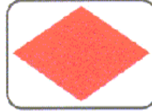
COMMUNITY VISITORS ANNUAL REPORT 2005

HEALTH SERVICES ACT 1988

PROMOTING THE RIGHTS AND DIGNITY OF PEOPLE WITH A DISABILITY, ENSURING THAT THEIR VOICES ARE HEARD

OFFICE OF THE PUBLIC ADVOCATE

AN INDEPENDENT STATUTORY OFFICE ACCOUNTABLE TO THE VICTORIAN PARLIAMENT



OFFICE OF THE
PUBLIC ADVOCATE

30 September 2005

The Hon. Gavin Jennings MP
Minister for Aged Care
Level 21, 555 Collins Street
MELBOURNE VIC 3000

Dear Minister

In accordance with the *Health Services Act 1988*, please find enclosed the Annual Report of Community Visitors.

This Annual Report has been compiled by the Community Visitors (Residential Services) Board elected at the Annual General Meeting of Community Visitors.

Yours sincerely

JULIAN GARDNER **Public Advocate**	JO CARTER **Board Member**	JENNIFER PERRY **Board Member**

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EXECUTIVE SUMMARY

Supported Residential Services (SRSs) are facilities registered under the *Health Services Act 1988* to provide care and accommodation to people who require support with everyday living. They are (with one exception) privately owned and managed services which operate for profit. On 30 June 2005, 203 SRSs were home to about 5,600 Victorians.

Community Visitors – independent volunteers appointed by the Governor in Council – make unannounced visits to SRSs and inquire into and report on issues of concern. Some issues are addressed immediately by SRS proprietors or staff; others require intervention by the Department of Human Services (DHS) or other authorities before being resolved. Health Services Community Visitors made 1,617 visits to 214 SRSs in 2004–05 (including SRSs closed during the year).

Community Visitors report some positive developments in 2004–05 including changes to the Health Services Act (the Act); a pilot program to improve the financial viability of pension-level SRSs; care planning training; the prosecutions of proprietors breaching the Act; and some positive moves in relation to fire safety and emergency management.

There are examples of excellent care in many SRSs. However, there are still issues of concern and some matters reported by Community Visitors this year are scandalous. Most of these issues relate to pension-level facilities, where residents pay 85–100% of their pension for accommodation, meals and support.

Major issues

- **The lack of accommodation and support options for people with complex needs**

The nature of the SRS population has changed. Initially SRSs catered mainly for the frail aged. Pension-plus facilities still cater mainly for frail older people but a significant proportion of residents in pension-level SRSs are now younger people with a mental illness, intellectual disability, or an acquired brain injury. Many have serious health problems or challenging behaviour. Most have little income and few family supports. A mix of residents (older people and people with a mental illness or disability) has led to problems in some SRSs.

Alternative forms of housing and support for people with a disability and people with a mental illness need to be created as a matter of urgency. Many proprietors running pension-level SRSs struggle to survive financially

and in the last year four pension-level facilities closed, resulting in the loss of 110 pension-level beds.

- **Poor quality care**

Many SRS staff and proprietors in pension-level SRSs do not have the skills and training to effectively meet the needs of their residents, who increasingly have complex needs. Community Visitors report visiting pension-level facilities and finding a cook, cleaner, volunteer, or staff member with a limited command of English, solely in charge of a facility with 20–40 residents. This is unacceptable.

Community Visitors believe that all staff involved in the direct care of residents should have first aid and emergency management training. Other training should relate to the needs of residents and the tasks the staff member performs. For example, if a staff person is working with people with a mental illness or dementia, they need to be able to communicate in a way that minimises resident distress and conflict and to be alert to signs that a person requires additional support. If a staff member is involved in the handling of medication, they must know how to administer, store and record medication. Community Visitors believe that the current regulations regarding the ratios and training of staff are not sufficient to ensure adequate care of residents at all times.

- **Unsafe, unhomelike environments**

Many pension-level SRSs operate from old buildings that are unsuitable for shared living and the support of individuals with complex needs. These buildings can be difficult to maintain and keep clean and expensive to heat and cool. A lot of facilities also operate from leased premises and disputes about responsibility for repairs and ongoing maintenance are common.

Residents often have to share bathrooms and they sometimes report feeling unsafe moving around an SRS or being in an unlocked room during the night. Complaints about the quality of food, the cleanliness of facilities, the lack of flexibility in routines, and the lack of resident choice and privacy are also common. Fire safety issues remain a serious concern in some SRSs, with many fire hazards reported such as residents smoking in bedrooms.

- **Meeting individual needs**

SRS residents frequently complain to Community Visitors about a lack of activities and days of boredom. While there are activities and support services funded through the Home and Community Care Program, more needs to be done to promote the participation of SRS residents in the community, and to provide enjoyable activities to those who cannot go out.

SRS residents are often vulnerable to exploitation and Community Visitors report some concerning issues in relation to financial issues and residential statements (written statements detailing the services to be provided and related fees and charges). Community Visitors report inconsistencies in the quality of both care plans and residential statements.

Conditions are accepted in privately run SRSs in this state that would not be tolerated in any government-funded facility providing accommodation and care for people with a disability or the frail aged.

Sadly, the following comment, which accompanied a Community Visitor report, reflects the feeling of many Community Visitors who visit pension-level SRSs in Victoria.

> *This SRS is so depressing. I am sure more could be done for the residents but not with current SRS resources and staff. The basics are provided but the quality of life is minimal. It is a sad place where I would hate anyone I cared for to end up.*

RECOMMENDATIONS

1. That the Victorian Government develops and funds further accommodation and support options for people with complex care and support needs to increase their accommodation choices and ensure they have a good standard of living. *(see Section 3.2)*

2. That the Department of Human Services completes the SRS research and pilot project evaluation and makes recommendations to the state government about the future support of pension-level SRS as soon as possible. *(see Section 2.2)*

3. That the government urgently considers ways to assist pension-level SRSs to provide an appropriate level of care, to financially survive and to improve the living conditions of residents through either:
   - the use of subsidies or packages for SRS residents
   - the lease of purpose-built and publicly owned building stock to reduce the current problems related to the poor fabric and maintenance of privately owned buildings. *(see Section 5.7)*

4. That the government reviews its current requirements for staff working in SRSs and consider the introduction of a minimum training requirement for all personal care staff working with SRS residents. At least one trained staff member should be on the premises at all times when residents are in the facility.*(see Section 4.6)*

5. That the government accepts the strategies trialled by the Emergency Management Group in the Greater Dandenong area and, as soon as possible, commence the rollout of fire risk prevention and emergency management training for all SRS managers and staff in Victoria. This training should be mandatory and a condition of registration. *(see Section 5.8.1)*

6. That, in line with the State Disability Plan, the government explores ways of promoting the participation of SRS residents in the community and building stronger links between the community and SRS residents to increase their recreational and social opportunities. *(see Section 6.1*)

1 INTRODUCTION

1.1 The Supported Residential Services industry in Victoria

Supported Residential Services (SRSs) are premises registered under the *Health Services Act 1988* (the Act) to provide accommodation and care to older people and people with a disability who require support in everyday life. With one exception, SRSs in Victoria are all privately owned and managed facilities which are registered with and regulated by the Victorian Government. On 30 June 2005 there were 203 SRSs providing care to approximately 5,600 residents.

Within the SRS sector there are two main types of facilities defined by the level of fees paid by residents:

- The above-pension or pension-plus SRSs, which usually have a population of older, frail adults.
- The pension-level SRSs, with a population of adults who are likely to have a mental illness or disability, chronic health problems or problematic drug and alcohol problems and a history of homelessness.

Some SRSs also provide a mixture of pension-level and pension-plus beds. All SRSs are expected to provide some 'special or personal care', as well as accommodation. While the physical environment and standard of care provided varies greatly from SRS to SRS, it is fair to say that the standard of buildings and care provided in the pension-plus facilities is often superior to that provided in pension-level facilities.

SRSs vary considerably in size. One SRS has only four residents while some others have between 60 and 100 beds.

1.2 The Supported Residential Services population

Historically, the SRS industry concentrated on the provision of accommodation and low-level care for the frail elderly. However, the population of pension-level SRSs has changed over time.

A census of SRSs conducted in 2003 (TQA Research 2004) showed that a large proportion of SRS residents have a psychiatric illness (20%) or some form of intellectual disability or acquired brain injury. Many residents (18%) have more than one disability. These percentages increase dramatically when one looks specifically at pension-level SRSs. Only 3% of pension-level residents are reported as having no disability and 45% of people are estimated to have a psychiatric disability.

A considerable proportion of pension-level SRS residents are people who would have difficulty surviving independently without support for daily living. Some are people whose behaviours have led them to be judged unsuitable for other shared accommodation options because of their effect on other residents. Some have lived in several SRSs, moving on from one facility to another when their behaviour was seen as too disruptive. More discussion about the challenges faced by SRS proprietors and issues related to the changing SRS demographic is found in Section 4 of this report.

1.3 The role of the Community Visitors

Community Visitors are independent volunteers who visit residential facilities in Victoria to safeguard the interests of people with a disability. There are three streams of Community Visitors: Health Services, Disability Services, and Mental Health Services.

Community Visitors who visit SRSs are appointed by the Governor in Council under the Health Services Act. They generally make unannounced visits to SRSs between six and twelve times per year and report issues of concern to the SRS proprietor, relevant authorities, and the Office of the Public Advocate. Many SRS residents do not have family or friends who regularly visit them. At some SRSs, Community Visitors are the only independent observers to regularly visit and talk with residents. In the 2004–05 year, Health Services Community Visitors made 1617 visits to 214 SRSs. For further information about the Community Visitors Program see Section 7 of this report.

