

3 Supporting people with a disability

At a glance

Background

Only those people with a current need that meet eligibility criteria are recorded on DHS's Disability Services Register. Support is provided based on a prioritisation process and matching vacancies to individual circumstances. An individual plan and a support plan are prepared for each person who receives support.

DHS has adopted a person-centred planning approach for preparing resident support plans to meet the requirements of the *Disability Act 2006*. Person-centred planning should be driven by the resident's needs, goals and aspirations and how these are to be achieved.

Key findings

- SSA resident information continues to be fragmented and not systematically recorded. There is no clear format specified for individual plans, and no recognised capabilities established for the people who prepare them. In consequence, plans vary widely in format and in quality.
- Planning for individual residents has been inconsistent. There is confusion at operational levels about what a 'person-centred planning approach' means, and what constitutes a support plan and an individual plan. Residents' involvement is not always clear. The variability in the quality of individual plans and approaches to preparing the plans was raised in our 2000 audit of disability services.
- Funding arrangements are inconsistent with the person-centred planning approach, with accommodation and day program funds allocated to service providers and not to the resident.
- A practical response to limited transport options and staffing is that houses often carry out group activities rather than adopt tailored individual approaches.
- In consultation with CSOs, DHS needs to identify core elements to be included in individual planning processes, and establish systematic monitoring and review.

At a glance - *continued*

Key recommendations

DHS should:

- provide focused support, guidance and resources to facilitate the development of individualised plans by service providers. This should involve:
 - adopting a team-based approach to preparing plans, comprising relevant support and professional staff
 - on-the-job training
- develop its information systems to provide relevant historical information relating to SSA residents for support staff to assist in meeting residents' day-to-day and long-term needs
- review the SSA funding model to better align it with the new service model of individualised support
- systematically assess the capacity and expertise of SSA staff to deliver support services in accordance with the new service (social) model and to address gaps subsequently identified.

3.1 Do SSA residents meet DHS eligibility criteria and are they adequately assessed?

3.1.1 Introduction

Under the *Disability Act 2006*, anyone with a disability can be assessed to establish eligibility for services and then approach a service provider to prepare for them a 'support plan'. A person who requests assistance is initially assessed for eligibility against the criteria specified in the Act.

Eligible people who have an individual plan are then assessed against DHS's criteria for registration on the Disability Services Register (DSR). The criteria applied are:

- they have a current and ongoing need for support
- mainstream or generic services are not available
- the disability support is not the sole source of support but a contribution
- they are supported within their own cultural identity
- the support will meet the person's needs in the most innovative and cost-effective way.

A person can be listed on the DSR with priority status if:

- they are a child in facility-based care
- their current living situation puts them at serious risk of harm or of harming others
- the support will maintain them in their home (or with their family, in the case of a child or young person) where the only and immediate alternative is a facility based setting; for example, in the situation of the serious illness or death of primary carer
- they are in a custodial placement or residential treatment facility after completing their order
- they want to move out of disability supported accommodation or a residential institution
- they have a degenerative condition and are deteriorating rapidly.

Before the DSR, DHS recorded people's service needs on the Service Needs Register (SNR). The SNR recorded people with current needs as well as those who may have a future need. The DSR only records those people with current needs (and those who's current need will manifest within 12 months) and matches these with an available resource based on prioritisation criteria.

People on the DSR are given a priority listing if they meet one or more of nine criteria specified in the DSR guidelines. At the same time, service providers (DHS and CSO) declare any vacancies within their SSAs. When a vacancy is declared the DHS region convenes an assessment panel. DHS officers put forward profiles of a number of people they consider best suit this vacancy. The panel determines who is offered the opportunity to fill the vacancy. The panel allocates individual support packages in the same way. A service provider must prepare a support plan for people with a disability receiving ongoing support.

3.1.2 Eligibility assessments

Audit found that:

- DHS has established policies and procedures to guide assessments of people to establish their eligibility for support
- of the 32 residents' files we reviewed, all met the disability eligibility criteria.

3.1.3 Conclusion

Processes for assessing eligibility were considered adequate.

3.2 Do SSA residents have individualised plans in accordance with the legislative requirements?

3.2.1 Introduction

Before 2006, there were two types of support plans:

- a general services plan – reviewed every three to five years, or as required – that identified a person's life-goals and required supports
- an individual program plan – reviewed annually – that supported the general services plan and addressed short-term skill development needs.

An individual plan (prepared by the person with a disability or a person they nominate e.g. parent, family member) was also required (and still is) in order to seek assessment for registration on the DSR.

The *Disability Act 2006* requires people with a disability to have a support plan if they are allocated SSA and it is anticipated that their support needs will be ongoing.

