those present and could be considered in the development of a template for the SRF sector.

The following comment from a CV report highlights Care and Support/Service Plans:

*Contracts and Care Plans were examined. The forms used are standard documents developed by the SRF Association. They have been updated recently. While some of this was confined to merely changing the date (which was quite possibly all that was required), other documents had been updated with notes on what has changed in regards to behaviour, requirements etc. These additional notes gave a sense of history and change for that resident. A record of the medication administered is kept in the communication daybook. This facility uses 'behavioural charts' for some of the residents with behavioural issues. These consist of a matrix covering seven days and a box for each shift to comment and over the week changes in behaviour can be tracked and provide early warning signs of any difficulties developing. The charts are kept with the day communication book and medication records. This had not been encountered before by the CVs conducting the visit and could possibly be investigated further as an example of best practice.*

## 7.8 Access

The most frequently reported Level 2 classification was that of *Service Availability*. This most clearly manifested within the context of isolation that can be experienced by those living in SRFs. This isolation is the culmination of many factors – including health and psycho/ social considerations, financial limitations and frequently a sense of disengagement from the general community. This too often results in difficulties for a resident attempting to access various resources and opportunities.

Comments demonstrating variance in this area have included:

*There are a number of residents who are socially isolated, lonely and are ineligible for a personal care package from one of the NGOs.*

*Finances as usual is a barrier - the issue of expensive costs of transportation limits residents' capacity to participate in social activities.*

The CVS is aware of the potential opportunities for SRF residents who would be eligible for transfer to the NDIS. However, a significant proportion of SRF residents have not gone through a formal assessment process and are therefore not already 'in the system'. In its 'Submission to the Social Development Committee, South Australian Parliament, Co-Morbidity Inquiry', the Office of the Public Advocate (OPA) states that 'the design of the Scheme has led to concerns that people with intellectual disability, autism, or brain injury who may not seek out services voluntarily, may not approach the NDIS to seek services and will miss out. This group can need assertive engagement.'<sup>9</sup> A key challenge in the future for service providers within the sector is how to support eligible SRF residents to access the NDIS system and advocate for those who are not. The CVS has continued to highlight in a number of key forums the importance of this client group not being missed in communication, provision of support and assessment in the role out of the NDIS in SA.

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<sup>9</sup> The Office of the Public Advocate, Submission to the Social Development Committee, South Australian Parliament, Co-Morbidity Inquiry – Section 6 point 6.3



## 7. SRF OUTCOMES AND THEMES

### 7.9 Issues Impacting the SRF Sector

The CVS recognises that there are a number of issues impacting the SRF sector, at both a strategic and operational level. Some of these issues have been identified for a period of time (and noted in a CVS 'SRF Issues document') while others are emerging issues, brought to the attention of the CVS by service providers within the sector.

#### 7.9.1 SRF Governance Structure

The Supported Residential Facilities Advisory Committee (the SRFAC) was established under the *Supported Residential Facilities Act, 1992* (the Act)<sup>10</sup>. Its role was 'to provide advice and information to the Minister for the Department for Communities and Social Inclusion, local government, the Supported Residential Facility (SRF) sector; and residents, their families and advocates'<sup>11</sup>.

The SRFAC played a key role across the sector acting as a conduit between the key stakeholders with provision of high quality advice regard licencing and administration of the Act, policy and strategy considerations and the introduction and promotion of sector wide improvements.

As part of the Government's rationalisation of committees, the SRFAC was disbanded at the end of 2014.

The demise of the SRFAC has highlighted the need for an SRF Reference and Discussion Forum to consider the more strategic issues being experienced within the SRF sector due to the current climate of extensive 'whole of government' changes. The CVS observes service providers who meet to discuss service provision issues, frustrated by lack of clarity as to where to refer issues for higher level discussion and resolution. The CVS is therefore seeking to canvas how this identified need within the SRF can be addressed.

#### Recommendation

24. That the CVS canvas the most appropriate forum through which to address concerns related to the 'whole of government' changes currently impacting the SRF sector.

#### 7.9.2 Premature Discharge of SRF Residents from Hospital

Health workers have identified that on occasions, SRF residents are discharged from hospital back to the SRF when the SRF does not have the capacity to manage their particular medical requirements. This has, at times resulted in a re-admission to hospital when other short-term respite options could have been used. This would put the resident at risk of forfeiting their SRF bed or being required to undertake an ACAT assessment. They report changes being implemented across the health system have reduced the length of stay available to them within the hospital setting.