1.4 Report outline

The first section of this report outlines some of the positive developments Community Visitors believe the government and the Department of Human Services (DHS) have made during the last 12 months as well as actions by the Community Visitors (Residential Services) Board. Many SRS staff and proprietors provide an excellent standard of care. Positive comments like the following are not uncommon in Community Visitor reports.

> *Community Visitors found this SRS clean and homely with a happy, friendly environment. Residents have a high quality of health care and personal care. Residents are treated with respect and dignity and they have the opportunity for privacy. They also enjoy activities of choice, have social independence and can participate in community life. Residents are treated fairly and are able to comment on the provision of services, and have the right to manage their finances (where possible).*

However, Community Visitors still note many issues of concern in relation to the care provided in SRSs, particularly pension-level SRSs. The body of this

report discusses in detail the observations of Community Visitors in relation to:

- SRS closures and a lack of accommodation and support options
- health care and support issues
- a home-like environment
- meeting individual needs.

2 YEAR IN REVIEW – POSITIVES

2.1 Overview of facilities

Community Visitors commend the many caring proprietors and hard-working staff who provide high quality care to SRS residents.

> *No complaints about anything in this SRS from any residents. They are all content and can't speak highly enough about the proprietors, Gino and Loretta, and other staff.*

The Community Visitors (Residential Services) Board thanks those who work cooperatively with Community Visitors to provide the best level of care possible.

> *In our region, we have no SRSs where the proprietor is aggressive or opposed to our visits. On the contrary, the Community Visitors are seen by most proprietors as part of the team for the care of residents. We appear to have the confidence of the DHS Authorised Officers and the level of cooperation has increased markedly. Another pleasing factor is the number of carers with whom we have a good working relationship.*

The key role of the Community Visitors is to inquire into the suitability and standard of facilities for the wellbeing of residents and there is still much to be done to ensure that every SRS resident has a pleasant, safe home and a life worth living. The Board is pleased to note some positive initiatives to improve the SRS sector.

2.2 Changes to the Health Services Act

During the last twelve months, the government introduced changes to the Health Services Act, most of which were implemented on 1 January 2005. Some of these changes strengthened legislative requirements in regard to the preparation of care plans and residential statements in SRSs. Interim care plans are now required to be prepared within 48 hours of a person becoming a resident and ongoing plans setting out the special or personal care needs of residents must be prepared within 30 days. Residential statements also need to be completed within 48 hours of a person becoming an SRS resident and these must be signed as soon as practicable by the proprietor and the resident (or the resident's administrator or guardian).

Stricter requirements in relation to the management of resident finances were also introduced. Section 108H of the Act now requires that accurate and up-to-date records of money managed and itemised records of expenditure are maintained where an SRS proprietor manages or controls the money of a resident. A statement must also be provided to the resident or his/her administrator at least every three months.

Community Visitors have lobbied for many of these legislative changes for some years and we congratulate the government on these amendments to the Act.

It is now an offence for an SRS proprietor to employ someone who is not a 'fit and proper person' to provide for the 'special or personal care needs' of residents. The department has attempted to define what constitutes 'fit and proper' in a new set of guidelines introduced in February 2005.

Community Visitors do not believe that the new guidelines will solve all the problems relating to the staffing of SRSs but the Board acknowledges that the new guidelines are a step in the right direction.

2.3 Supported Residential Services Research and Pilot Project

The SRS Research and Pilot Project aims to test the effectiveness of cost-relief funding as a way of improving the financial viability of pension-level SRSs and slowing the closure of these facilities. The project has provided packages of care to residents with medium and higher level needs in seven pension-level SRSs in Victoria. According to DHS, the key reason for the project was to facilitate a sustainable SRS industry with a secondary emphasis on increasing the capacity of SRSs to support residents with medium to high needs and enhancing the care and wellbeing of SRS residents. Community Visitors have urged the department to focus on outcomes for residents as a major part of the project evaluation. To date the focus of the evaluation has been on financial viability.

The pilot funding was not allocated directly to SRS proprietors or designated to particular residents. Assessments of individual residents were not conducted. Instead, the department allocated a funding amount ($5,000 per resident up to a maximum of $100,000 per SRS) based on studies which estimate that 60% of pension-level SRS residents have medium to high support needs. The funding has been channelled through non-government organisations which have a relationship with the SRS involved in the pilot.

Community Visitors have reported anecdotally the positive impact of the packages in some of the SRSs involved in the pilot.

The pilot program has enabled an additional 42 hours of staffing. This has been used to provide additional personal care and activities. Fourteen of the 16 residents require some assistance with showering and dressing. Tai Chi, group games and one social afternoon a week have been introduced. Community Visitors have noticed that residents are mixing more, are more vocal and are participating more in daily events. Staff have commented on a noticeable rise in morale among residents and they themselves feel happier.

Additional personal care staff have been employed including a Division 2 nurse. In addition, one person is employed 3 evenings per week from 6.45 pm to 9.45 pm to introduce additional activities such as movies and card games…. These activities have proven very popular. The 'one on one' personal care includes taking residents shopping and for walks.

A particular focus has been to spend time with one female resident who has very aggressive behaviour which includes self harm. On a monthly basis the nurse is monitoring and recording every resident's blood pressure, pulse and respirations, weight and temperature. This is proving very useful when residents have occasion to visit their GP.

The staff have been able to be paid for the unpaid work they were doing and some have had their hours increased. The proprietor now works fewer hours and that means he is more relaxed and able to cope. Some specific maintenance has been paid for including the repainting of one room where the residents' behaviour results in frequent painting being required… A new off site activity has been offered to residents and laundry services are paid for residents who are incontinent.

2.4 The future of the pilot project

If the government decides that SRSs are an appropriate option for low income Victorians in need of support, then strategies to increase the financial survival of pension-level SRSs and to improve the general standard of care must continue to be implemented. If the pilot project is evaluated as having a positive impact on residents in pension-level SRSs, then it should be expanded as soon as possible. Financial assistance can improve the quality of life of residents and relieve some of the stresses currently borne by proprietors and staff trying to provide adequate care to people with complex needs on about $35–$40 a day. However, funding alone will not address all the current issues about the standard of care in pension-level SRSs.

Community Visitors believe that the government should not fund SRS proprietors directly. While most proprietors are honest, hardworking people, there are some less trustworthy proprietors who may use additional funds for their own benefit rather than that of residents. Suitable accountability measures must be in place to ensure that any additional funds benefit resident care – rather than just improving the financial situation of SRS proprietors.

The Board questions the allocation of funds to SRSs on the basis of 60% of residents having medium to high support needs and the setting of an upper limit of 20 packages or $100,000. SRSs vary significantly in size and their proportion of residents with medium to high needs. The Board believes that many pension-level SRSs have more than 60% of residents with medium to high needs and government support should recognise this.

Rather than delay the introduction of further support for pension-level SRSs, it is strongly suggested that the government expands the pilot scheme using the current formula. The needs of residents should then progressively be independently assessed so that payments more accurately reflect the actual needs of residents and the costs incurred by SRS proprietors.

2.5 Alternative accommodation and support options

Community Visitors believe that alternative forms of supported accommodation with suitably qualified support staff need to be urgently created. We congratulate the government on the funding of one such project in Queens Road Melbourne which will provide low cost housing and a mix of support to 64 single people, 29 of whom will be people requiring support with everyday living. This low cost housing development is expected to open in September 2005.

One pension-level SRS in the Southern region, Scottsdale, had struggled financially for many years to support its residents, even with a small amount of government subsidy. The facility, which is managed by a non-government organisation, has now become a funded mental health service and it is no longer registered as an SRS. This seems appropriate given that all the residents have a mental illness and many have other disabilities or significant medical conditions.

More such options are urgently needed. Community Visitors believe that different models using the expertise of not-for-profit specialist agencies and reputable service providers, as well as public housing stock, should be explored.

2.6 Budget initiatives

The Victorian State Budget contained a number of other initiatives that may assist the SRS client population. These measures include:

- additional residential rehabilitation and outreach support services for people with a mental illness
- individualised support packages for 100 people through the Support and Choice program
- the establishment of a Disability Housing Trust
- increased eye care and dental services for disadvantaged Victorians.

Community Visitors commend the government on such initiatives. However, more action is urgently needed to address the unmet needs of people with a mental illness, people with a disability, and older people in our community who need support in their daily lives.

2.7 Action by the Department of Human Services

New quality processes which involve both agency self-assessment and auditing by DHS staff have been introduced this year, and these should allow SRSs of concern to be given greater attention by departmental staff.

DHS has also improved the assessment and approval process for prospective SRS proprietors. Regional Convenors from the Community Visitors Program and a number of authorised officers trialled a written questionnaire for prospective proprietors.

DHS successfully prosecuted a number of SRS proprietors for breaches of the Act this year. Matters related to nutrition, cleanliness, adequate staffing levels, medication administration, resident care plans, resident finances, and other records matters have formed the basis of charges. What astonishes Community Visitors is that despite some proprietors receiving substantial fines, they persist with practices that may well find them back in court.

Over the last three years, care planning training sessions have been organised in different regions of Victoria for the managers and staff of SRSs. Two sessions were held for Community Visitors and DHS Authorised Officers. These sessions were facilitated by independent consultants who have expertise in the aged care field. Unfortunately the training was optional and some SRS proprietors and staff, who may have benefited most from the training, chose not to attend. Community Visitors hope that the changes in legislation in relation to care plans, combined with the new auditing processes and training, will lead to greater improvement in the standard of care plans.