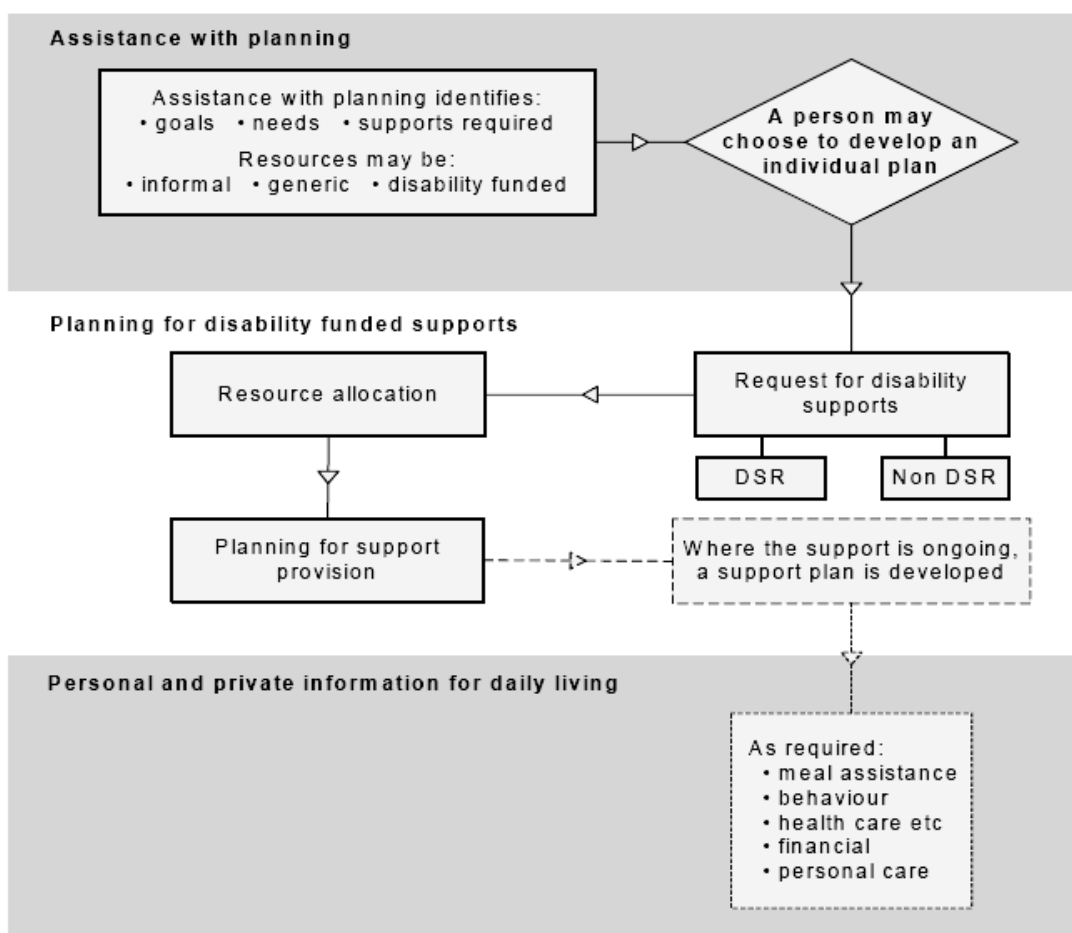
General services and individual program plans prepared before 2006 continue to have effect until their review date, at which time the requirements of the 2006 Act come into effect. These pre-2006 plans must be updated to reflect the 2006 Act's requirements by 1 July 2008.

Before 2006, the plans of the residents were designed around the available services. Plans prepared since 2006 focused on support needed to fulfil residents' goals and aspirations.

DHS has adopted a person-centred planning approach for preparing resident support plans to meet the requirements of the *Disability Act 2006*. Person-centred planning is directed by the resident (or a person nominated by the resident such as a family member) and describes their needs, goals and aspirations and how these will be achieved. The *Disability Act 2006* states that resident's should direct their planning and have the ability to exercise control over their lives.

Figure 3A shows DHS's approach to preparing a resident's support plan.

Figure 3A
Preparing a resident support plan



Source: Department of Human Services.

3.2.2 Consistency of support plan preparation

With respect to support plans, the *Disability Act 2006* specifies that, 'Planning encompasses a range of responses from a brief discussion and agreement about actions required through to an extensive process and the development of a plan across a whole range of life areas documented in a format that is meaningful to the person and their network.' The Act does not specify the content or format of support plans nor minimum qualifications for people who prepare the plans.

All 32 residents' files we examined included a plan: 26 of which having been prepared in 2007. Most files had three or four different plans (as well as general services and individual program plans) that addressed issues such as health and nutrition, care, behaviour management, day program attendance and external activities.

There is no mechanism to ensure the resident makes an informed decision about whom they choose to prepare their plan. There is also no mechanism to ensure that the person doing the planning will have access to all relevant resident information, as this information is kept in many different places.

We found that the content of plans and approaches to their preparation varied widely. Specifically:

- plans varied considerably in quality and detail: for example, some plans consisted simply of lists of tasks while others were more comprehensive, with specific staged goals and suggested activities on how to achieve these goals
- plans were developed by various people (for example, case manager, house supervisor, team leader, health professional, all of whom had different qualifications and backgrounds, resulting in a variety of plans of variable quality)
- the level of involvement by the resident in the development of their plan was not always clear, even where a person-centred planning approach had been used.