Effective communication between the SRFs and the discharge planners is encouraged so that the appropriate services may be initiated within the SRFs as at times this may be all that is required. In other situations, long stay respite is sought after for example, a resident is recovering from a debilitating fracture.

#### Recommendation

25. 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.

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<sup>10</sup> The Supported Residential Facilities Act 1992 – Historical versions up to and including to 30.6.2015

<sup>11</sup> Supported Residential Facilities Advisory Committee Annual Report 2011 – 2012.

### 7.9.3 Role of Environmental Health Officers

The CVS recognises the value in establishing collaborative working relationships with local government Environmental Health Officers (EHO) and the complementary nature of the two distinct roles. As stated in Section 7.4, the Scheme has been invited to present at the local government *Environmental Health Australia (SA) – SRF Special Interest Group* and looks forward to consolidating the positive contribution both roles can play within the SRF sector. The CVS considers that there would be value in establishing an information sharing protocol when responding to issues that are raised within the SRF sector.

#### Recommendations

26. That the CVS continue to strengthen its relationship with local government Environmental Health Officers, recognising the critical role they have within the SRF sector.
27. That the CVS promotes establishment of an MOU between the CVS and Environment Health Officers with respect to sharing of information relating to issues raised within the SRF sector.

### 7.9.4 NDIS, Aged Care Reform and Transforming Health

The concurrent, system wide changes that are occurring have the potential to significantly affect the SRF population. SRF residents over the age of 65 are now required to access the My Aged Care Portal for aged care services. Feedback from health providers suggests that this has proved difficult. Reforms in the aged care and disability sectors have impacted funding provision to the SRF sector. SRF residents stand to also be negatively impacted by the lack of certainty surrounding the continuation of allied health services they currently access. In addition, a key challenge for the sector is managing and highlighting the issue of premature ageing across this population group.

The individualised housing model favoured by the NDIA, indicates that the larger congregate model currently represented by the majority of SRFs will largely disappear. There is concern that as a significant number of SRF residents are not currently in receipt of support packages, or indeed have even gone through an assessment process, they are at risk of 'falling through the gaps'. It is acknowledged that at the very least, eligible SRF residents need to be supported in the future to access the 'NDIS process'. In addition, concern has been expressed for current SRF residents who will not be eligible for the NDIS, but are still regarded as living with significant issues and are currently supported within the SRF environment. The CVS recognises that increased intersection between the SRF sector and others, such as the homelessness sector for example, is likely.

The significant proportion of SRF residents living with both a dual-disability and mental health diagnosis creates specific issues when considering the rollout of the NDIS. Service providers have raised concerns about maintaining continuity of service provision for this population group within the proposed model and posed the possibility of the sector being transferred as one rather than on a regional basis.

#### Recommendations

28. That the CVS continue to promote to key stakeholders the specific support requirements of individuals with complex needs and co-morbidities to access the NDIS and My Aged Care Portal, ensuring the needs of this group are being represented within the decision making and change process currently being implemented.
29. That consideration be given to assessing how best to accommodate the transition of the SRF sector to the NDIS, recognising the multiple and complex needs of this population group and their high rate of dual-diagnosis.

## 7. SRF OUTCOMES AND THEMES

### 7.9.5 Review of the Supported Residential Facilities Act, 1992 (the Act)

It is a widely held view within the sector, that the Act in its current form creates difficulties for licencing authorities due to its vague definitions, which are subsequently open to varied interpretations. In 2009, *the Supported Residential Facilities Regulations, 2009* was released in an effort to guide interpretation of the Act. An explanatory guide on the new regulations was distributed and presented to key stakeholders at a number of information forums. Every SRF was also visited as part of this process.

However, the need for review remains. In the Co-Morbidity Inquiry of 2016 undertaken by the Social Development Committee of the South Australian Parliament, Recommendation 28 states '*It is recommended that the Supported Residential Facilities Act, 1992 be amended to include adequate provisions for comorbidity to ensure appropriate accommodation and support is provided.*'<sup>12</sup>

The Government's response to this recommendation tabled in its submission to the social Development Committee is that it is supported in principle. However, it further adds, '*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.*'

#### Recommendation

30. That the CVS continues to advocate for a review of the *Supported Residential Facilities Act, 1992* which reflects the complex and specific requirements of this population group and provides for genuine enforcement by those bodies assigned licencing and regulation responsibilities.

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<sup>12</sup> Co-Morbidity Inquiry of 2016 undertaken by the Social Development Committee of the South Australian Parliament.

