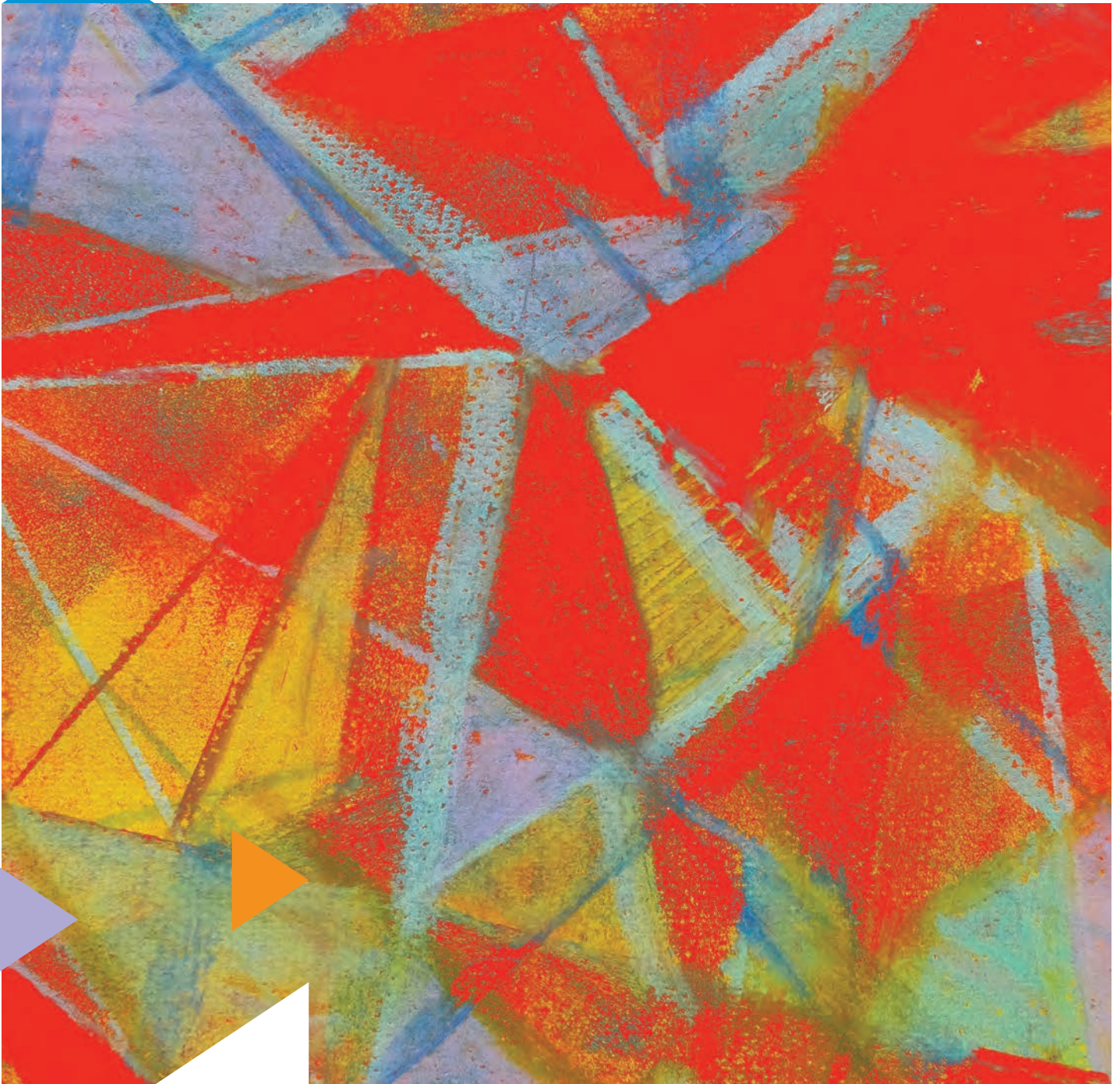




Office of the  
Public Advocate

*Safeguarding the rights and  
interests of people with disability*

# **Community Visitors Annual Report 2017–18**



*Residential Services  
Disability Services  
Mental Health*



**Christa Soames**

*Dark to Matches Stick*

Pastels on paper

**About the cover image by artist**

**Christa Soames**

The artwork chosen as the cover for this annual report is a treatment of four-pointed diamonds.