The results of our file reviews were consistent with a 2007 DHS quality review of one region's disability services. This also identified that plans were not current and needed review; that resident profiles were outdated; and that a recommended pain management plan had not been written. The review recommended that all residents' profiles include critical information about each resident including any specific behavioural issues and associated management.

We found it particularly difficult to determine whether information was current, as dates were often missing. The absence of dated documentation made chronological histories hard to compile from the resident's files: indeed some older DHS forms did not even have space for a date.

Finding of 2000 audit

The variability in the quality of individual plans and approaches to preparing the plans was raised in our 2000 audit of disability services. That audit concluded, inter alia, that, 'The quality of individual program plans varied as did the processes for developing and reviewing them. Overall, they were not of a standard adequate to meet the legislative intent. Common problems include: the absence of objectives to promote the development or community integration of clients; plans written in a way that did not allow progress on objectives to be assessed; and lack of documentation on progress and poor processes for reviewing plans.'

3.2.3 Revising plans to meet new legislative requirements

The *Disability Act 2006* requires residents' general service plans and individual program plans prepared prior to 2006 to be revised in line with the new requirements.

DHS has not assessed the resourcing implications of this legislative requirement.

We observed that DHS's person-centred planning approach required a greater staff time commitment. Only one of the four DHS regions we visited had allocated extra time for staff to carry out this work. Most regions expected staff to take on this role after attending training.

CSOs have traditionally had a planning function, or referred planning to a more appropriate service. However, CSOs have not received additional or specific funding to enable them to bring residents' plans into line with the new Act.

In the CSOs we visited, we saw active support and person-centred approaches embedded in their service delivery. In DHS houses, those involved in a pilot program to introduce person-centred planning had a greater understanding of what this meant for their work practices. In other areas, staff had not yet been trained and did not understand the implications for their work practices.

3.2.4 SSA residents' information

SSA residents' information is held at a variety of places:

- the early history, assessment information and general service plans of DHS residents was kept on a client services file held at the regional office
- recent information and individual plans were kept on an accommodation file at the SSA house
- background and assessment information on DHS's Client Relationship Information System (CRIS).

CSOs and DHS record residents' information differently. DHS recently completed transferring data from its disability information system (DISCIS) to CRIS in an effort to standardise client information. Staff of some DHS regional offices confirmed that not all data had transferred across from DISCIS and that locating original assessments on CRIS relied on the ability of the staff member to remember the assessment date. We also encountered this problem with our file reviews.

A number of staff in DHS regions commented that the recent adoption of CRIS had reduced their efficiency. For example they missed resident's information, had difficulties in navigating the system and had no ability to reconcile information with the previous DISCIS database.

The problems DHS staff encountered with CRIS may be temporary. The staff from one DHS region that had involvement in the development and testing of CRIS and had been using it for a longer period viewed the system's functionality favourably. Roll out of CRIS and training of DHS staff is underway.

As house staff do not have access to CRIS they relied on manual records. At least one DHS region is planning to make CRIS accessible from accommodation houses. In CSO houses we found that intake information (including original assessments) remained with the DHS regional office in a client services file. CSOs do not have access to CRIS. DHS has advised some CSOs have requested access to CRISSP (external agency version of CRIS) and that this will be organised.

Resident information was fragmented and not systematically recorded: for example, information was kept in house folders, day books, sheets on the wall, filing cabinets, DHS regional offices and on CRIS. Information about the residents' health and behaviour management – and their individual plans – was recorded separately. Residents' history, assessment, proposed treatment and evaluation information was not stored in a consistent place (such as a book or file) or in a logical way.

Because residents' information is not managed strategically, it is difficult for support staff to have the information they need to hand to manage residents day-to-day. It also creates problems for staff when residents transfer between DHS and CSO houses. It is also difficult to readily identify residents who are suited to live independently outside their SSA.

These issues had led one region to review their residents' complete histories in an effort to improve their knowledge of residents and to be better informed when preparing support plans. Most houses we visited had prepared a simple (usually one-page) summary of available information to enable support staff to manage the resident day-to-day.

A number of the CSOs we visited – and some DHS regions – had started to standardise their residents' information. However, the information had only been standardised within the CSO or region.

DHS has developed a quarterly data collection (QDC) report to gather information about SSA residents to meet state and Commonwealth Government reporting requirements, assist in planning and inform policy development.

3.2.5 Conclusion

Consistency of support plan preparation

Although in line with the *Disability Act 2006* a support plan is prepared based on a person-centred approach, there is no evidence this plan will be any more effective than previous planning approaches.

Planning for individual residents is inconsistent. There is confusion on the ground about what a 'person-centred planning approach' means, and what constitutes a support plan and an individual plan. The extent of a resident's involvement is not always clear.