## 8. Day Options Programs

Inclusion of Day Options Programs within the scope of the Disability Community Visitor Scheme 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 also featured in a number of 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.

To assist the successful progression of this initiative, the CVS and Disability SA, Department for Communities and Social Inclusion (DCSI - Contracting and Sector Liaison), organised an *Information Forum* for registered Day Options Program providers. This was an opportunity to share information about the CVS and the visitation and inspection process; gain a greater appreciation about the variety of programs being offered; and identify any considerations that could impact implementation.

The *Information Forum* took place 31 May with 20 key organisations represented.

While visits and inspections will not formally commence until the 2016-17 reporting period, two 'preliminary' visits have occurred during this reporting period.

A primary task has been to establish initial connection and presence within the sector, and identify the total number of Day Options Programs operating throughout the state in preparation for visitation scheduling.

Some of the organisations providing Day Options Programs are already familiar with the CVS through visits to their disability accommodation. For others, it is their first contact with the Scheme.

Overall the response has been positive, with providers identifying the CVS visits as a valuable resource for both individual consumers and the service system.

In the 2014-15 Annual Report, the anticipated benefits were listed as:

- » Increased surveillance 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 the 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.

With the consolidation of Day Options Programs during 2016–17, the Scheme is very positive about being able to incorporate these anticipated benefits.

## 9. Workforce

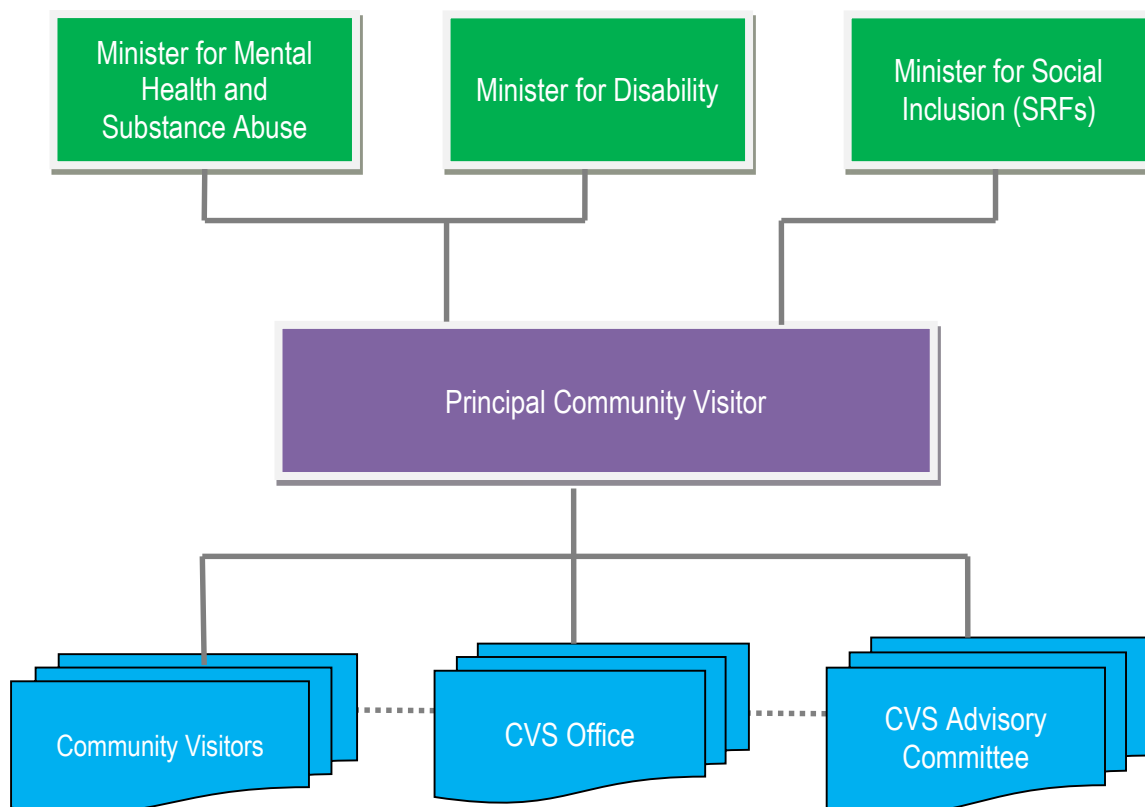
### 9.1 Governance of the Community Visitor Scheme

The Principal Community Visitor (PCV) and Community Visitors (CVs) 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 (SRFs).

Amalgamation of the Ministerial portfolios of Disability and Mental Health and Substance Abuse under Minister Vlahos has 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.