Last year's annual report discussed a pilot project in three regions which aimed to improve the provision of information to SRSs when prospective residents were referred. This year, DHS has undertaken work in other regions to improve the relationships between SRSs and referring agencies. Unfortunately, Community Visitors report that some SRS proprietors still have problems in obtaining adequate information about individual care needs at the time of referral.

An emergency management working group involving representatives of the Country Fire Authority, local government, DHS, Worksafe, and the police, as well as representatives of the Community Visitors Program, was established this year to pilot a coordinated approach to fire safety and other emergency management issues in the Greater Dandenong area. Training for proprietors and staff is to be trialled with the aim of promoting awareness of emergency management issues and ensuring the development of emergency management plans.

Issues related to fire safety are discussed in Section 5.2 of this report. Community Visitor reports suggest that a rollout of emergency management training and strategies to improve fire prevention awareness is urgently needed to prevent deaths and injury.

Quarterly meetings between DHS staff and Community Visitors were held in all regions this year. These meetings provide an opportunity to share information and discuss issues of concern related to SRSs. Community Visitors appreciate the opportunity to talk directly with Department staff and to work cooperatively in the best interests of residents.

2.8 Action by the Community Visitors (Residential Services) Board

On 18 February 2005, the Board met with Minister Jennings to convey concerns about many of the SRS care issues raised by Community Visitors. We were pleased to then have Minister Jennings attend the Community Visitors' annual conference to hear first hand about issues of concern and to discuss government action.

The Board has also raised issues of significance with DHS in quarterly meetings with managers of the department's Aged Care Division, who are responsible for the statewide monitoring of SRSs in Victoria and policy development for the sector.

The Board and DHS reviewed the existing OPA/DHS protocol to ensure it reflected current practice and was in line with complaints handling guidelines introduced by DHS to improve the documentation and accountability of staff in regard to the follow up of complaints.

Community Visitors also raised concerns about the possibility of large land tax increases leading to the closure of pension-level SRSs. The Victorian Government has since approved land tax exemptions for SRSs and aged care facilities.

Two joint meetings with DHS and the State Trustees were held to discuss issues related to the management of the finances of SRS residents.

The Board also introduced new guidelines and trialled a new reporting format to assist Community Visitors in the identification and recording of issues observed during visits to SRSs. The following sections of this report outline the issues raised during the last twelve months.

3 LACK OF ACCOMMODATION AND SUPPORT OPTIONS

Community Visitors have reported for over a decade that there is a shortage of support and accommodation options for people who have ongoing support needs as a result of their mental illness or disability. Pension-level SRSs are often used to fill the gap.

The 2003 SRS census (TQA Research 2004) states that 45% of residents in pension-level SRSs have a psychiatric disability, 14% have an intellectual disability, 8% have an acquired brain injury and 2% have serious medical issues. Only 3% of pension-level SRS residents are reported to have no disability. In past decades many people with severe or chronic disabilities would have been locked away in institutions. Now a large number reportedly have periods of homelessness between stays in hospital or prison. Many end up living in SRSs or boarding houses.

Many SRS residents have complex needs and some have challenging behaviours that make it very difficult for them to live in a communal setting. Community Visitors acknowledge the significant role that many SRS proprietors and staff play in supporting individuals who often have nowhere else to live and few other resources or supports.

> *Kathy was discharged from the acute mental health ward at the hospital to the SRS and referred to the local mental health clinic for ongoing treatment. She is on Clozapine and needs two weekly blood tests and medication. The hospital arranged for Kathy to be transported to the mental health clinic by the Continuing Care Team but they have told the SRS proprietor that they can't transport her anymore. Kathy is not capable of going out unescorted, particularly on her own in a cab – she is impulsive and could open the door while the cab is moving. Kathy doesn't have a case worker which we find amazing, taking into account her history and recent past.*

3.1 Supported Residential Services closures and loss of pension-level beds

In the last twelve months, 110 beds have been lost from the pension-level SRS sector. This continues the decline in the number of pension-level beds that has occurred since the early 1990s. In 1992 there were 315 registered facilities, with a total of 9,100 beds (Green Report 2001). At 30 June 2005, there were a total of 203 facilities with 6,796 registered beds. Of these beds, 2,399 were occupied by people paying pension-level rates.

Some of the facilities that closed during the last year were of very poor quality and they did not provide a decent standard of living for their residents. Community Visitors are not sad to see such places shut their doors. However, at other SRSs, compassionate staff provided an adequate standard of care but the proprietors simply could not afford to continue to provide meals, accommodation and staffing support for about $35 to $40 per person per day (85–100% of the Disability Support Pension plus rent allowance).

It is not surprising that in areas of high land value, proprietors often struggle to lease premises and cover day-to-day running costs or, if they own the property, to fund ever increasing rates, fees and maintenance and repair costs. Very few pension-level SRSs are in purpose-built buildings. Most are old rambling homes or aged mansions. Some SRSs were previously motels or boarding houses. Such places are often very expensive to heat and cool and residents are often required to share bedrooms and bathrooms. The cost of repairs and renovations (if done properly) can be exorbitant.

As stated earlier, most SRSs do not receive **any** government subsidies and their only source of income is resident fees. Pension-level SRSs charge between 85 and 100% of the pension and the disability pension for a single person is only $476.30 (plus $98.00 rent allowance) per fortnight. The lack of government support for people living in privately run SRSs contrasts starkly with the costs of government funded accommodation options for people with a disability and people with a mental illness.

- The annual cost of supporting a person with an intellectual disability in a Community Residential Unit (group home) is currently estimated to be about $70–80,000 and each purpose-built five or six bedroom house costs on average between $900,000 and $1 million to build (including the property purchase).
- The cost of supporting a person with a mental illness in a Community Care Unit is estimated to be $120,000 per year.
- The subsidy provided to Commonwealth-funded aged care facilities for residents with the lowest level of assessed needs is about $23,000 per year.

Direct comparisons with these options can be misleading as the support needs of residents in the above facilities are often significantly higher than those of SRS residents. However, it is interesting to note than when one SRS closed in the Southern Region during this year, seven of the eight were assessed as being suitable for hostel care. In another SRS closure, six or seven residents (out of 23) transferred to a Commonwealth facility. One SRS in the Eastern Region became a Commonwealth facility and all the existing residents were able to remain at the facility following assessment.

It raises the question, how many other SRS residents would be eligible for subsidised care if widespread assessments were carried out?

As Maughan and Sparrow (2005) point out in their excellent article about the SRS industry, a principle of the market economy is that 'participants act according to their own self-interest'. In order for proprietors of facilities to make a profit they need full occupancy and 'are often willing to accommodate anyone regardless of their ability to provide adequately for that person's needs. The result is that although SRSs are only meant to provide care for people with low needs, they actually accommodate many individuals with high and complex needs.'(p.13)

A care plan was sighted for Gerald, a very fragile 92 year old gentleman. Gerald has many health issues, including a recent fall, chest infections, and presently an infection due to the catheter he has. He is on medication for this. This gentleman is too ill to be in an SRS and should be in a nursing home.

The Manager discussed his belief that nine residents could now be classified as very high care, seven as high care and eight as medium care. Community Visitors suggested that the Manager have the residents assessed by the Aged Care Assessment team.

3.2 Limited options

Health and community service workers and guardians often refer people being discharged from hospital or prison to pension-level SRSs, not because they believe these facilities will best meet the person's needs but rather because there is nowhere else where their clients can afford to live. The mixed population of some pension-level SRSs can lead to serious problems.

The mix of frail elderly with younger disturbed people who have entirely different sleeping hours/habits etc. means that the long term elderly residents are not getting the privacy they desire and they feel very intimidated. Disability case managers are hard to contact. After they've placed a client, there is little or no follow-up, and with a proprietor who is reluctant to pick up the phone (it is almost certain that language is the problem here) elderly residents are distressed and the younger ones run amok.

Some SRSs now rely on respite care and transitional referrals to supplement their incomes. Community Visitors in several regions report that SRSs are taking people directly from hospital. In one SRS in the North and West Region, a hospital pays for two beds and provides 24-hour higher care. In the Loddon Mallee Region, an SRS has a room leased by the local

hospital for people being discharged from the Aged Mental Health Service. The bed must be available to the hospital at all times. In the Barwon-South West Region, Barwon Health funds 15 beds for transitional care. This is staffed by registered nurses (upright) 24 hours a day. In other cases, no extra funding support is provided but proprietors are willing to take people for respite in order to reduce vacancies.

Whilst these arrangements are often appropriate for the individual resident, Community Visitors are concerned about the impact on other residents and the provision of a home-like environment. Concerns also remain that DHS has still not introduced universal guidelines for these arrangements in SRSs, despite reporting more than 12 months ago that they were in discussion with the Commonwealth Government to make these arrangements.

Community Visitors are pleased that there was some funding in the 2005 state budget for mental health and disability accommodation and support options. We hope that this will begin to relieve the pressures on SRSs to accommodate younger people with disabilities and people being discharged from hospital with nowhere else to go. However, there are already long waiting lists for supported accommodation and Community Visitors believe more options are urgently needed.

4 HEALTH CARE AND SUPPORT ISSUES

4.1 Health care issues

A variety of health issues have been reported by Community Visitors during the last 12 months. One of the major concerns is that people are still being discharged from hospital to SRSs without appropriate referral information being supplied to the SRS.