The broad description of planning in the Act needs clarification. A more consistent approach to planning and assessment could be achieved by identifying appropriately qualified people to carry out this work and determining the key elements required in the support plans, and the form they will take. DHS also needs to assess whether DHS and CSO employees have the capability and capacity to prepare new plans and revise existing plans.

A more consistent approach is required to enable DHS and CSOs to reliably develop individualised support plans and to facilitate monitoring and evaluation. A consistent approach should also narrow the information gap that can occur when residents transfer between DHS and CSO SSA. This should also better integrate the sector and thus lead to better outcomes for residents. The need for greater consistency in the preparation of individual plans was raised in our 2000 audit, yet it remains to be resolved.

Given the prominence of individualised planning in the new service delivery model, it will be important for DHS to address these issues. If it does not there is a risk that significant resources will be ineffectually applied.

Revising plans to meet new legislative requirements

Regions who had allocated specific time for staff to review and revise plans achieved a better result than those who required support staff to complete this task on top of their normal duties. It is difficult to see how CSOs and some DHS regions will achieve the legislative requirement to have individual plans prepared by 1 July 2008 unless time is set aside for staff to complete this task.

Resident information

DHS has not taken a systemic approach to determining 'who needs to know what'. Information is inconsistently collected and its storage in many different places greatly reduces its usefulness. This makes support staff less efficient and less able to address the needs of residents.

SSA residents suitable for relocation into the community would be better identified if there was one standard statewide information system used by all DHS and CSO service providers.

Recommendations

DHS should:

- 3.1 provide focused support, guidance and resources to facilitate the development of individualised plans by service providers. This should involve:
 - adopting a team-based approach to preparing plans, comprising relevant support and professional staff
 - on-the-job training
- 3.2 allocate specific resources for undertaking individual planning for residents within SSA
- 3.3 develop its information systems to provide relevant historical information relating to SSA residents for support staff to assist in meeting residents' day-to-day and long-term needs.

RESPONSE provided by Secretary, Department of Human Services Recommendation 3.1

This recommendation is supported and the department has strategies in place that it will continue to implement.

The department has provided support, guidance and resources to facilitate the implementation of individualised planning. It is acknowledged that there is an ongoing need for training and support for staff in SSA services to continuously improve their individualised planning practice.

The individualised planning approach is fundamental to achieving the goals and objectives of the Victorian State Disability Plan 2002–2012 and the Disability Act 2006. This legislative and policy framework provides a mandate for planning that is tailored to each person's needs, is directed, to the greatest extent possible, by the person and their network and promotes participation in community life.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.1 – continued***

The proclamation of the Disability Act 2006 (the Act) on 1 July 2007 has provided a new legislative framework for people living in SSA. The Act requires that a disability service provider must ensure that a support plan is prepared within 60 days of a person commencing to access a SSA service. The support plan must be developed in consultation with the person and their network and must include goals and strategies related to the supports being provided.

In preparation for the implementation of the Act, Disability Services has undertaken a number of activities to provide support, guidance and resources for disability service providers, people with a disability and their families and carers and the broader community, with regard to the new individualised planning approach. This included:

- a highly consultative approach to the development of the Planning Policy that involved all key stakeholders and included public forums, a working group, and the release of a draft policy document in February 2006 for broad consultation and comment*
- information forums across the State from April to July 2007, for disability service providers that provided guidance about the changes to practice and the associated responsibilities*
- resources provided prior to the proclamation of the Act, outlining the legislative and practice requirements for individualised planning, including the Disability Services Planning Policy and the Disability Act 2006 – A guide for disability service providers*
- information forums across Victoria, in July – August 2007 for people with a disability, their families and carers and the wider community*
- provision of the Planning Policy Resource Kit and Implementation Guide to provide a foundation for shared practice amongst all disability service providers. The Resource Kit offers information, practical advice and resources to guide best practice in individualised planning*
- learning and development initiatives across Victoria for both government agency and non-government disability service providers, including SSA providers to further develop their capacity to undertake planning within an individualised framework. These initiatives provide training for staff on preparing plans, facilitating planning meetings and developing behaviour support plans.*

RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.1 – continued

The legislative and policy framework for individualised planning clearly articulates that where a person with a disability is receiving more than one disability support, planning should be collaborative and coordinated. The Planning Policy outlines that a SSA provider has the responsibility to offer the person with a disability the opportunity to involve their other disability service providers in the development of the support plan. In line with the guiding principles for planning in the Act, a person with a disability can choose the people who are to be involved in the planning process. This team-based approach to planning may include family and friends, relevant professionals, support staff and other community service providers.

Whilst some progress has been made, the department will conduct further professional development for staff in department managed shared supported accommodation. Additionally the department will discuss implementation of similar strategies for community service organisations' (CSOs) managed homes with National Disability Services (NDS) and the Disability In-service Training Support Service (DISTSS) funded by the department to provide learning resources and support to the funded sector.