Since 1 July 2014, the CVS has been auspiced by the Department for Community and Social Inclusion (DCSI) for administrative purposes only.



## 9.2 Staff of the Community Visitor Scheme

Following is a list of paid staff members who worked in the CVS Office during the 2015-16 reporting period:

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

## 9.3 Community Visitors

CVs are an integral and valued component of the scheme and following is a list of all the CVs who have contributed during the 2015-16 reporting period:

Adil Saleem	Jim Evans
Alfred Piu	Joan Cunningham
Angela Duigan	John James Leahy
Angelikh Koutsidis	John Lykogiannis
Ankur Patel	John Sheehan
Ann Rymill	Judith Harvey
Annette Glover	Julie Margaret
Anthony Rankine	Karen Atkins
Anwitha Allam	Kim Steinle
Baile Bonokwane	Lindy Thai
Brian Day	Marianne Dahl
Carly Luzuk	Michele Slatter
Cecil Camilleri	Elle Churches
Chandani Panditharatne	Sara Elfalal
Colleen Gavan	Stephanie Keightley
Fiona Pullen	Sultana Razia
Gail Stubberfield	Susan Whittington
Gregory Wilton	Tracy Haskins
Hannah Allison	William Zhao
Ingrid Davies	Maurice Corcoran AM (Principal Community Visitor)

## 9. WORKFORCE

### 9.4 Advisory Committee

The members of the Advisory Committee during 2015-2016 were:

Ms Anne Burgess	Chairperson – CVS Advisory Committee
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Anne Gale	Equal Opportunity Commissioner/Public Advocate
Dr John Brayley	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
Ms Carol Turnbull	Private Mental Health Services Representative
Mr Jason Cutler	Consumer Representative
Ms Julia McMillan	Carer Representative
Ms Joan Cunningham	Community Visitor Representative
Ms Marianne Dahl	Community Visitor Representative (Proxy)
Mr Ian Bidmeade	Community Visitor Representative

#### **Disability Representatives:**

Dr David Caudrey	Executive Director Disability SA
Professor Richard Bruggeman	Senior Practitioner Disability SA
Ms Sandra Wallis	Government Disability Accommodation Representative
Ms Narelle Jeffery	Non-Government Disability Accommodation Representative
Mr Geoff O'Connell	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Mr Nigel Baker	Disability Consumer Representative
Ms Ann Rymill	Disability Community Visitor Representative
Mr Tony Rankine	Community Visitor Representative (Proxy)

## 9.5 Community Visitor Recruitment

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 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. Five (5) interviewers from Volunteering SA&NT were met and updated on the CVS recruitment requirements.

People interested in applying to become a CV 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.

One hundred and twenty-four (124) Expressions of Interest were received during the reporting period. Of these, thirty (30) applications were received.

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 workshop (see Section 7.5);
- » Undergo the screening checks and referee checks; and
- » Undertake a minimum of two orientation visits with the PCV.

Fourteen (14) applicants did not proceed 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. Sixteen (16) applicants were recommended for appointment representing 53.33% of viable applicants. Compared with 2014-2015, there was a 3.33% increase in the number of viable applicants going through to appointment.

A cabinet submission is prepared recommending the appointment of the applicant to the role of CV and endorsed by His Excellency, the Governor of South Australia. Fourteen (14) CVs were appointed through four (4) Cabinet Submissions (2 withdrew before appointment).

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

## 9.6 Initial and Ongoing Support and Training for Community Visitors

### 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 CVS;
- » **Module Two:** Role, Functions and Scope of the CVS;
- » **Module Three:** CVS Visits and Inspections;
- » **Module Four:** Practical Matters for CVs;
- » **Module Five:** Lived Experience;
- » **Module Six:** Mental Health;
- » **Module Seven:** Communication Strategies;
- » **Module Eight:** Disability and restrictive practices;
- » **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 July, September and November in 2015 and February and May 2016. Thirty-two (32) people attended training sessions which is an 8.47% increase from the previous year (up by 5).

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 participation interaction and if they felt confident in meeting the learning objectives of that module.

A summary of the feedback obtained over those five two-day sessions are as displayed in the chart below.

