

4 Accommodation and service delivery standards

At a glance

Background

By 2003, all service providers were required to fully comply with service standards established by DHS in 1997. Five outcome standards that align with the goals of the State Disability Plan were also developed by DHS in 2006.

Key findings

- Commencing in 2009, a selection of houses operated by all service providers will be independently audited to assess compliance with service standards.
- DHS has identified approximately 200 of its houses did not meet building and occupational health and safety standards and has begun a process to address the issue.
- By July 2008, service providers are required to have provided residents that entered SSA prior to July 2007 with a statement covering aspects such as the respective rights and duties of the provider and resident.
- A more systematic approach is required for measuring resident satisfaction with SSA accommodation.

Key recommendation

- DHS should assess residents' satisfaction, directly or through their family and friends, with their accommodation on an on-going basis, and incorporate the results into a system of continuous improvement.

4.1 Accommodation and service delivery standards

4.1.1 Are SSAs subject to service standards and do they comply with these standards?

In 1997, DHS issued nine Victorian Standards for Disability Services that set minimum operational standards for DHS and CSO service providers. By 2003, all service providers had to fully comply with these standards. In 2006, DHS developed a further five disability outcome standards to align with the goals of the State Disability Plan. In 2007, DHS incorporated the nine operational standards and five outcome standards into its *Quality Framework for Disability Services in Victoria* shown in Figure 4A.

Figure 4A
Quality Framework for Disability Services in Victoria



Source: Victorian Advocacy League for Individuals with a Disability Inc (VALID).

Figure 4B shows the implications of each of the five outcome standards for the person with a disability and their support provider.

Figure 4B
Disability outcome standards and their implications for disability support services

| | Standard 1 Individuality | Standard 2 Capacity | Standard 3 Participation | Standard 4 Citizenship | Standard 5 Leadership |
|------------------|--|--|---|---|---|
| Individual | Each individual has goals and aspirations and makes choices about their life. | Each individual's abilities and potential are identified and encouraged. | Each individual is able to access their community. | Each individual has rights and responsibilities as member of the community. | Each individual has the opportunity to inform the way that supports are provided. |
| Support provider | Support providers actively encourage individuals to be themselves and to make choices and decisions about their life and their future. | Support providers work together, develop their capacity to respond to individuals. | Support providers work with individuals to assist them to actively engage in their community. | Support providers actively encourage and support individuals to exercise their rights and responsibilities. | Government and support providers develop, promote and implement good practice. |

Source: Department of Human Services.

Monitoring compliance with the industry standards

Service agreements between DHS and CSOs require a CSO to assess itself against the industry standards and to develop and implement a quality plan. They also require a CSO to conduct two new quality improvement activities each year.

All SSA houses visited had conducted an annual self-assessment report. However, they placed little value on them and DHS provided no feedback about the reports. CSOs considered the process would be improved if the report was used to benchmark their performance against other CSOs and against DHS houses.

DHS advised the exercise was considered as a self-assessment and that it had never intended to provide feedback. DHS publishes aggregated results of the self-assessments on their website.

In 2008, DHS proposes to follow-up all service providers that do not submit self-assessments. It has asked houses to identify what they did well throughout the year, what they could improve and whether improvements identified in the past year's report were implemented.

Under the *Quality Framework for Disability Services in Victoria*, a selection of SSA houses will be independently audited over a three-year period commencing in 2009. All DHS and CSO houses we visited were aware of the intention to introduce the quality framework, and were concerned they would not meet its requirements.

Since 2007, DHS regional disability services managers, independent of the house, have been conducting 'better practice' audits. Aspects reported on include:

- compliance with mandatory training requirements (such as first aid, fire and emergency and cardiac pressure resuscitation training)
- the completion of police checks of new staff and those staff who have not had a shift within six months.

At January 2008, 40 houses had been subjected to a 'better practice' audit.