Another issue is that residents do not always have access to their own doctors. Community Visitors became aware of one SRS where one of two doctors visited the SRS every week. Residents would line up for the doctor and they reported to Community Visitors that the doctor gave them lollies and cigarettes. This was reported to the Health Insurance Commission and Medical Practitioners Board and the doctors no longer visit the SRS on a regular basis.

SRS residents in small country towns can find it very difficult to access health services.

> *In response to our enquiry, the proprietor informed Community Visitors that the residents have had no podiatry, physiotherapy, dental etc services for about six months.*

Other health issues reported include:

- a resident who had a PEG feed blockage and needed hospitalisation
- a resident with recurrent urinary tract infections. Staff needed to assist this resident with personal hygiene 6–8 times per day.
- a resident with a cyst in the eye needing attention
- a resident with a broken hip who had an unstable bed
- concern about a resident – dribbling on face, chest and clothes, reported lost clothing, only one pair of pants left, incontinence also a problem
- a strong smell of urine
- no soap in toilets
- dental issues
- a resident needing hearing aid
- a resident's hearing aids not working
- a resident's dentures continually slipping when eating and speaking and not being taken to the dentist. This lady lost eight kilos in seven months.
- a resident needing nails cut
- an outbreak of head lice.

June has been waiting for new spectacles and there has been a long delay in obtaining these. The delay, according to management, was the failure of the administrator to issue a cheque for payment. Community Visitors were concerned at the attitude of one staff member who said that the delay was not a problem as the resident will only break the new glasses in a short time.

One resident had an epileptic seizure and fell out of a wheelchair. An xray revealed a fractured rib and an analgesic was prescribed. Community Visitors spoke to the resident. He had no complaints.

John became very ill; his diagnosis was cancer of the throat. Two months later he passed away. Community Visitors believe his condition could have been detected earlier if proper health checks had occurred but because he suffered with a depressive illness his constant complaints were put down to depression.

Community Visitors also reported a number of issues related to the handling of medication.

- A resident had loose pills in a drawer.
- Medications had been removed from dosette boxes and placed on saucers on a table.
- Medication sheets were not up to date and the system used to update scripts was not clear.
- Kitchen staff handing out medications.
- Majority of residents regularly having Panamax – no correlation in progress notes; i.e. when given, site of pain and if relieved.
- No supervision of medication at meal times. Medication placed on the table for self administration.

However, some SRSs have good practices in place to ensure correct administration of medication. In one facility, there is a colour-coded system in place which includes a photograph of each resident on special packs.

Community Visitors also comment on the emotional and mental health needs of residents. Community Visitors question the ability of many staff in pension-level SRSs to effectively support people who were previously institutionalised or those who have become brain injured as a result of an accident, degenerative disease or alcohol and drug use. It is worrying to Community Visitors that they sometimes need to point out health and support issues to the people responsible for the daily monitoring of these aspects of care.

We have noticed a deterioration in Gavin over our last few visits – he is withdrawn, looks 'unwell' – other residents say he is very angry all the time. We noted his knuckles are red and swollen, his nose looks blue – could his case manager be informed?

Many residents are vulnerable to abuse and exploitation because of the nature of their disability and earlier disempowering life experiences. Sometimes residents are reluctant to let Community Visitors follow through issues raised, for fear of reprisal.

The Office of the Public Advocate's Telephone Advice Service received a call from a resident complaining that the SRS Manager was treating her and other residents badly. She alleged he is a bully and is verbally aggressive to residents and their families. She maintains that she and the other residents are afraid to complain and the manager cleans up his act when he knows Community Visitors and others are visiting.

4.2 Staff–client ratios

The Regulations (2001) that govern SRSs state that as a **minimum** an SRS proprietor must employ a personal care coordinator (or two part-time coordinators) for not less than 38 hours a week and this person must have a Certificate III in Community Services (Aged Care Work/Personal Carer) or an equivalent qualification. The Regulations also state during the day at least one special or personal care staff member must be 'employed and on duty for each 30 residents or fraction of 30 at the service.'

The Regulations also require the proprietor of an SRS to employ enough adequate and appropriately trained staff to 'ensure that the special or personal care requirements of each resident are fully met in a timely manner'. However, it is evident to Community Visitors that some SRS proprietors think they are complying with regulatory obligations if they employ one person with Certificate III for 38 hours of the week.

Community Visitors find it difficult to assess staffing rosters when they only visit SRSs an average of eight to twelve times per year, usually for an hour or two hours per visit. However, Community Visitors frequently report that they arrive at an SRS to discover the cook, cleaner or an unqualified attendant solely responsible for the facility. In some SRSs, the proprietor regularly appears before the Community Visitors complete their visit and Community Visitors suspect that the person left on duty has telephoned the proprietor to say that Community Visitors are on the premises. Some Community Visitor reports in relation to staffing are truly shocking.

When we visited there was a volunteer preparing and serving lunch in the kitchen, with no other staff member in sight.

Jasmine was in charge. Jasmine is an older woman (about 70 years?). She did not know anything about Community Visitors. At first she called herself a volunteer. (Joe, the proprietor is interstate). It turns out she does Friday until Monday morning for 60 dollars. She sleeps on the sofa in the study. The whole thing is her baby – night and day. There was some confusion about whether there were 10 or 11 residents in the place. She said 10, a resident following us around said 11. She then did a count and her first go was right. She is a nice woman who likes to be there and is kind to the residents – but she would not be skilled or trained to cope with emergency situations, I wouldn't have thought. She would certainly be tired – the couch in the office would not be conducive to sleeping.

The Regulations also state that at night there must be at least one special or personal care staff person available 'to meet any special or personal care circumstance that a resident or residents may require' and, if necessary, additional staff should be employed 'to ensure the safety of the residents'. Community Visitors report that there are rarely staff who work an active night shift in pension-level SRSs, even when there are large numbers of residents who have complex needs, or dementia that leads them to being active at night.

Sometimes the SRS proprietor or sleepover person sleeps on the premises but upstairs or in a separate wing away from the residents' bedrooms. One wonders how much they know about what goes on during the night.

An elderly gentleman Ken had a fall during the night. When he fell he telephoned his family rather than ringing the emergency bell. His family then called the SRS and an ambulance was called and Ken was taken to hospital where he died about ten days later. Following his death the police took a statement from the staff member who attended to Ken. Recently that same staff member was required to make a further statement and he was advised by the police that the Coroner was planning an investigation into falls occurring in SRSs.

Community Visitors reported that they were called to one SRS seven times in a quarter because of incidents and the residents feeling unsafe. The proprietor of this residence lives on the premises but some distance from the residents' bedrooms. She has told Community Visitors that she is on call 24/7, rarely having a break.

Some SRSs do employ adequate numbers of staff and the staff make every effort to make life comfortable and enjoyable for residents. Reports like the following are encouraging.

> *A library is being established and a water cooler has been installed for the use of residents and visitors. There is a very good ratio of staff/residents particularly in the 'dementia ward' as Community Visitors have always found two personal care staff supporting the 12 residents there.*

4.3 Lack of training of Supported Residential Services staff

A census of the SRS industry in 2003 reveals that there is considerable variance in the qualifications and training of SRS staff. According to the census, 7% of staff were registered nurses, 5% have Certificate IV PCA and 38% have Certificate III PCA. It is of serious concern that 42% of SRS facilities report that the highest qualification held by any staff member is Certificate III PCA. The Act states that a person must not be employed as a personal care coordinator unless the person has a Certificate III in Community Services (Aged Care/Personal Carer) or equivalent, yet when surveyed, 1% of metropolitan and pension-level SRSs reported that 'an unqualified PCA was the highest qualification held by any staff member.' (TQA Research 2003)

Staff at pension-plus facilities tend to be better qualified than staff in pension-level facilities.

Many SRS proprietors employ family members as staff. The 2003 census states that 81% of SRS proprietors employ at least one family member full-time and of the 2,088 staff working in the sector as at October 2003, 505 staff are family members. The employment of family members is often a cost-cutting measure in pension-level SRSs.

Community Visitors acknowledge that most SRS proprietors are well meaning people and some provide an excellent standard of care. However, many SRSs do not have adequate numbers of appropriately trained staff to effectively support their residents at all times.

> *Community Visitors are concerned at the staffing situation in this SRS. Only two young girls were on duty, one cooking (she is working towards a hospitality course) and the other housekeeping.*

The Board believes every SRS should be required to have at least one staff person with a minimum of Certificate III on duty at all times when residents are active in the facility and **all** staff involved in personal care should be trained in basic first aid and emergency management. All staff involved in

the dispensing of medication should have basic training in medication handling to ensure that medication is correctly administered and appropriate records kept.

SRS staff also need training that relates specifically to the needs of the residents they support. For example, SRSs that support older residents with dementia need training related to this group. Staff in SRSs that support people with an intellectual disability or people who have a mental illness or an acquired brain injury need to understand how they can best support their residents and encourage them to fulfil their potential, rather than just providing a housekeeping service. Many SRS residents have complex needs and if SRSs are to be viewed as an acceptable model of service for people who have high needs, then the government needs to lift the bar in relation to the training of staff in these facilities.

This is a high care facility. There are 11 residents in wheelchairs, two who are PEG fed. All residents have significant disabilities. There are no nursing staff.

Residents with dementia need to be stimulated. They are always in the same seat and same place every time Community Visitors see them.

The Victorian Government has accepted that in the accommodation for people with a disability run by their own department (over 500 facilities), a Certificate IV level qualification is desirable. All ongoing employees in these services are required to sign an agreement upon employment to state that they agree to obtain this qualification within two years. Casual staff are required to have Level 2 First Aid prior to undertaking a shift. Community Visitors believe the government should expect staff in privately run services to also be appropriately trained to support people who have a disability or a mental illness.