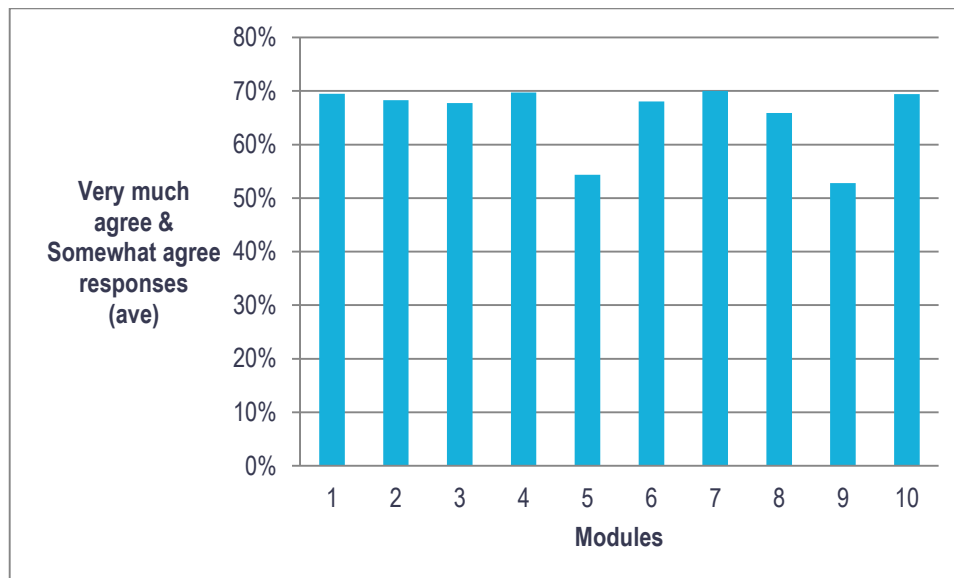


Figure 7.5.1 Orientation training overall feedback satisfaction. Note: Module 10 is presented as information and readings only, therefore not assessed in feedback process.

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

*Well explained, comprehensive, well-structured and also inspiring.*

*Guest speakers experience was very vital to learning and information.*

*Most informative and sensitive to the clients, and volunteers. Delightful, illustrative stories sensitively delivered. Inspirational! Thank you.*

*Great practical advice. Sessions were very interactive and insightful.*

*Real eye opener, presentation challenged, informed and encouraged. Enjoyed the case studies and group activities.*

*The whole course was excellent and well thought out and delivered.*

*Felt confident and encouraged with the participations and interaction and sharing of experience and knowledge.*

Overall, training session participants 'very much agreed' or 'somewhat agreed' that the training sessions met their needs and objectives. The CVS team is confident that prospective CVs are receiving the necessary information to prepare them for the role.

A minimum of two observation visits are undertaken with the PCV for further assessment. This provides the trainee CV with an opportunity to see the practical application of key areas covered in the training program. A total of forty-seven (47) observation 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 19 prospective CVs.

From the number of viable applicants, 46.67% 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

CVs continue to receive support with the online reporting tool that was implemented in January 2015. This is either over the telephone, via email or in person. Online reporting refresher training was offered in November 2016 to all CVs with four (4) taking up the offer.

In March 2016, a workshop was held for CVs to refresh their knowledge about Treatment and Care Plans to assist them with the focus on Treatment and Care Plans during May and June visits. Fifteen (15) CVs attended.

CVs are invited to participate in the Restrictive Practices, and Communication training modules during training workshops. One (1) CV has participated in the Communication training to date.

CVs 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.

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Seventeen (17) yearly reviews were due throughout the year with ten (10) CVs participating in performance and development discussions with the PCV. CVs are encouraged to pursue development opportunities and discuss other interests with the PCV.

There are presently 37 active CVs, and 11 inactive CVs who are no longer participating in the CVS.

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, 2015 – Online Reporting Tool;
- » October, 2015 – Mental Health Week: Looking After Your Own Mental Health;
- » December, 2015 – Morning tea with (then) Minister for Disability, Hon Tony Piccolo;
- » April, 2016 – Guest speaker Dr David Caudrey, Executive Director Disability SA; and
- » June, 2016 – Focus on Treatment and Care Plans.

There were 71 attendances by CVs across the 5 'Get Togethers'. Notes from the 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 CVs on a monthly basis providing general updates and information regarding strategic direction and issues arising.

CVs can also access the SA Government Employee Assistance Program.

## 9.7 Recruitment Strategies External to the CVS

Networking opportunities have occurred with Volunteering SA&NT, Country Health SA and Southern Volunteering. Attendance at relevant meetings has happened with the Recruitment and Training Officer attending the National Volunteering Standards workshop, Adelaide City Council National Volunteer Week meeting, Central Volunteer Managers meetings (4) Disability, Ageing and Lifestyle Expo, and the Adelaide University Volunteer Expo.