Each point could be said to represent the four entities in the life of many people visited by Community Visitors in Victoria: their family and carers, their service providers, the National Disability Insurance Scheme, and their safeguards, the volunteer Community Visitors.

Some people do not have any family or unpaid carers in their lives, some are not participants in the NDIS but they all receive dedicated oversight of their care, treatment and human rights by OPA's 470 Community Visitors.

**About the case studies**

All names and some identifying features have been changed in the case studies used throughout this report to protect the privacy of the individuals involved.

**Community Visitors Annual Report  
2017–2018**

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# Message from the Public Advocate

COMMUNITY VISITORS INQUIRE, ADVOCATE AND MONITOR FACILITIES FOR PEOPLE WITH DISABILITY AND REPORT ON THEIR CARE AND TREATMENT.

They are fearless advocates for the human rights of people with a disability. For more than 30 years, they have been an essential component of Victoria's safeguards for people with disability, playing a crucial role in protecting their rights, advocating for improvements in the service system, and promoting social inclusion.

As Margaret Mead famously said: "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

## The future of the Disability Community Visitors Program

Community Visitors have been heartened by the unequivocal support for the continuation of the program from the State Government and welcomed their commitment to strengthen safeguards across the disability sector during the transition to the NDIS.

Despite this, the future of Community Visitors under the National Disability Insurance Scheme (NDIS) is uncertain. The long-awaited Australian Government review of the nation's community visitor programs to determine the role that Community Visitors will play in the future is yet to commence, and the delay has caused considerable uncertainty and unease that there may be a diminution of safeguards in this state.

Community Visitors are particularly concerned about their ability to visit disability accommodation facilities when the NDIS is fully implemented in Victoria on 1 July 2019.

It is imperative that the current level of safeguards in Victoria are guaranteed as a minimum and this includes maintaining the Community Visitors Program. Community Visitors are dedicated advocates who pursue the resolution of concerns both for and with the residents they support. They are an integral part of Victoria's safeguarding system having been in place for over 30 years and, without them, there will be a significant gap in the NDIS safeguarding regime.

Community Visitor Boards are concerned about the possibility that this will lead to situations where abuses of the fundamental human rights of people with disability will be unobserved and unreported.

Nevertheless, the volunteer champions who are at the heart of this safeguarding program continue to diligently advocate for the resolution of issues they identify and support the people they visit to exercise their rights. This report is testament to their dedication, reporting on their work to uphold and promote the rights and interests of people with disability.

## Abuse

For a number of years, Community Visitors have focused on the unacceptably high levels of violence people with disability experience because they see this as a pressing safety and human rights issue. They identify and report on abuse as it is often hidden, underreported, and rarely investigated. Only a few cases reach court, and an even smaller number result in a successful prosecution.

Community Visitors continue to strive to eliminate abuse, neglect and exploitation by bringing this important issue to the attention of the community through their annual report. They document the conditions in the residential accommodation they visit, including whether residents are safe in the places where they reside.