A learning resource for use by both department and staff employed in CSOs to develop support plans is in progress, and planned for implementation by July 2008.

Community Services Training Package Review – The Disability Services Division is actively involved to ensure the redeveloped community service training package meets current and future needs of the workforce. The new Community Services Training Package is due for implementation in 2008.

A number of team based approaches to planning and training opportunities are operating within the department's regions:

Communities of practice relating to individual planning. Five communities of practice across the Barwon South-West region are being established to support planning practitioners. Outcomes of the project will be that people with a disability will have access to planning and services which provide them with the skills to lead their own planning as much as possible, provide opportunities to direct their lives as much as possible and maximise their opportunities to be part of their communities. These communities of practice include Disability Services staff in Disability Accommodation Services and Disability Client Services as well as CSOs and people with a disability and their families.

Funding has been provided to regions to progress a number of learning and development opportunities for staff in relation to the requirements under the Disability Act 2006.

These approaches will be reviewed and a broader statewide strategy developed in 2008.

**RESPONSE provided by Secretary, Department of Human Services
– continued**

Recommendation 3.2

This recommendation is supported in principle.

Resources are currently allocated by the department to undertake planning. Further resource allocation for planning needs to be considered alongside other demand and resource priorities.

The department and CSOs also continue to provide learning and development opportunities for staff to drive culture and practice change within existing resources, for example, implementation of person-centred active support across department-managed accommodation services and some CSOs. Many residents within SSA have key workers appointed who are responsible for the development of the resident's plan. A range of resources have been developed to support staff when preparing plans which complement the Planning Policy resource.

Recommendation 3.3

The department agrees that its information systems need to be enhanced to provide more relevant and streamlined information to SSA staff to assist them in meeting residents' needs. The department has investigated the applicability of the existing Client Relationship Information System (CRIS) to SSA units, and has found CRIS information required at the regional level for planning, intake and assessment purposes to have limited application at a group house level.

An integrated ICT strategy for Disability Services, aligned with the Disability Services Division's strategic planning process, is currently in development and will incorporate residential services' information and IT requirements.

It is recognised that records management is an area that requires an ongoing focus and work continues to occur to standardise processes at the regional level. The Disability Services Division will implement a number of strategies to address records management. In 2007-08, funding has been allocated to support records management and systems improvements within department managed group homes. In one metropolitan region this initiative is focusing on documentation being consistently held and consolidated within the house and is up to date. The Disability Services Division will discuss the implementation of similar strategies with National Disability Services, for application in CSO managed homes.

3.3 What are the potential barriers to implementing plans effectively?

3.3.1 Block funding of SSA houses

DHS regions and CSOs receive block funding for SSA, which is based on providing accommodation and personal care assistance to residents.

Funding for accommodation and day programs is allocated to the service provider and not the resident. Thus, when residents are ill, and they cannot attend their designated day program and remain in the house, the house must cover the cost of day staff for them (except if they have flexible rostering, as one we visited did). One CSO recouped the resident's day program funds when the resident did not attend the program. These types of arrangements were rare but did indicate how a more individualised service could be achieved.

Houses often carried out group activities rather than tailored individual approaches. This was a practical response to limited transport options and staffing arrangements. A number of houses did not have regular access to vehicles, or used a bus-type vehicle. This often meant residents' individual wants were subsumed and activities were carried out as a group. This was a particular issue in rural areas and outer suburbs where public transport was limited. In the metropolitan area, public transport is proving a useful way to encourage residents to integrate into the community.

Our 2000 audit concluded that, 'The Department cannot be assured that current resource allocation processes for shared supported accommodation are always delivering services for clients on the basis of relative need. Nor do they allow the expectations of the Act and the Victorian Standards for Disability Services to be met, regarding opportunities for all clients to develop and maintain skills and to participate in the community.'

This finding is still relevant today. There has been little systemic change to resource allocation processes in that:

- SSA continues to be block-funded, based on an historical assessment of the residents' needs rather than assessed current need
- in 2004-05, DHS assessed the needs of around 2 000 residents in DHS managed houses to better determine resourcing requirements. However, there is no ongoing system for aggregating residents' needs and using this to influence budget requests and allocations. Information about residents' needs is gathered through budget meetings between central office and regional staff but is based on local knowledge rather than an aggregation of needs identified within the support plans

- both DHS and CSOs identified instances where funding had not matched residents' needs (for example, many residents are ageing and their support needs increase as they age). An increase in support needs translates to an increase in demand for staff assistance or services, such as physiotherapy, massage, taxis, attendance at a medical or employment or leisure activity or active night shifts
- as the disability pension is not indexed to the consumer price index its purchasing power is declining over time. It is evident that funds were shrinking in real terms and this limited the activities that residents could do and hence the extent to which individual plans could be realised.