Staff in all government-funded disability services have also been required to have police checks for some years. This is still not a requirement of people employed in SRSs. Community Visitors find it particularly ironic that as volunteers who visit services for a few hours a month, they are required to have police checks, but full-time SRS employees are not.

This year, several Community Visitors expressed concerns about the poor English of some SRS managers and staff. Community Visitors question how such staff can have a good understanding of their responsibilities under the Act and effectively carry out their roles when they clearly have difficulty discussing matters such as care plans and quite basic issues related to resident rights. It is questionable how effectively these staff would manage in an emergency situation where communication with residents and relevant authorities could be a matter of life and death.

Two SRSs in different regions were taken over by a company which brought in workers from the Phillipines. Community Visitors reported a number of concerns to DHS. DHS reported the matter to the Dept of Immigration. The company was later exposed on Today Tonight *as exploiting their workers who had moved to Australia on the promise of nursing jobs. In one of these SRSs, DHS also learnt that the proprietor had accepted 'volunteers' from the Office of Corrections (people on court orders) to work in the kitchen and garden of the SRS.*

Other concerns expressed by Community Visitors during the year include a lack of interaction between staff and residents and one staff member being on duty all weekend.

Additional mandatory training and more rigorous checks on the qualifications of staff and the adequacy of staff rosters need to be implemented if the existing issues are to be addressed.

4.4 Support by external agencies

Some SRSs report good relationships with local service providers and the active support of case managers and allied health providers. Other SRSs complain that once residents have settled in they rarely see their guardians or case managers. Given the case loads of some case managers and guardians, this is perhaps not surprising but it is still disturbing that sometimes proactive support or attempts to find more appropriate accommodation only occur after serious issues arise.

Community Visitors regularly reported concerns about a resident in the back bungalow of an SRS – smoking in room, and some evidence of use of illegal drugs. The mental health clinic said they could no longer provide case-worker support to this resident. The resident was later charged with assault and is now in prison.

Community Visitors were contacted by a day program provider who was concerned that an SRS resident, Susan, was often arriving at her day placement with body odour and hair that needed shampooing. Community Visitors enquired into her situation and discovered that Susan (a young woman with intellectual disability and epilepsy) had been placed at the SRS by her case manager in 2001 'as a temporary measure'. Staff at the SRS initially said Susan could attend to her own hygiene. However, when Community Visitors checked her care plan at the SRS, this stated that she needed to be prompted to shower! Susan now has a case manager who is exploring other accommodation options for her.

Female resident causing trouble for staff and residents. Her lithium treatment was stopped. Staff rang the CAT team but so far they haven't responded.

Community Visitors were also very concerned about a lone female resident in an SRS with 16 male residents. The Community Visitors contacted a Community Connections worker seeking further support for the female resident. A psychiatric assessment was carried out. Now a case worker from a community mental health team is visiting her.

Some agency staff are critical of SRS proprietors who do not contact them when behavioural difficulties or health issues arise. One guardian reported that it was only after she made contact with the proprietor that she discovered that there had been significant problems with her client, who had been placed at the SRS by his mental health case manager. The guardian arranged to meet with the proprietor and the client's case manager but the proprietor was not at the SRS when the others arrived at the SRS for the meeting. An email to Community Visitors from the guardian reported the following.

Jeff, (my client) complained about the food saying if you were hungry and asked for food they did not give it to you. The place was dirty and disorganised. I am appalled at the Manager not being present and not having the courtesy to ring me. ... I subsequently called the SRS a number of times and left messages but no one has returned my calls. I called DHS and reported my concerns to the Authorised Officer who did not really seem surprised. I am now in the process of relocating Jeff elsewhere.

While Community Visitors have been concerned about a reduction in activities programs in some areas (see Section 6.1), we are also pleased to note some very positive attempts by community agencies to provide support to SRS residents.

In the Southern Region, the Alfred Psychiatry team is working with three pension-level SRSs to identify care agencies working with Alfred registered clients who live in the SRSs and then developing crisis care plans in cooperation with proprietors, general practitioners and relevant agencies.

There is also a group of people exploring the use of Community Aged Care Packages for selected SRS clients and a fantastic program under the auspices of the Caulfield Aged Mental Health Service, which has a psychiatrist and psychiatric nurse checking and adjusting the medication of residents in pension-level SRSs.

In a large SRS in the west of Melbourne, 'Health Time' is held bi-weekly at the SRS. It is supported with funding from DHS. The residents have an opportunity to meet with a range of health and community service professionals to discuss their individual needs and issues. Representation at Health Time typically includes representatives from the Salt Water Clinic, Centrelink, and housing, legal, dental, medical, physiotherapy, podiatry, and employment services. Morning tea is served to the residents on these occasions.

From the observations of the Community Visitors, this program has proved to be very positive in encouraging the residents to discuss their issues with appropriate agencies and also to mix with other residents. It allows residents to have some control over their futures.

Considerable support to SRS residents is provided through the Home and Community Care (HACC) program. This support includes planned activity groups, social support and volunteer coordination. *Who Gets HACC* (DHS 2004 p.30) identified that nearly 2,000 people living in SRSs and Rooming Houses accessed a planned activity group and about 1,300 accessed social support. Community Visitors think these support programs are invaluable and would encourage the government to expand them.

Other agencies providing support to SRS residents include the Royal District Nursing Service, arbias, disability day programs, mental health services, advocacy services, dental services and community health services.

5 A PLACE LIKE HOME?

5.1 The challenge of providing a home-like environment

SRSs are home to about 5,600 people in Victoria. The challenge for SRS proprietors is to provide a home-like environment where residents feel safe and cared for. Some proprietors do provide appropriate and caring facilities that have a warm and homely feel. Others find it difficult to supply all the facets of service required such as quality staff, varied menus, clean and well maintained buildings and activities. Health care and the provision of transport to day-care centres, medical and dental appointments, and leisure activities also need to be considered as well as the emotional and spiritual needs of residents.

Many SRSs have more than 20 residents in a congregate setting; some have between 60 and 100 residents. Where an SRS has a large number of residents it can be a particular challenge to avoid regimentation and to cater for the needs and personal preferences of individuals.

5.2 Basic rights – food, clothing, shelter and safety

The International Covenant on Economic, Social and Cultural Rights (1966) recognises the right of everyone to have 'an adequate standard of living ... including adequate food, clothing and housing'.

With this in mind, the following observations are reported:

5.3 Nourishment

At many pension-level facilities, the only time that residents meet is at meal times. For them, meals break up an often monotonous and lonely day – frequently one without activities. Community Visitors report that some SRSs have welcoming dining rooms, whilst others are dreary and depressing. It has been reported that at some facilities, the evening meal is served at 5 pm, leaving a long time before breakfast at 8 am the next day. Some facilities do not serve any form of supper and at one SRS the kitchen is locked by 7 pm so no drinks can be prepared by residents after this. The food served is not always nourishing or tasty, and rarely are there up-to-date menus.

Examples of other inadequacies reported by Community Visitors are:

- poor quality food
- insufficient food/small portions
- no fresh milk

- no fresh vegetables; all frozen food
- mostly mince and not enough greens
- no fresh fruit
- milk and bowls of custard sitting uncovered
- two dogs in the kitchen
- breakfast served at 6.00 am or earlier
- lunch over by 11.45 am
- breakfast comprising only dry toast (no butter or jam) plus cordial or water; no tea or coffee
- special dietary needs not catered for; eg. no special food for diabetics
- no bun or biscuits for morning tea.

> *A resident said she would like bread and butter with her meal. On speaking with the proprietor, the CV was informed that the reason for refusal of the request was that if he gave it to one resident, everyone would want bread and butter.*

> *One SRS does not allow residents' input into meal choice as 'they would ask for steak and I (proprietor) can't afford that. I don't have it myself'.*

On the other hand, Community Visitors report some very positive food and menu practices. In a number of places, meals are varied and planned with a lot of input from residents. Fresh milk and cold water are available at all times.

> *Food is cordon bleu category. Extensive menu, many choices.*

> *At one SRS, a Community Visitor reported that two main meal menus are cooked each day – one for Sri Lankan residents, and one for Europeans.*

5.4 Heating and cooling

Community Visitors report that some facilities are cold in winter, with inadequate heating. As many of the pension-level SRSs are not purpose-built, but old buildings with high ceilings, draughty corridors and no insulation, the cost of heating is prohibitive. Since many of the residents are frail and inactive, they need to be warm and comfortable. In some SRSs, residents say they stay in bed to keep warm. Staff are often physically busy and may not be aware of how cold it gets sitting for any length of time.

5.5 Clothing and grooming

At most SRSs, the purchase of clothing is the responsibility of the resident or his/her family. However, where residents give between 85 and 100% of

their pensions to the SRS, it can be difficult for them to afford decent clothing as well as other necessities such as haircuts, medical expenses and personal items. In one facility, there is a room where all residents choose their clothing for the day from a common pool. Some of this clothing is sub-standard and purchased from opportunity shops. With few personal possessions, suitable clothing of their own would seem to be a small requirement for the dignity and self-esteem of residents.

5.6 Maintenance and cleaning issues

Lack of maintenance is evident at many SRSs. Many of the issues listed below are ongoing issues:

- dilapidated floor coverings and broken lino
- loose or missing railings
- old, unsafe and sub-standard furniture
- inadequate lighting or lights not working
- broken or missing toilet seats
- no towel rail; toilet not flushing properly
- windows which don't close
- torn blinds and slats missing from blinds
- nails protruding in various places in back deck
- paint in bathroom peeling badly from walls and ceiling
- bad cracks in wall
- shower head broken.