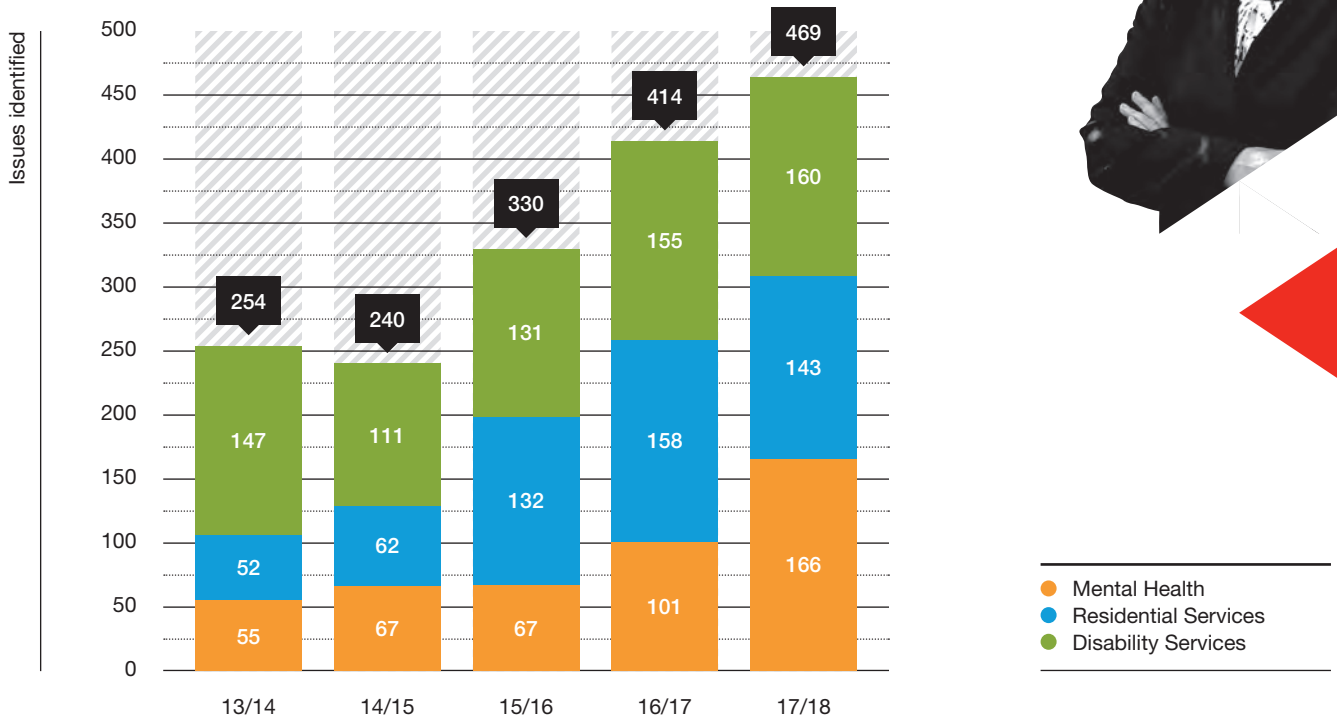
Figure 1 on the page opposite captures their work in this respect over the past year.

## Mental health

In the past year, Community Visitors have identified concerns in the mental health sector. The most urgent relate to the Transitional Support Units which were established following many years of Community Visitors lobbying for better support for people with an intellectual disability and mental illness.

These Victorians often fall between the gaps in the two service systems, so, the proposal to establish two dedicated units – one at the Austin and the other at Monash Hospital - was welcomed. The Austin unit is now operational but does not seem to be meeting the need effectively, particularly as disability services are unable to refer people directly to them. At the time of writing, the Monash unit is yet to open.

The case study on page 73 illustrates what happens for these people as they get shunted between the disability and mental health sectors, where neither are well-placed to deal with their complex needs.



**Figure 1.** Community Visitor reports of abuse, neglect and assaults across all streams, 13/14–17/18

Community Visitors have reported on the increased acuity in consumers in acute units which exacerbates the pressure on mental health beds across the state. This, in turn, can lead to inappropriate discharges to PARCs, step-down facilities. They are not staffed to deal with consumers who are still very unwell and who can have challenging behaviours. This has resulted in some very serious incidents in PARCs and readmissions to acute units.

Reports of increased seclusion of adolescents and young people is a matter of grave concern to Community Visitors, particularly as seclusion can induce long-lasting trauma and have dire consequences. A recent newspaper report about the seclusion experience from a consumer reported them as saying: “I was treated against my will...I was even secluded...to lock me up, alone, in a tiny, bare room, for hours...it just made me feel more ashamed and deserving of death.”<sup>1</sup>

## NDIS

Community Visitors volunteer in a complex operating environment that includes the United Nations Convention on the Rights of Persons with Disabilities, Victorian legislation including the *Charter of Human Rights and Responsibilities Act 2006* and now the Commonwealth National Disability Insurance Scheme legislation. With the roll out of the NDIS, they also must navigate and understand an increasingly complex service system in order to inquire into and report on the wellbeing of those they visit.

The impact of NDIS on the disability environment as it continues its steady roll out is to present a range of new and thorny challenges. Key among these is the dearth of accommodation options for clients with complex needs, facility-based respite, and the lack of a provider of last resort.

<sup>1</sup> Daya, I ‘When mental health treatment becomes a violation’ In Daily 30 August 2018

## The lack of accommodation options for complex clients

Accommodation is emerging as the most critical of all the issues under the NDIS.

The challenge of finding appropriate long-term accommodation for people with complex needs in the disability sector can be a difficult, if not an impossible, task and often leads to a plethora of unsustainable short-term arrangements. A lack of suitable housing options can result in people having no alternative but to live in inappropriate situations which can exacerbate stress.