3.3.2 Incompatibility

The compatibility of residents is a key factor in the successful placement of a resident in SSA and in the successful implementation of their support plan. DHS considers compatibility in the placement of a resident in SSA. The DHS region's case manager prepares two or three potential resident profiles that are discussed at a regional assessment panel meeting. CSOs then choose the person they consider would best suit current residents. Residents are not involved in this initial selection process, nor are they advised they are being considered (so as to avoid disappointment).

We found instances of incompatibility that had adverse effects on the resident. Staff and residents' file notes sometimes revealed deterioration in their health and well-being. In some houses staff recognised the problem and tried to make adjustments; whereas in others, staff did not see an issue and accepted the situation. Some examples of the impact of an incompatible placement were:

- one resident had a disorder that meant they were not suited to communal living yet there was no option but for them to live with others, and staff had to manage the conflict that arose with other residents. This resident reacted positively when staff worked with the resident one-on-one. DHS has rented flats for aggressive residents in the past, but considers this to be too expensive as a longer term solution
- DHS could not find suitable accommodation for one person listed on the DSR and about to be paroled as neither CSO nor DHS houses considered this person to be compatible with their residents. The likelihood of this person's successful integration back into the community diminishes if a suitable support plan cannot be implemented for them
- some residents find themselves living in SSA although they do not want to, and this reinforces their – and other residents' – unhappiness. This may also reflect a service gap in that the service provider may not be able to provide individualised support.

3.3.3 Staff qualifications and work loads

Qualifications

Staffing is the most important influence on budgets and the quality of service delivery. It is particularly important as, under the new service model, the role of disability support staff changes from that of carer to providing more holistic support.

Notwithstanding the importance of staffing and the changed role, we found that there are no industry-wide minimum requirements for the qualifications, training, experience or competencies of staff who provide direct care and support to people with an intellectual disability. DHS has established standard selection criteria for staff employed in government-run services, but not for staff in non-government services that it funds.

The importance of establishing minimum staff qualifications was also raised in our 2000 audit.

In 2007, about 94 per cent of DHS staff had a Certificate IV qualification (compared to DHS's estimate of about half at the time of the last audit). Many CSOs we audited did not have a minimum qualification requirement for their staff. Instead, they chose staff on the basis of their attitude and ability to provide support rather than care.

Work loads

In most DHS and CSO houses we audited, funding and work arrangements did not readily allow for staff to care for residents individually. Staff were often under pressure to complete basic care tasks in the time allotted (6.30 – 9.30am and 3.30 – 9.30pm). In some houses, supervisors were only allocated one hour a week to:

- match residents goals with activities provided
- review residents' progress against their support plan and to adjust individual programs.

In almost all SSA houses, support provided to residents' through the day was highly structured and little time was devoted to helping them develop new skills. Staff were well-equipped to manage residents' daily activities (such as meals and personal hygiene) but had limited time available to implement all aspects of resident support plans including residents' aspirational goals.

The 2000 audit also found that, 'Overall, there are insufficient mechanisms to ensure that all direct care staff in all services are of sufficient numbers, or appropriately competent to provide quality services in line with the principles of the Act and the Victorian Standards for Disability Services.'

DHS is now addressing the issue of workforce planning and development through its disability industry plan *Partnering for the Future: The Victorian Industry Development Plan for the provision of support for people with a disability*. One aspect of this Plan, which was issued in 2006, is the development and implementation of a five-year workforce planning strategy aimed at ensuring there is a skilled and qualified workforce.

Service providers generally accepted the need to professionalise the workforce and standardise service delivery conditions regardless of where the service is delivered, whether it be a DHS house, a CSO house or the disabled person's own home. Service providers also noted the difficulties in recruiting and retaining qualified staff.

Residents with high physical support needs (such as those who cannot walk unassisted) usually need at least two staff when they go out (such as shopping or go to movies or concerts). DHS advised that it does not have fixed staff ratios and that staffing levels are set according to residents' needs. Most houses we visited had five residents: DHS and CSOs would roster on two staff in the mornings, evenings and weekends (and would have one staff sleeping at the house on each night), regardless of level of disability of residents. Two houses had staff who remained on duty throughout the night.

3.3.4 Fitness for purpose of disability housing

DHS has audited its houses against the following criteria:

- occupational health and safety requirements
- disability access standards
- functional suitability
- building regulation (compliance)
- building condition.

DHS has not assessed the fitness for purpose of its houses in terms of achieving the goals of the State Disability Plan (except for newly constructed houses) and the *Disability Act 2006*. Specifically, DHS has not assessed its houses from the perspectives of being able to integrate residents into the community, being able to provide support to residents and the houses primary purpose, being a comfortable home for residents. We observed some conflict between residents' requirements (of living in a comfortable home) and staff requirements (of working in a safe and efficient workplace).

Many SSA houses we visited were easily identifiable from the street as SSA, by factors such as ramps, the style of construction and sometimes their state of disrepair. Community acceptance of SSA houses is mixed. Some houses have good relations with their neighbours. Others have no contact with their neighbours. The design brief of one older house included a buffer zone to isolate it from its nearby rural community.