Disputes between landlords and SRS proprietors about responsibility for building maintenance are quite common. Disputes are particularly an issue where major electrical, plumbing or building works are required to address everyday problems. For example, in one facility, Community Visitors frequently report that light globes are blown when they visit (on one occasion eight lights were not working). As soon as the globes are replaced they seem to blow again. This SRS requires major electrical works but because the property is leased these works have not been carried out.

Community Visitors understand that all premises are inspected prior to the initial registration of an SRS. However the condition of some buildings suggest that more stringent requirements need to be applied when registrations are either transferred or renewed. The development of purpose-built and publicly owned building stock for pension-level facilities may be required to reduce the current problems related to the poor fabric and maintenance of privately owned buildings.

The standard of cleaning at some facilities is also a constant disappointment to many Community Visitors. Issues raised this year include:

- toilets smelly and unclean

- faeces on toilet and wall
- tiles missing in the shower and substantial mould growing
- no toilet paper
- ants crawling over pillow and bed
- mouse droppings in drawer in resident's room
- urine bottle in bedroom unemptied
- dining room floor very soiled
- dirty sheets
- three rooms with animal faeces on the floor
- moss growing on window frames
- no pillow cases and dirty pillows
- grubby hand towels.

Many of these issues were addressed after being raised with SRS Managers or reported to the Department of Human Services' Authorised Officers. However, it is a sad indictment that some SRS proprietors required external visitors to the facility to point out, and in some cases repeatedly raise these issues, before they were fixed. Older frail people and people with a disability should not be expected to live in unclean and dilapidated surroundings. Community Visitors worry about the risk of infection. While some issues may seem minor, when a number of issues are present in the one facility the picture is a depressing one.

Stove top being used for lunch preparation, rm17 bathroom floor, shower sink soiled, faeces on toilet bowl, rm2 toilet – no paper, faeces on wall, sink, floor mirror need cleaning, no rubbish receptacle, hallway light out, rm4 bedroom floor very dirty, beds unmade, desk top dirty, rm6 beds unmade, cigarette butts on side table, ash on floor, rm8 tiles off vanity basin, rm11 toilet – no paper, tiles off sink, sink and shower rose leaking, curtains still off rails in living room, no fire evacuation plan visibly displayed for residents/visitors.

5.7 Safety issues

5.7.1 Fire safety

It is noted by Community Visitors that some proprietors are cooperating with fire safety regulations and some SRSs have regular fire drills, checks of fire equipment, and evacuation plans in place. However, between January and June 2005, Community Visitors reported 23 facilities where there were fire safety issues. The issues reported include:

- lack of fire drills
- residents smoking in rooms
- fire alarm switched off or on mute
- fire-fighting equipment requiring maintenance
- blocked or locked emergency exits

- no fire blankets in kitchens
- no evacuation plans or plans not displayed
- staff person unable to remember key code to open doors
- no list of residents and their room numbers, or lists incorrect
- piles of inflammable objects
- clothes draped over heaters.

At a recent visit to one residence; within the space of 15 minutes it was observed that three residents could not be accounted for; after much research it was discovered that one had gone to visit a relative; one had been picked up by a relative to attend a hospital appointment, and two frail residents had gone for a walk. This residence does not have a list of residents/staff in the case of an emergency evacuation.

The following fire hazards were noted – Flammable building materials stacked against walls. Pine needles filling spoutings. Cigarette butts amongst pine needles on ground. No inspection tag on fire hose. No visible evacuation plan. No checks of fire equipment. Cigarette butts on floor.

Such places are a tragedy waiting to happen.

Community Visitors noted two smoke detectors ripped from the roof in two bedrooms and evidence of several fires (mattress and wall burned) within the bedroom of one resident who has a mental illness. This was reported to DHS who contacted the Council who visited and required immediate action to be taken. The proprietor subsequently announced the closure of the SRS and 33 residents (most of whom have either a mental illness or acquired brain injury) had to be relocated.

In July 2004 a fire at an SRS in the Outer Southern Region of Melbourne, resulted in 38 residents having to be evacuated and temporarily relocated. Fortunately there were no deaths or serious injuries as a consequence of the fire. Following an investigation by the Country Fire Authority (CFA) into this fire, and discussions between the CFA, DHS and the Community Visitors Program, the pilot for a coordinated emergency management approach commenced in the Greater Dandenong area.

A working group involving representatives from the DHS, police, local government, the CFA, WorkSafe Victoria and the Community Visitors Program was established to develop guidelines, training and information to improve fire safety and emergency management in SRSs. Community Visitors look forward to the outcome of this project and hopefully the roll-out of a strategic and coordinated approach to fire safety and emergency management throughout Victoria.

5.7.2 Violence

Some SRS residents feel unsafe in their homes. This year Community Visitors have heard about several instances of violence between residents and towards staff. Community Visitors reported responding to seven 'distress calls' in three months at one SRS. Most of these calls related to acts of violence or conflict that led to the residents feeling unsafe. Some issues relate to the mix of residents and the higher percentage of people with mental illness living in SRSs.

> *We spoke with a resident Tony on arrival. He stated he was depressed … He then went and sat at a table and put a knife to this chest and arm. He has a birthday in seven days and stated 'I won't be here. I'll be in heaven'. June, the Manager, came down from upstairs. While we were talking in the office one of the residents told June, Tony had a cut on his throat. June rang the Mobile Support Team. The person she spoke to suggested she call an ambulance. Tony was taken to hospital.*

> *Isabel was causing arguments with other residents, She started having behaviour problems when her doctor changed her medication. She threatened a resident with a knife and punched the same lady in the face while she was asleep. Isabel is now in hospital and she will not be returning to this SRS.*

In one instance, the only female of seventeen residents barricaded herself in her room at night and used a bucket to go to the toilet, presumably because she felt unsafe moving around the SRS at night. When another SRS involved in the SRS pilot project was able to introduce an active night shift, a number of incontinence problems disappeared because residents felt safe enough to get up at night and go to the toilet, or could be assisted to do so.

> *A woman with an intellectual disability reported to Community Visitors that she had been sexually assaulted by someone who worked at the SRS and lived on the premises. The proprietor initially accepted the worker's denial of the incident but after advocacy by the resident's family and Community Visitors, the worker was moved on. The resident's sister raised the matter with police and organised counselling for the resident.*

Sometimes residents report incidents to Community Visitors confidentially but they say they do not want Community Visitors to follow them up in case they are perceived as trouble makers.

One resident was assaulted at an SRS and required hospitalisation. The incident was investigated by police but the resident would not press charges. The assault was allegedly by the SRS proprietor but the resident who has ABI would not identify his attacker. The resident was moved to another SRS following the assault.

In conclusion, many proprietors strive to present their residents with a home which is safe, warm and comfortable. However, there are other SRSs which are far from home-like, where proprietors seem to skimp on every cent and the conditions may reasonably be described as Dickensian.

A resident requested they have access to a kettle to make a hot drink before bed – this request was denied by management. Complaint from resident that the heating was cold and hot water in one bathroom was tepid – making it hard to shave.

6 MEETING INDIVIDUAL NEEDS

6.1 Lack of activities

As discussed earlier, many pension level SRSs, now have a significant proportion of residents who are younger people with psychiatric or physical disabilities, acquired brain injuries or drug and alcohol issues. These residents are, in the main, physically able and willing to participate in interesting recreation and social activities. However, in many SRSs there are not a lot of activities or recreation opportunities available.

It is important to everyone that they are able to participate in some activities which they enjoy. This participation helps the residents express themselves and it brings meaning and pleasure to their lives. A lot of SRS residents do not have any close family or friends who are able to take them out or accompany them to social activities.

Over the past year, some activities have been reduced by agencies such as arbias, because of budget limitations or funding issues. It is now very common to hear the residents telling the Community Visitors that they want more activities. On discussing this with facility management, the Community Visitors are always advised that it is because of lack of funds that more activities cannot be offered.

Community Visitors would like to see a much greater choice of activities for residents. Because of the limited income of residents, pension-level facilities face particular challenges in providing activities. However, in some cases, the creativity and enthusiasm of staff makes all the difference. Some SRSs have bingo sessions or celebrations for resident birthdays and special events such as the Melbourne Cup and Christmas. Some residents go walking together to lose weight, some have pets, and some go fishing or on shopping trips.

> *Some residents take part in looking after the roses in the garden. The erection of a chook run has been a great activity and talking point for some residents. They are now able to have their own fresh eggs and the enjoyment of being involved in a communal activity. This has made a big difference.*

Some pension-level facilities manage to offer a variety of activities with the help of outside agencies. Some examples of this are:

- All the residents of an SRS were able to participate in an art program and then exhibit their work in a community art show. In this instance

the residents were all very excited about their work being on display and some pieces of art were even sold.

- Female residents of an SRS made 'fun' bras for a local exhibition. Breast Screen Australia saw the exhibition and used the exhibits as part of their travelling exhibition against breast cancer.
- One SRS assisted three residents to go on a holiday together.

One resident on respite has fifty dollars a fortnight allowance from State Trustees, and a Carers' Agency supply a carer to take him out to wherever he chooses.

Most activity programs in pension-level facilities that engage people in their community are funded through the Home and Community Care Program or by DHS' Disability Services Division, not by the SRS management. The transportation of residents to activities is mostly done by council or other volunteers. Community Visitors have been advised that some volunteers are not able to enter the SRS to pick up a resident, which means if a resident cannot get into the vehicle by their own means they cannot be taken out. Work Cover requirements and the risk of litigation have been cited as a reason for this.