DHS and CSOs noted the challenge of measuring quality-of-life outcomes for residents, and all considered it important but difficult. They considered the new quality framework to be a step in the right direction, but not the final answer. About half the CSOs we visited had established their own quality assurance processes (mainly an internal audit function), including resident satisfaction surveys. Three of the 11 CSOs covered by this audit were also monitoring residents' quality-of-life outcomes.

Compliance with administrative requirements

All the houses visited had carried out some form of internal auditing. Some regions relied on house support staff to identify problems while others used non-house officers to conduct internal audits.

DHS monitors whether or not CSOs comply with the requirements of service agreements. These include occupational health and safety standards, building regulations, emergency responses, financial accountability, employee safety screening and complaints management.

4.1.2 Office of the Public Advocate — Community Visitor Program

Under the Community Visitor Program, volunteers visit each house and report to the Office of the Public Advocate, among other things, about resident satisfaction, the physical condition of the house, living conditions with other residents and the support provided. Many SSA support staff valued this program but saw it as focusing on micro, rather than macro, issues. All the houses we visited had been visited by community visitors in 2007. In any year, the community visitors make repeated visits to their allotted houses. The reports of community visitors mainly focused on physical condition issues, with very few focusing on residents needs (such as their support plan and their compatibility with other residents). Although the community visitors annual report (tabled in Parliament) raises more substantive issues, neither DHS nor CSOs are required to act on the recommendations in the report.

The Community Visitors Program is the only independent review of houses. If community visitors find a problem at a house, they record it in their record of visit, identify any required action and follow-up with a management letter.

DHS and CSOs value the program. They acknowledge the work of the community visitors by endeavouring to resolve concerns as quickly as possible and to maintain cooperative relationships with their community visitors. We also support the program.

4.1.3 Monitoring the condition of houses

In 2003-04, DHS carried out condition audits of 458 DHS owned houses (this excluded houses owned by the Director of Housing and a private company). The audit found significant condition, functional and occupational health and safety issues. DHS estimated it would cost \$225 million to bring 443 houses up to the required standards.

DHS subsequently identified that approximately 200 of its houses did not meet current building and occupational health and safety standards, and therefore needed to be replaced or significantly refurbished. The cost to bring these houses up to standard has not been estimated by DHS.

To date, DHS has requested a total of \$123.2 million (\$59 million in 2005-06 over three years and \$64.2 million in 2007-08 over three years). To date, funding totalling \$44.5 million has been received which will provide 51 new (replacement) houses and nine refurbished houses. A further \$10 million was funded for minor upgrades to facilities that did not meet occupational health and safety or building regulations. There will be no net increase in beds.

In 2006-07, \$15 million was provided to replace facilities and provide equipment to the CSO sector.

We found no evidence that any house kept a maintenance schedule, other than maintenance relating to fire risk and occupational health and safety.

The response to maintenance requirements differed among house owners, as did whether it was in a metropolitan or rural area. The private company that owned SSA houses responded promptly to minor requirements (such as a door hung or hole in the wall) in rural areas, but resisted responding to larger works (such as hand rails and hoists), believing these would reduce resale value.

DHS's Office of Housing maintains its houses and those owned by DHS's Disability Services Division. CSOs that managed DHS houses advised that they often carried out maintenance because it was quicker and easier than going through DHS.

4.1.4 Conclusion

DHS has established appropriate service standards with the development of the *Quality Framework for Disability Services in Victoria*. The Framework, which will apply to DHS and to CSO houses, establishes minimum service standards. Although quality assurance processes have been in place they are being strengthened. Compliance with the standards will be monitored through independent audits of SSA houses to be completed over a three year period commencing in 2009.

The Framework also incorporates outcome standards for residents and a process for progressively monitoring results, which has not occurred to date.

In addition, several CSOs have proactively established quality assurance systems to measure residents' satisfaction and outcomes. The work done by some CSOs clearly goes beyond minimum requirements and indicates leadership and innovation in meeting residents' needs.

DHS has audited the condition of its houses but lacks resources to implement all the identified improvements required. To date, DHS has received \$44.5 million of the \$123.2 million it requested to bring its SSA houses up to the required standards. This indicates a significant proportion of houses (approximately 200) still do not meet current building and occupational health and safety standards.