The PCV has officially thanked the CEO of Volunteering SA&NT via letter, for their ongoing support of the CVS and for the number of referrals of potential CVs.



## 10. Complaints

### 10.1 Public Complaints

No public complaints in regards to the Community Visitor Scheme were received by the Principal Community Visitor in 2015-16.

## 11. Conclusion

As can be seen throughout this report, the Community Visitor Scheme (CVS) has been able to recruit, maintain and support an exceptional team of Community Visitors (CVs) to undertake the legislative required visits to our disability facilities, Supported Residential Facilities (SRFs) and now Day Options.

The CVS has significantly improved our methods of tracking issues that arise from visits with our Coordinators and CVS Manager regularly meeting to review progress and status of all the issues arising from visits. The Coordinators and CVS Manager also keep the PCV informed of all these individual issues that are numbered and coded through monthly tracking meetings.

The Coordinators have also 'locked' in meetings with both non-government organisation (NGO) managers and Disability and Domiciliary Care managers to follow up on all issues that have been referred to them and have forwarded a summary of visit reports to agencies on a regular basis. This keeps both the CVS and agencies accountable to both the individual complaints the CVS has advocated for and some of the systems issues that have been raised.

It would be negligent of me if I did not acknowledge the general responsiveness of the vast majority of agencies when issues have been raised. The CVS has really appreciated this and has been able to, in a number of instances, highlight to Dr David Caudrey, the DCSI Chief Executive and the Minister these positive responses and improved outcomes for clients/residents.

Over this past reporting year, I believe the CVS has continued to improve scheduling and coordinating of visits and many of its operational procedures such as the monitoring and tracking of issues. The State Government has committed through its Bi-Lateral Agreement with the Commonwealth related to the transition to the full roll out of the NDIS, to continue funding the CVS until 30 June 2018, which includes both the mental health and disability areas of the Scheme.

### 11.1 Next Steps

#### **Regional South Australia**

The CVS has been successful in obtaining a wheelchair accessible vehicle through Fleet SA to enable the PCV to visit regional areas of South Australia. The majority of disability accommodation sites to be visited in the rural areas have now been visited with a small number yet to be visited and we will continue to try and recruit regional CVs.

#### **Community Visitor Workforce**

The CVS has undertaken targeted recruitment in all of the regional areas and have been able to appoint some great local people. This will need to continue to alleviate travelling and associated costs which will otherwise be a significant burden. These CVs are undertaking visits to the Integrated Mental Health Units in Whyalla, Berri and Mt Gambier and also the rural disability accommodation sites and SRFs in those areas. The CVS will also continue to endeavour to recruit CVs from an Indigenous background.

#### **Visits and Inspections of Day Options Programs**

The CVS successfully developed a business case detailing reasons, cost and strategy to expand the CVS visits and inspections into Day Options Programs.

With employment of an SRF and Day Options Coordinator in March, commencement of visits to Day Options Programs will formally begin in the next reporting period, although two 'preliminary' visits did occur in this current reporting period. This increased surveillance on the quality of care provision to people with disabilities is vital and provides an 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.

#### **Development of New CVS Information Management System**

The CVS team has historically used spreadsheets to manage its business processes and to manage its data. This creates many challenges that the team projects could be resolved through the design and implementation of a custom designed, data based Information Management System. Business process mapping has been completed and the ICT design team utilising the 'Salesforce' application as a base, have commenced developing the CVS system. Its implementation during the next reporting period will be a significant development for the team.

## 11. CONCLUSION

### 11.2 Recommendations

This report discusses a range of significant issues that have emerged in Sections six and seven of the report and attempts to arrive with a set of recommendations as a means of continuous improvement. These are recommendations from the PCV alone and do not necessarily represent views of the CVS Advisory Committee or the collective views of CVs.

It is important for any reader of this report to refer to Sections 6-7 to appreciate the context for the below recommendations.

#### Disability Accommodation Services

##### Activities & Structured Programs

1. That CVs 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.

##### Suitable Facilities, Maintenance and Transport

2. 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.
3. 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.

##### Respectful Communication

4. 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.
5. The CVS to highlight the above observations and continue to report these to Senior Management in DCSI and the relevant NGO managers.
6. The CVS to highlight the importance of staff recruitment, training and consistency through the ongoing benefits of being able to acknowledge, reward and retain quality staff.
7. The CVS to highlight the importance of retaining the specialist disability programs to ensure ongoing training and support for new and current staff in the management of residents with complex needs and behaviours.