In contrast, the pension-plus SRS facilities (particularly the larger ones) often have the resources to offer a greater range of activities. These facilities have scheduled activities ranging from singalongs to day trips away. One facility has introduced 'happy hours' on Friday afternoons, with music, lollies and soft drinks. Another has aromatherapy. Activities at these SRSs are carefully planned and they offer a good variety of interest – although of course not all residents wish to participate in group activities and not everyone enjoys singalongs. Sometimes residents have family or friends who take them out.

In summary, the lack of participation in activities by residents in many pension-plus facilities is simply a matter of resident choice – the activities are available, but residents simply do not wish to participate. Whereas in the pension-level facilities, activities are less freely available and the residents frequently say they wish there were more offered.

6.2 Dignity and privacy issues

There are still pension-level facilities where residents share bedrooms. Some have three to four residents in one room. In some rooms, areas are screened by a curtain or divided by furniture. Others do not have any partitioning. In some places this makes it very difficult for the resident to listen to a radio or watch television or to have the space to read and think alone. Sometimes the only time people have privacy is when they go to the toilet; however in SRSs with shared bathroom and toilet facilities, especially those with several cubicles in the one area, residents do not even have this.

One facility has three residents who have been sharing the one bedroom for 15 months. This is despite the building having been extended by 10 new rooms. The occupancy certificate for these rooms has not been issued yet. At the end of the reporting period, issues between the Council, SRS Proprietor and property owner remain unresolved. In the meantime, several residents continue to share cramped and cluttered bedrooms.

Many residents do not have locks on their bedroom doors and some do not have drawers or cupboards where they can store their belongings securely. Community Visitors often receive complaints from residents about other residents taking their things.

As mentioned earlier in this report, residents in some pension-level SRSs are not able to purchase their own clothes. In some SRSs, clothing is provided from a central store at the SRS and rarely is this new. This clothing is often donated or purchased from opportunity shops.

Most residents on pensions cannot afford mobile phones. Residents sometimes find it difficult to access a telephone where they can make and receive calls in private, although the SRS Regulations require this.

6.3 Financial issues

Pension-level SRSs charge residents between 85% and 100% of the pension. This leaves residents with little or no discretionary income. In some SRSs, proprietors control all the residents' money. It is difficult for residents to maintain a sense of dignity and self-worth when they have to ask for money to purchase a stamp, personal toiletries or an ice-cream on a hot day.

Joseph receives a disability pension and says this is paid to the SRS who administer his funds. Joseph complains he has no cash at all and cannot even make phone calls or purchase lotions needed for his treatment. Community Visitors have had this type of complaint from other residents as well and the manager is reluctant to provide answers about particular residents' finances. The matter has been raised with DHS.

Community Visitors have followed up a number of financial issues on behalf of residents or members of their families this year. Some concerns could not be substantiated but others are disquieting.

Donald said he did not have a heater for his room yet. I spoke to the proprietor who said that his finances were managed by State Trustees. I spoke to State Trustees who advised me that State Trustees had not managed his money since January 2001 when VCAT revoked his administration order. I spoke again to the proprietor who said yes that was right she had forgotten the administration order had been revoked. I asked how much spending money Donald got. The proprietor was unsure, perhaps $20 a fortnight. Apparently all the other residents, with the exception of June and Roberto, have this facility fully in control of their finances on the basis that the residents are learning to handle their own money. I have never seen any evidence of this happening and would question whether this is within the capacity of some residents.

Issues related to financial matters are not confined to pension-level facilities. Because of the nature of their disabilities, including conditions like dementia, residents can be extremely vulnerable to exploitation.

Community Visitors were contacted by the son of a resident when he discovered a large financial mistake made at a pension plus SRS where a $50,000 bond is required to be paid in advance. ... Community Visitors wonder about people who do not have family members or State Trustees checking agreements and transactions.

Fees have gone up two or three times. Items put on bills such as room spray and gloves which you would think would be supplied as part of SRS fee.

The Community Visitors Board has met with State Trustees representatives to discuss issues related to financial administration. One of the issues that has been discussed is the best way of balancing the right of residents to know how much money they have with the need to protect from exploitation those who are vulnerable. The specific issue is whether financial statements should be sent by the administrator automatically on a regular basis, with the risk that other persons may see those statements and seek to extract a financial advantage for themselves or whether to only send the statements on request. The discussions will continue with the goal of ensuring that residents have access to funds to purchase essential items and other things that will bring pleasure to their lives.

6.4 Residential statements

A number of issues about residential statements and the services provided in exchange for fees were noted by Community Visitors.

We have concerns regarding the treatment of residents and their families if they complain and demand the accommodation they were originally promised. Janet came to this SRS after breaking her hip in July 2003, and after a short respite period, she decided to stay permanently. She was told she could have her own room with en-suite a.s.a.p. but until then she would have to find her way to a bathroom some distance away. This was an issue for her due to her age and frailty. The family were constantly told a room with an en-suite would be available soon, but in early December 2004, there was still no room with en-suite available. Community Visitors spoke with the proprietor and were told Janet would have the next available room with en-suite. Finally, in Jan 2005, Janet was given a room with an en-suite, but at our last visit in Feb we found out she is no longer a resident.

The structure and format of residential statements varies considerably. Some are only one or two pages, others lengthy.

The residential statement at this SRS is 25 pages long, very well set out, but it could be hard for elderly residents to understand. It reads more like an admission form to a nursing home/hostel. For example it recommends that all PATIENTS (!!) have private health cover and says 'please ensure that a bag or suitcase is packed and ready for any emergency.' There are also extra charges for special diets.

Residential statements are required to detail the goods and services offered to residents and all fees and charges applying to those goods and services. According to the Regulations, residential statements must explain the mechanisms for changes to fees and charges. Community Visitors report that residential statements do not always detail the mechanism for fee rises or note when fees increase. Over time residents can become confused about what fees they are paying and why.

When Community Visitors have questioned proprietors about why changes in the fee structure are not shown on the residential statement, some proprietors say that residents are informed of all fee increases by letter. Community Visitors are adamant that residential statements should either be updated to reflect all changes in fees and services, or records detailing these changes should be kept with the residential statements. This would allow a resident or person acting on his/her behalf to track any changes and to ensure that all fees increases are legitimate. Community Visitors believe such record keeping should be required as part of the Act.

Some SRSs charge admission payments or bonds ($8,000– $100,000). If the residents decide to leave, it is not always clear whether they can obtain

the whole payment back. It is unclear whether SRS proprietors, like real estate agents, are required to keep bond monies in a trust account. Under the *Retirement Villages Act 1986*, SRSs can charge this type of payment if they meet the criteria of a retirement village and are registered as such. However, the Retirement Villages Act only requires them to be registered if they charge a payment of more than $10,000. Community Visitors are concerned about the vulnerability of some SRS residents and believe that further safeguards are required.

Community Visitors recognise that the Regulations require residential statements to include matters that an administrator may consider are outside their normal responsibility, such as the health and community services available to residents from outside the service; and the times of routines affecting residents of the service. The Act now requires a residential statement to be 'signed and returned to the proprietor as soon as practicable after the statement is received ... by the resident or the resident's guardian or resident's administrator'. This raises the question of the role of an administrator in relation to these statements and whether there is an opportunity to pursue the concern of Community Visitors, that administrators should take a greater role in monitoring the quality of services to determine whether a represented person is receiving value for money.

6.5 Care plans

Community Visitors have consistently raised care plans as an issue in previous Health Services annual reports. After recent amendments to the Act, facilities are now required to prepare an interim care plan within 48 hours of a person becoming an SRS resident and an ongoing care plan must be prepared within 30 days. The plan must be a written document that covers '(a) the health and special or personal care needs of the resident; and (b) the services to be provided to the resident to assist with those needs.' Ongoing care plans should be reviewed and updated at least every six months.

Care planning training for SRS proprietors and staff has now been completed in all regions of Victoria. Community Visitors would have hoped that this would have resulted in a marked improvement in the standard of care plans but the quality of plans is still 'patchy'.

Community Visitors report that the format and content of plans varies enormously. Community Visitors sometimes have difficulty accessing care plans, with staff saying the plans are on a computer that they cannot access or that the plans are away being updated. Other proprietors and staff are happy to provide Community Visitors with copies of plans but the quality of the plans is often disappointing.

We found the care plans to 'be very minimal in almost all cases – with most of the entries being anecdotal jottings. Of most concern is the fact that there is very little planning in these documents. For example, where it has been noted that a resident has experienced a fall there is nothing in the care plan which indicated how the staff will attempt to ensure that this can be avoided in the future.

Care plans did not reflect individual needs very well. Resident that was blind – his blindness was not noted on plan.

Progress notes and evidence of a plan's implementation are rare. There is also little of evidence of residents and their significant others being involved in the review of plans in SRSs.

When we asked about six monthly reviews one proprietor's response was 'none will be done as we know the residents and don't need to look at them (plans).'

7 THE COMMUNITY VISITORS PROGRAM

7.1 About Community Visitors

Community Visitors are independent appointments by the Governor in Council. They have a unique role as volunteer community representatives in monitoring the quality of services for people who live in eligible facilities. These facilities are defined by the *Mental Health Act 1986*, the *Health Services Act 1988,* the *Intellectually Disabled Persons' Services Act 1986* and the *Disability Services Act 1991*. The Community Visitors Program is accountable, through the program manager, to the Public Advocate and, through the Community Visitors annual reports, to parliament.