In some cases, already fragile families are put under intolerable pressure to provide last-resort support and accommodation. For some, it means being kept for long periods of time in inappropriate settings such as hospitals and prisons because there is no other suitable accommodation within the community. In other cases, it can lead to homelessness or accommodation in facilities that fail to meet the needs of clients with complex needs and challenging behaviours.

## Respite access

This year, Community Visitors have reported on the underutilisation of facility-based respite in NDIS roll out areas. Two factors appear to be contributing to this: the additional fees being charged to cover staff needed for people with complex needs and low levels of funding for respite in NDIS plans. As a consequence, it appears that families are reluctant to use respite until absolutely necessary which has led to underutilisation of these services in some areas.

## Provider of last resort

As the NDIS system progressively rolls out across Victoria, DHHS is withdrawing from direct service provision. One of the important functions DHHS has effectively performed in disability services over many years has been as a 'provider of last resort', particularly for people with complex needs and challenging behaviours.

Community Visitors, along with many other organisations, are already identifying significant problems with service providers becoming increasingly reluctant or declining to provide services to those with highly complex presentations, particularly where there is a high level of violence directed at staff or where the client's symptoms cause property damage. For these residents, their future access to accommodation and supports is unclear especially without that fall-back support of a last-resort provider.

The following case study is one example of the serious concerns that Community Visitors documented this year for people in such situations.

## Notification to the Public Advocate

i

In May 2018, an incident resulted in six police cars and four ambulance attending a Department of Health and Human Services (DHHS)' Disability Accommodation Service house where a resident's violent behaviour resulted in three co-residents being injured and one hospitalised, as well as property being damaged.

The 77-year-old mother of the resident took him home after a hospital assessed he did not need admission to a mental health service. DHHS placed him with his mother as there was no other placement to offer him. This arrangement broke down within weeks due to his behaviours of concern which could have exposed his mother to serious harm. Subsequently, DHHS issued him with a Notice to Vacate which is, in effect, an eviction notice.

OPA and the resident's support coordinator advocated for DHHS to fund short-term alternative accommodation and support for the resident in a serviced apartment. This is occurring.

Community Visitors are not empowered to visit private accommodation. So, individual arrangements, such as this, place the resident outside the safeguarding system of external scrutiny that Community Visitors would normally provide, thus reducing the safeguards for this very vulnerable man.

It is still unclear where the resident will live in the longer-term.

In conclusion, I pay tribute to the hundreds of volunteer Community Visitors who fight for justice, and fairness for Victorians with disability.

They monitor the care and treatment of thousands of their fellows to ensure they are treated with respect and dignity, and have the right to make choices about their own life. Their collective courage and dream of a better world continues to inspire others in a world that is increasingly characterized by inequality and injustice.

*Colleen Pearce*

Colleen Pearce  
Public Advocate

409

Community Visitors

6284

Issues identified

5261

Statutory visits

Snapshot  
of CVP

1467

Facilities visited

240

Requested visits

# Introducing the Combined Board

## Public Advocate and Board Chair

### Dr Colleen Pearce

Dr Colleen Pearce has been Victoria's Public Advocate since September 2007.

In this role, she is the guardian of last resort for adults with disabilities in Victoria. Under legislation, she is also chair of the Community Visitor boards.

Colleen fearlessly advocates for the human rights and interests of people with a disability and a mental illness, and is outspoken on the significant issues of abuse, neglect and exploitation.

Colleen has more than 30 years' experience managing community and health services in both the government and non-government sectors.

Colleen's outstanding contribution to community services in Victoria has been recognised with a Commonwealth Centenary Medal, membership of the Victorian Honour Roll of Women and, this year, an honorary doctorate from RMIT University.

She is a board member of Connecting Home, an organisation established in response to the recommendations arising from the Stolen Generations Taskforce Report, and Wintringham, Specialist Aged Care.

Colleen is a proud Yuin woman from southern NSW.

## Residential Services Board

### Marj Munro

Ms Marj Munro was first elected in 2015 to the Residential Services Board and was re-elected last year for a second two-year term to 30 June 2019.

She was appointed as a Community Visitor in the disability stream in 2009 and, the following year, became a Regional Convenor team leader in it. Her involvement as a Residential Services stream visitor commenced in 2010. She now concentrates on residential services and has been a Regional Convenor since 2011.