##### Supporting Independent Living

8. The CVS to 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.
10. The CVs continue to check and report on concerns raised regarding the cost of utilities and how costs are shared within accommodation settings.

##### Food Preparation and Provision

11. 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.

##### Care Planning

12. That CVs continue to monitor and report on Lifestyle/Person Centred Plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
13. That CVs enquire into the implementation of the Plans and seek out evidence that the Plan is being implemented and regularly reviewed.

### **Gender Safety of Residents and Protective Behaviours**

14. That CVs check with residents who require a support worker for personal support, that they are receiving that support from a worker whose gender is one that they prefer.
15. The CVS continues to monitor gender safety and protective behaviours of both residents and staff.

### **Clients with Disabilities Such as Intellectual Disability, Brain Injury or Autism in Acute Mental Health Units Especially in Forensic Care**

16. That the independent review report into forensic care be released to the public together with the Government's response.
17. That all patients with dual-disability be linked to a key worker with expertise in this area who establishes a detailed Case Plan.
18. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
19. That individual case planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.

### **Medication and Restrictive Practices**

20. The CVs continue to check resident's medication charts and report unusual behaviours (including the appearance of excessive drowsiness) to the PCV.
21. The CVS to continue to monitor progress of the Chemical Restraint Project and agreed actions from the planning session.
22. 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.

### **Delays in Responding to Requests for Provision of Equipment by ASSIST**

23. The CVS continues to monitor, report and follow up any individual delays in the provision of equipment or services.

## **Supported Residential Facilities**

### **SRF Governance Structure**

24. That the CVS canvas the most appropriate forum through which to address concerns related to the 'whole of government' changes currently impacting the SRF sector.

### **Premature Discharge of SRF Residents from Hospital**

25. 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.

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

26. The CVS continue to strengthen its relationship with local government Environmental Health Officers, recognising the critical role they have within the SRF sector.
27. The CVS promotes establishment of an MOU between the CVS and Environment Health Officers with respect to sharing of information relating to issues raised within the SRF sector.

## 11. CONCLUSION

### **NDIS, Aged Care Reform and Transforming Health**

28. The CVS continue to promote to key stakeholders the specific support requirements of individuals with complex needs and co-morbidities to access NDIS and My Aged Care Portal, ensuring the needs of this group are being represented within the decision making and change process currently being implemented.
29. That consideration be given to assessing how best to accommodate the transition of the SRF sector to the NDIS, recognising the multiple and complex needs of this population group and their high rate of dual-diagnosis.

### **Review of the *Supported Residential Facilities Act, 1992* (the Act)**

30. The CVS continues to advocate for a review of the *Supported Residential Facilities Act, 1992* which reflects the complex and specific requirements of this population group and provides for genuine enforcement by those bodies assigned licencing and regulation responsibilities.



## 12. References

### 12.1 The Community Visitor Scheme (CVS)

The following documents can be found on the CVS website [www.sa.gov.au/cvs](http://www.sa.gov.au/cvs)

- » Community Visitor Scheme brochure;
- » Introduction to the Community Visitor Scheme booklet (Disability Accommodation);
- » Community Visitor Conditions of Appointment and Code of Conduct; and
- » Community Visitor Scheme Advisory Committee Terms of Reference.

### 12.2 External References

Australian Bureau of Statistics, Survey of Disability, Ageing and Carers 2012.

Shut Out: The Experience of People with Disabilities and their Families in Australia. National Disability Strategy Consultation Report prepared by the National People with Disabilities and Carer Council, 2009.

National Disability Strategy 2010-2020. An initiative of the Council of Australian Governments, 2011.

Specific program information provided by the SRF Intake and Support Service (SRFI&SS) – Exceptional Needs Unit (ENU) Department for Communities and Social Inclusion (DCSI)

Literature Review – The Health of the Vulnerable, Disadvantaged People Living in Supported Residential Facilities - Independent Study by Diane Pinchbeck SRF Health Access Team SA Health

SRF Advisory Committee Annual Report 2009 - 2010

SRF Advisory Committee Annual Report 2011-2012

The Office of the Public Advocate, Submission to the Social Development Committee, South Australian Parliament, Co-Morbidity Inquiry – Section 6 point 6.3

The *Supported Residential Facilities Act, 1992* – Historical versions up to and including to 30.6.2015

Supported Residential Facilities Advisory Committee Annual Report 2011 – 2012.

Co-Morbidity Inquiry of 2016 undertaken by the Social Development Committee of the South Australian Parliament.