The core role of the Community Visitor is to safeguard the interests and rights of people with a disability. Community Visitors are independent of service providers and through regular visits to facilities are able to assess whether the service is observing the rights and needs of individual residents and meeting expected community standards.

The credibility of the program is central to its capacity to effect positive change and resolve issues encountered during visits. To a large extent this credibility is dependent on Community Visitors being fair, reasonable and unbiased. There are no formal qualifications for becoming a Community Visitor but volunteers need to demonstrate a commitment to people with disabilities enjoying the same rights as other members of the community.

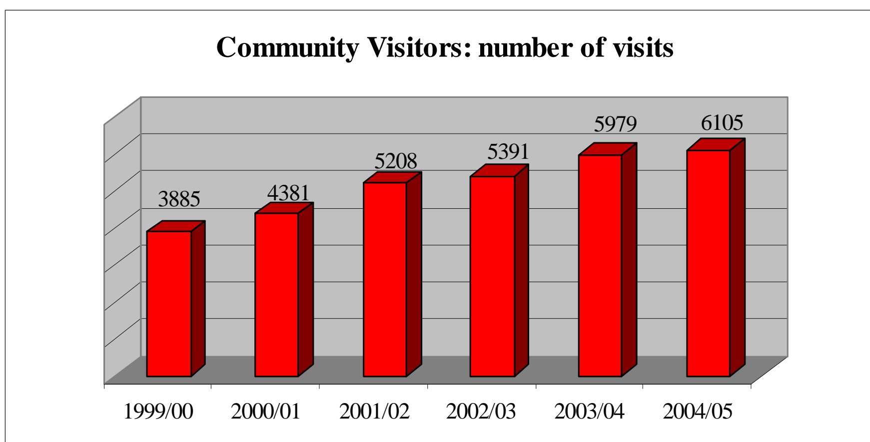
7.2 Year in review

The Office of the Public Advocate was responsible for training and supporting 599 volunteer Community Visitors across the state during 2004–05. This support and coordination function was undertaken by the Community Visitors Program Unit within the Office of the Public Advocate.

Community Visitors made 6,105 visits this year. The issues raised during these visits represent a significant contribution to improving service quality and also contribute to the systemic advocacy undertaken by the program and by the Public Advocate.

The reports of visits also contribute to the three annual reports submitted to parliament by the respective Community Visitors Boards: Disability Services; Mental Health Services; and Supported Residential Services.

Issues and developments in relation to Supported Residential Services form the basis of this annual report. A summary of issues from the two other annual reports – Disability Services and Mental Health Services – is provided over the page.



7.2.1 Disability Services

The Office of the Public Advocate welcomed the release of the state government's plan for the redevelopment of the Kew Residential Services site (formerly Kew Cottages) in June 2005.

Community Visitors are pleased that the government has now progressed with its commitment to provide better care for the hundreds of people with intellectual disabilities still languishing in the 'Dickensian-like' institution that is Kew Residential Services (KRS).

The plan provides the 100 residents who will remain on the Kew site with quality, personalised accommodation and care that is the benefit of smaller, community-based houses. The Office of the Public Advocate is monitoring houses for ex-KRS residents and is generally happy with outcomes to date.

Community Visitors remain concerned that the continuing debate around the heritage value of the site may be compromising the needs of people with a disability. Any restriction on development of the site through heritage listing will inevitably restrict the funds available for services for people with a disability.

We understand that the retention of the current heritage listings represents a loss of $15 million for people with a disability. We are not convinced that the preservation of these buildings respects the interests of residents remaining on the site, for whom the buildings may represent fear and a reminder of the dark days of institutional care.

It is now time to focus on redeveloping the remaining institutions in Victoria: Colanda in Colac, Sandhurst in Bendigo, and Plenty Residential Services in Bundoora.

7.2.2 Quality Project – Community Visitors Program

The DHS – Disability Services provided funding for a 12-month project in order for the Community Visitors Program to review visiting and reporting in the Disability Services stream. The project commenced in late 2004.

The project is in line with the current changes within disability services in Victoria and international approaches to determining the quality of services in disability, through care planning based on the choices of the person with a disability and evidence of individually-based outcomes.

7.2.3 Mental Health Services

In April 2005 the state government announced a $180 million funding package for the mental health system.

Community Visitors were particularly delighted with measures such as the $8 million to replace Bunjil House, as for five years they have been calling for a new facility to be built. The current facility at the Austin Hospital has 25 beds for medium- to long-term rehabilitation. The facility lacks personal privacy and adequate access to outdoor areas and provides an unacceptable quality of life.

The Office of the Public Advocate will now be focusing its efforts on ensuring that the money allocated is spent as soon as possible, and continues to be allocated to areas of need.

The long-term under-funding of the mental health sector, combined with the growing needs of Victorians experiencing mental illness, demands that this $180 million package be only the beginning.

Community Visitors continue to be particularly concerned about the lack of accommodation and support options for people who are discharged from acute inpatient facilities.

7.3 Legislative requirements for visits

Each stream of the Community Visitors Program has different requirements for a minimum number of visits by Community Visitors to each facility. The number of visits made by each stream of Community Visitors is outlined in the following table.

Community Visitors: visits

	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
Disability Services	1165	1399	2284	2389	2945	3008
Health Services	1619	1862	1771	1652	1587	1617
Mental Health Services	1101	1120	1153	1350	1447	1480
TOTAL	**3885**	**4381**	**5208**	**5391**	**5979**	**6105**

7.3.1 Health Services

There is no legislative requirement relating to the regularity of visits to SRSs. The Health Services Board, however, set a target for this year of an average of eight visits to each SRS (as at 30 June 2005 there were 203 SRSs), which would translate as a requirement of 1,624 visits across the state. This year 1,617 visits were made by Community Visitors, representing a shortfall of seven visits. Of the visits conducted, 70 were callout visits, made at the request of a resident or other interested party.

7.3.2 Disability Services

There is a legislative requirement for Community Visitors to visit the three gazetted residential institutions (Kew Residential Services, Colanda Centre and Sandhurst Centre) on a monthly basis.

While there is no legislated minimum number of visits to the other 1,005 accommodation services, which are generally houses accommodating up to five people, the Disability Services Board set a target of once a quarter, which translates to a target of 4,464 visits per year. In 2004–05 Community Visitors visited 1,004 of the 1,042 services and 3,008 visits were conducted. This means there was a shortfall of 1,456 visits under our ideal target. Of the 3,008 visits conducted, 134 were callout visits made at the request of a resident or other interested party.

7.3.3 Mental Health Services

The *Mental Health Act 1986* requires Community Visitors to visit each approved mental health service on a monthly basis. There are 107 approved services which means that the target of visits for the year is 1,284 scheduled routine visits plus responding to any requests directly from individual patients to visit (callout visits). Of the 1,480 visits conducted by Community Visitors in 2004–05, 1,210 were scheduled routine visits and 270 were callout visits in response to requests from individual patients. On this basis there were 74 visits less than the number required by legislation.

7.4 Target number of Community Visitors

At 30 June 2005, there were 499 Community Visitors, of whom 95 were in training. An additional 100 Community Visitors resigned during the year (20%), making a total of 599 Community Visitors trained and supported this year.

There is a current high number (95) of prospective Community Visitors in training. The process for selecting and training Community Visitors is, appropriately, an extensive one. Recruiting, selecting and training is an ongoing part of the Community Visitors Program. It is estimated that to meet the current visiting requirements of the Program, some 536 Community Visitors are needed across Victoria (316 in Disability Services, 120 in Health Services and 100 in Mental Health). If the

resignation/retirement rate of 20% per annum continues, it is estimated there will be a need to recruit a further 140 volunteers in 2005–06.

7.5 Training and development program

Training is a critical factor in the provision of a high quality Community Visitors Program. Great effort has been put into improving the quality of the training delivered by the program. The feedback provided by Community Visitors who have attended training this year indicates that these efforts have been worthwhile and that the training program in place is of a high standard.

This year, 106 training sessions were conducted for 1,490 attendees. Fifty-three of these days were run centrally for 681 attendees and a further 53 sessions were run locally with 809 attendees. This compares with 13 training days offered in 1999–2000. The high quality of our training program and the commitment of Community Visitors to attend training is fundamentally important to the quality of the program.

7.6 Value of the Community Visitors Program

The Community Visitors Program provides invaluable social benefit to the Victorian community and to people with disabilities. There is also a very clear economic benefit which derives from the program. It was reported in *A National Agenda on Volunteering: Beyond the international year of volunteers* that, based on Australian Bureau of Statistics Time Use data, the value of volunteering across Australia is estimated to be $42 billion per year.

The New South Wales Community Visitors Program uses paid sessional staff to conduct visits. The rate of pay for these staff is $25.13 per hour and they are paid for visits conducted and other related activities such as travel time to visits, and attendance at training and meetings. Using this rate to calculate the contribution of volunteer Community Visitors in Victoria making 6,105 visits, attending meetings to raise concerns and resolve issues, attending training, and the time volunteers spend on administration for the program, the figure is approximately $2,170,955 for this year. This represents a significant contribution to the Victorian community.

The *Whistleblowers Protection Act 2001* encourages and facilitates disclosures of improper conduct by public officers and public bodies. For the 12 months ending 30 June 2005, the Office of the Public Advocate did not receive any disclosures covered by the Act. The Office of the Public Advocate is committed to the aims and objectives of the Act and a copy of the Office of the Public Advocate's Whistleblower Procedure Manual is available on our website at www.publicadvocate.vic.gov.au or from level 5, 436 Lonsdale Street, Melbourne.

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