We observed differences in the layouts and furnishings of houses that we consider correlate with the approach that staff adopted with residents. In two houses, residents had incontinence problems. One house had linoleum floors extending half-way up the walls, and staff took a hospital-like approach to deal with the results of incontinence: they cleaned up after the event but not necessarily with due regard for the residents' privacy and dignity. In the other house, staff were focussed on maintaining the privacy and dignity of residents and ensured that staff were available to monitor events immediately they occurred so as to prevent issues escalating rather than simply expect that they would occur and deal with the consequences later.

Many houses visited had design features (such as the linoleum walls) that clearly communicated to staff and residents the now-outdated paradigm of care, versus support. In some houses, staff identified the shortcomings of their environment and were overcoming them. Others had not recognised that the house design was affecting residents' behaviour and staff attitudes to residents. We observed that the former were more likely to advocate changes to better meet the individual needs of their residents, such as changing staff from a sleepover shift to an active night shift where staff stay awake all night.

3.3.5 Conclusion

A number of impediments have emerged which create a disconnect between the new social model and its actual delivery by service providers. Two of these impediments — block funding of SSA houses and the capacity and expertise of service providers — were raised in our 2000 audit yet have not been resolved.

DHS needs to establish mechanisms to monitor how well the new service model is being implemented and applied. It will be critical for DHS to address these barriers if residents are to achieve their goals.

Recommendations

DHS should:

- 3.4 review the SSA funding model to better align it with the new service model of individualised support
- 3.5 systematically assess the capacity and expertise of SSA staff to deliver support services in accordance with the new service (social) model and to address gaps subsequently identified.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.4***

This recommendation is partially supported.

The department will consider the framework for the SSA funding model and options to align it with new models of individualised support following consideration of its application to other services. The department has focussed individualised support on in-home support and day activity services in the first instance where an individual support package is more easily applied.

Work on a SSA funding model has commenced. The approach recognises that an individualised support model needs to take account of a number of factors. Initiatives, such as Person Centred Active Support and the Community Residential Unit exit strategy, demonstrate that individually tailored approaches can occur in the group home setting. While the principle of individualised funding continues to be a priority for the Disability Services Division, in the short to medium term the focus will, in the first instance, be on areas such as day programs, individual support plans and respite to realise the objectives and intention of the State Plan and the Disability Act 2006.

As a funding and resource benchmarking tool, the SSA output model will be the subject of reviews and refinement to take account of contemporary best practice, including policy changes within the context of an individualised planning and support framework.

Recommendation 3.5

This recommendation is supported.

Given the relatively small number of houses examined as part of the review, the report does not acknowledge the mechanisms already in place and the scope of activities underway to enhance the capacity and expertise of service providers.

The Disability Act 2006 was implemented following a four year consultation and development process, and reflective of changing approaches in the provision of support for people with a disability.

The guiding principles for planning outlined in the Disability Act 2006 reflect the principles of an individualised planning and support approach, which was introduced, through the Support and Choice initiative in 2003.

The Monitoring framework for health, housing and community services sectors (August 2006) incorporates complaints management as core monitoring and the Quality Framework for Disability Services in Victoria was introduced in 1999 (including industry standards associated with complaints management) and is not a new requirement.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.5 – continued***

As part the implementation strategy, the Disability Services Division will be conducting an evaluation of compliance with the Disability Act, following the first year of implementation to identify areas where additional supports/mechanisms are required to increase the capacity of support providers.

In 2006-07, the government allocated \$1 million to assist the disability support sector to meet the compliance requirements of the Act. Part of this funding supported National Disability Services Victoria, to provide information about the Act to member organisations, promoting member participation in information sessions, consulting about draft policies and assisting member organisations to undertake practice and cultural changes required by the new Act.

It also resulted in local implementation strategies and activities being developed, including opportunities for shared learning, coaching and mentoring activities such as communities of practice. For example, one metropolitan region allocated funds to CSOs to assist in the development of initiatives in relation to access and planning, residential rights and restrictive interventions and a range of procedures and documents to assist CSOs to comply with the complaints mechanisms and quality requirements under the Act.

Initiatives to address gaps in the capacity and expertise of SSA staff to deliver support services focussed on individualised approaches also include Person Centred Active Support (PCAS) being implemented across all department managed group homes. PCAS provides a person-centred approach to working with residents and encourages the choice and participation of residents in all aspects of their daily living.

By the end of June 2008, PCAS will be implemented in 60 per cent of all group homes, with support staff receiving formal training in this approach. PCAS will continue to be rolled out to the remaining Group homes during 2008/09.

The evaluation findings of the implementation of PCAS across DHS rural regions are due to be released in March 2008.

A number of CSOs continue to also implement person-centred planning and active support.