## 13. Glossary of Acronyms

Acronym	Definition
ACAT	Aged Care Assessment Team
ASSIST	Adult Specialist Services Intervention and Support Team
CEO	Chief Executive Officer
CLCA	Criminal Law Consolidation Act
CMH	Community Mental Health
COAG	Council of Australian Governments
CV(s)	Community Visitor(s)
CVS	Community Visitor Scheme
DCSI	Department for Communities and Social Inclusion
DD	Dual-Disability
DDA	Disability Discrimination Act
DOP	Day Options Programs
DSA	Disability Services Act
EHO	Environmental Health Officer
ENU	Exceptional Needs Unit
GP	General Practitioner
HCSCC	Health and Community Services Complaints Commissioner
ICCs	Intermediate Care Centres
ICT	Information and Communication Technology
ID	Intellectual Disability
IT	Information Technology
KPI(s)	Key Performance Indicators
MOU	Memorandum of Understanding
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation

OPA	Office of Public Advocate
OT	Occupational Therapy
OHWS	Occupational Health, Welfare and Safety
PCP	Person Centred Plans
PCV	Principal Community Visitor
PRN	Pro Re Nata (Medication used when necessary)
S269 Clients	Section 269 of the Mental Health Act, 2009
SA	South Australia
SACAT	South Australian Civil and Administration Tribunal
SA&NT	South Australia and Northern Territory
SASP	South Australian Strategic Plan
SEP	SRF Entry Point (Assessment Team)
SRF(s)	Supported Residential Facility
SRFAC	Supported Residential Facility Advisory Committee
SRFI&SS	Supported Residential Facility Intake & Support Services
UNCRPWD	United Nations Convention on the Rights of Persons with Disabilities

## 14. Appendices

These new Regulations are to be read in conjunction with Subsection 50 – 54 of the *Mental Health Act, 2009*. Copies of both are provided in full in the Appendix to this Report.

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

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.

#### **Note—**

As required by Section 10AA(2) of the *Subordinate Legislation Act, 1978* the Minister has certified that, in the Minister's opinion, it is necessary or appropriate that these regulations come into operation as set out in these regulations.

#### **Made by the Governor's Deputy**

With the advice and consent of the Executive Council

on 2 May 2013

No 31 of 2013

DCSICS-12-021



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

### 50—Community Visitors

- (1) There will be a position of Principal Community Visitor.
- (2) There will be such number of positions of Community Visitor as the Governor considers necessary for the proper performance of the Community Visitor's functions under this Division.
- (3) A person will be appointed to the position of Principal Community Visitor, or a position of Community Visitor, on conditions determined by the Governor and for a term, not exceeding three years, specified in the instrument of appointment and, at the expiration of a term of appointment, will be eligible for reappointment.
- (4) However, a person must not hold a position under this section for more than two consecutive terms.
- (5) The Governor may remove a person from the position of Principal Community Visitor, or a position of Community Visitor, on the presentation of an address from both Houses of Parliament seeking the person's removal.
- (6) The Governor may suspend a person from the position of Principal Community Visitor, or a position of Community Visitor, on the ground of incompetence or misbehaviour and, in that event—
  - (a) a full statement of the reason for the suspension must be laid before both Houses of Parliament within three sitting days of the suspension; and
  - (b) if, at the expiration of one month from the date on which the statement was laid before Parliament, an address from both Houses of Parliament seeking the person's removal has not been presented to the Governor, the person must be restored to the position.
- (7) The position of Principal Community Visitor, or a position of Community Visitor, becomes vacant if the person appointed to the position—
  - (a) dies; or
  - (b) resigns by written notice given to the Minister; or
  - (c) completes a term of appointment and is not reappointed; or
  - (d) is removed from the position by the Governor under subsection (5); or
  - (e) becomes bankrupt or applies as a debtor to take the benefit of the laws relating to bankruptcy; or
  - (f) is convicted of an indictable offence or sentenced to imprisonment for an offence; or
  - (g) becomes a member of the Parliament of this State or any other State of the Commonwealth or of the Commonwealth or becomes a member of a Legislative Assembly of a Territory of the Commonwealth; or
  - (h) becomes, in the opinion of the Governor, mentally or physically incapable of performing satisfactorily the functions of the position.
- (8) The Minister may appoint a person to act in the position of Principal Community Visitor—
  - (a) during a vacancy in the position; or
  - (b) when the Principal Community Visitor is absent or unable to perform the functions of the position; or
  - (c) if the Principal Community Visitor is suspended from the position under subsection (6).

## 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;
  - (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.

## 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*.

### 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 Programs (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 OH&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