4.2 Are systems in place to monitor residents' satisfaction with their accommodation?

4.2.1 Addressing grievances

The SSA houses visited had various processes to ensure that residents could raise concerns or grievances and participate in day-to-day decision making. While processes varied among houses, residents' meetings were the most common mechanism used. Some houses had documented grievance procedures and explained them to residents. In others, we found no evidence of these procedures.

Where residents found verbal expression difficult or impossible, support staff relied on staff knowledge of the resident. Some houses encouraged a resident's family or guardian to attend meetings. There was little effort to find alternative means of engaging residents, although some residents were supported by external advocacy groups. We identified primary carers, support staff and families as the most active advocates for residents.

We found that DHS and CSOs listened and usually acted on grievances expressed by residents and their families. However, while DHS and CSOs generally acknowledged the need for grievance processes, most were internal processes with little independent accountability: residents made their complaints known through staff, who may have had a conflict of interest.

The *Disability Act 2006* establishes a Disability Services Commissioner. The Commissioner will, among other duties, investigate complaints, conciliate where complaints are made in relation to a disability service provider and publish information about complaints. The effectiveness of the Commissioner is yet to be tested.

4.2.2 Residential statements

Under the previous Act, service providers were not obliged to provide residents with a statement outlining the obligations of the service provider and the resident. The *Disability Act 2006* requires, from July 2007, a residential statement for all residents upon entry into their accommodation. A residential statement includes items such as the period of residency, a description of the services provided, the respective rights and duties of the service provider and the resident, and the conditions under which the service is provided.

The *Disability Act 2006* also requires all residents that entered SSA prior to July 2007 to have a residential statement by 1 July 2008.

4.2.3 Resident surveys

DHS had carried out surveys of residents in some regions but not all.

Some CSOs have established a 'client committee' to help them gauge the impact of their services. Several CSOs conduct satisfaction surveys of residents. One such survey identified a range of needs including support arrangements for the resident being unsustainable because the resident's parents were very old. The CSO then identified the need to register this person on the Disability Support Register.

4.2.4 Conclusion

DHS and CSO grievance processes should be improved by making houses more accountable for addressing the concerns of residents.

The recent (2006) establishment of the Disability Services Commissioner, and other changes to the Office of the Senior Practitioner, may provide the accountability that has been missing to date.

Adopting a more systematic approach to measuring resident satisfaction in all DHS and CSO houses would provide useful information for improving service delivery.

Recommendation

- 4.1 DHS should assess residents' satisfaction, directly or through their family and friends, with their accommodation on an on-going basis, and incorporate the results into a system of continuous improvement.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported.

There are a range of activities across programs, regions and agencies that assess satisfaction but this needs to be more systematic, and the data aggregated so that it can be used for continuous improvement activities across the State. Some examples of activities are client surveys, annual 'Family Forums', Program Advisory Group meetings and house meetings. Feedback from these is incorporated into strategic planning and also used to inform the planning process for residents.

Service user satisfaction with services and continuous improvement of those services are driving principles of quality management in disability services. Processes to drive both are articulated in quality management systems documentation from 1997 – the Disability Services Self Assessment System [DSAS] – and 2007 – the Quality Framework for Disability Services in Victoria [Quality Framework 2007]. Both systems apply across all disability service providers and not just to accommodation services.

DSAS incorporates organisational self-assessment and reporting but lacks verification. However, service user [including families] feedback is integral to the process of self-assessment. The DSAS handbook documents an annual, three-stage process of self-assessment – beginning with service user assessment - and provides guidance on potential feedback mechanisms. These include satisfaction surveys however, it is neither a mandatory nor singular requirement.

The Quality Framework 2007 includes a process of organisational self-assessment against industry standards and outcome standards as well as independent monitoring for verification proposed for implementation from 2009. In the Quality Framework, the importance of service user satisfaction with services is identified. The Outcome Standards require the person's perceptions of service to be reflected in assessing service provider performance and it is through this process that information on satisfaction with services will link with continuous improvement.