The department has also introduced changes to the health planning requirements for people who reside in DHS managed group homes. These changes guide staff through a process of integrating all health-related programs and procedures, and result in a more individualised health planning process for people. Commencing in December 2007, the revised process enables a streamlined health monitoring and review process for every person in SSA that incorporates comprehensive health assessment, nutrition and swallowing risk screening, weight monitor, health promotion, medication review and specific health management. The new health planning process facilitates the maintenance of up-to-date records that are relevant to day-to-day supports for residents.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.5 – continued***

Additionally introduced in July 2007, the Residential Services Practice Manual reflects significant practice improvements around issues such as medications and monitoring change in health status. The manual also guides staff in a person centred approach to the development of support plans, including active support concepts.

Commencing in mid 2007, the Promoting Better Practice in SSA initiative aims to strengthen the capacity of Disability Services to anticipate and respond to critical incidents through reviews of department-managed SSA to identify areas for improvement in systems and practice affecting safety and quality. The methodology incorporates a systemic quality audit and surveillance approach to analyse causes and develop approaches that can lead to a reduction in incidents and minimise their recurrence and impact. The demonstration project is due for completion in March/April 2008.

The department acknowledges that these approaches should be consolidated and systematically applied, across SSA. The Department will undertake this work in relation to department managed group homes and discuss similar approaches to be applied to CSO managed homes with National Disability Services.

3.4 Are SSA residents' plans regularly reviewed?

Plans – to match the circumstances of people's lives – must be considered living documents. As such, they should be regularly reviewed and updated, as well as implemented by staff with the skills and knowledge to do so. The *Disability Act 2006* requires that a support plan be reviewed at least once every three years, and that the support plan of an SSA resident be reviewed annually (or when so requested by a resident, staff or other health professional).

3.4.1 Conduct of reviews

We found that reviews of plans varied considerably in quality. Some reviews were conducted by checklist where the same boxes had been checked for up to three years. Only one CSO had documented how residents were progressing towards their goals. No reviews audited referred to the goals of the resident's original plan, or noted their progress toward their goals. Reviews were not always signed. Staff with varying levels of qualification and experience had conducted the reviews.

One DHS region had developed a standardised person-centred planning format that included a section for recording issues to be included in a review. One CSO kept records of residents' annual reviews but these were archived off-site and not accessible. Only one CSO house visited kept comprehensive notes of the review process on file. Other agencies and most DHS houses had little review documentation on file.

Residents' progress — and how residents could be best supported to achieve their goals — was discussed at staff meetings. In DHS houses, one worker was assigned to each resident. That worker reported verbally to the meeting about the resident's activities, well-being, concerns or wants (such as holidays and sporting interests). In the houses we visited, staff meetings were held weekly, fortnightly or monthly and were rostered. All DHS houses had rostered staff meetings. This was not the case with CSOs, one of which told us that it was not funded to cover staff costs of its weekly staff meetings.

Where meetings were minuted, we could not identify where a resident's reported progress was used to update their individual plans, or how plans were used to guide decisions about their activities. Residents' progress was documented in various places, such as daily handover communications, progress notes, communication books and house diaries. We noted instances of the failure to document progress resulting in oversights including a seemingly significant medical request for an ECG not being followed-up.

Resident care relies strongly on support staff's (undocumented) knowledge of a resident's needs and plans. Because an individual resident's information is held in numerous locations (both on- and off-site), we found it extremely difficult to track residents' progress from assessment, to planning, to achievements, to further review. Where there was documented information from reviews, the consistency and quality of this information varied from house to house: DHS has no prescribed format for documenting reviews.

The houses visited did not have standardised filing systems. DHS and CSOs had standardised formats for some files, but the quality and accessibility of files varied.

Some houses had compiled information sheets or folders for individual residents in addition to their accommodation file. These information sheets were a snapshot of a resident's basic care requirements and planned activities and enable support staff to quickly understand a resident's daily support needs. There was often not a clear link between the information sheet and a resident's support plan.

Some CSOs took the view that support plans were dynamic (not static) and should be reviewed whenever needed.

3.4.2 Conclusion

The outcomes of planning review processes were neither well documented nor generally reflected in updated plans.

DHS needs to engage with CSOs to:

- identify core elements for inclusion in individual plans
- determine how information from reviews of plans would be best recorded and analysed.

If support staff are to take a person-centred approach there needs to be a more consistent way of recording and storing resident information. The connection between (and recording of information about) a resident's needs, their support plan and its implementation needs to be clear, as the basis for a sound and useful assessment.

Recommendation

- 3.6 DHS should guide and support service providers on the conduct and documentation of the review of individual support plans.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported.

The department has provided advice in the Planning Policy and Resource Kit and Implementation Guide regarding the process and practice for the review of support plans.

In line with the intent of the guiding principles for planning in the Disability Act 2006, disability service providers are required to adopt a flexible and individualised approach to planning. It would be contrary to this intent to develop a standard format for the recording of support plan reviews however, the Planning Policy describes the key elements that must be included in every review process.

The department will undertake further work with SSA providers to conduct reviews in line with the Planning Policy requirements whilst developing the capacity to document support plan reviews in formats that are tailored to each person with a disability.