Ms Munro taught history, english and politics for over 30 years and served two terms as a municipal councillor. She is still actively involved in her community.

### Dave Parker

Mr Parker joined the Community Visitors Program in 2004, has been a Regional Convenor since 2006. This is his third term on the Residential Services Board.

He is a retired former Royal Australian Navy serviceman. While in the navy, Mr Parker spent over six years as an instructor in submarine daily operations and electrical systems.

Previously, Mr Parker completed an Advanced Welfare Officers course as he volunteered as a Welfare and Pension Officer for the Submarine Association of Victoria for many years. He was also a volunteer facilitator in Nutrition Australia's Cooking for One or Two program.

## Disability Services Board

### Kaye Manners

Ms Kaye Manners commenced volunteering with the disability stream of the Community Visitors Program in 2011. This is her first term on the Disability Services Board.

She was formerly a Regional Convenor in the Eastern Metropolitan Region and is currently a Community Visitor, Panel Secretary and member of the Training Steering Committee.

She has had careers in nursing and social work in varied community health, public and private hospital settings and has held volunteering roles with a sporting, phone counselling and a migrant support organisation.

Her previous committee experience includes an office-bearing role on a cultural diversity committee with a public health service, and a sporting organisation.

### David Roche

This is Mr Roche's third term on the Disability Services Board having served one year in 2009-2010 and then was re-elected last year.

He is chair of the Combined Board's Policy Review Steering Committee, a Panel Secretary and a former Regional Convenor and has served on the Training Steering Committee.

He lives in Korumburra, South Gippsland, and has a history of active involvement in local and regional community-based organisations.



Mr Roche has qualifications in public policy and management, business and project management and training.

Mr Roche views collaboration and openness to change as key roles of the Board to ensure that Community Visitors remain a primary safeguard for those with a disability.

## Mental Health Board

### Judy Heron

Ms Judy Heron was appointed as a Community Visitor in 2015. She is a Regional Convenor for the Community Visitors Program and this is her first term as a Mental Health Board member.

She has a degree in Behavioural Sciences from La Trobe University and graduate studies from Monash University and the University of Melbourne in Psychology and Teaching English to Speakers of Other Languages (TESOL).

Ms Heron was registered with the Australian Health Practitioner Regulation Agency for 24 years. Employed as a general manager in student services for more than 20 years at the University of Melbourne, she is now volunteering at a residential facility of St Vincent's Health, Prague House.

### Above (L-R)

Back row: David Roche, Debra Sevastianov, and Judy Heron.  
Front row: Marj Munro, Colleen Pearce, and Kaye Manners.  
Absent: Dave Parker (RS)

### Debra Sevastianov

Ms Debra Sevastianov was appointed as a Community Visitor in 2013. She is a Regional Convenor for the Community Visitors Program and this is her first term as a Mental Health Board member.

She is qualified in aged care, disability, finance, education and mental health and also volunteers with the local CFA and runs her own construction business.

Ms Sevastianov has a lived experience of mental health and enjoys contributing her time to the Community Visitors Program because it means she can make a difference for people with lived experiences of mental health.

# About Community Visitors

Community Visitors are independent volunteers who safeguard the interests of people with a disability. They are supported by the Community Visitors Program which is part of OPA.

The program is organised into three streams to reflect the type of services visited:

- Residential Services – visits are made to people who reside in supported residential services (SRS) and require additional support
- Disability Services – visits are conducted to community-based facilities for people with disability and the one remaining institution in Victoria.
- Mental Health – visits are made to consumers and residents in mental health facilities providing 24-hour care including the community stepdown or stepup facilities, Prevention and Recovery Care (PARC) services.

The legislative framework is derived from the following Acts of Parliament:

- *Supported Residential Services (Private Proprietors) Act 2010*
- *Disability Act 2006*
- *Mental Health Act 2014*

The legislation establishes three respective boards: Residential Services, Disability Services and Mental Health. These boards are responsible for reporting the activities, issues and findings of the Community Visitors to the Victorian Parliament each year, through the relevant minister.

Community Visitors are appointed for three years by the Governor in Council. They are empowered by legislation to visit specified facilities, to make enquiries of residents and staff as well as examine selected documentation in relation to the care of people residing at the facilities.

Community Visitors usually make unannounced visits and visit in teams of two or more. At the conclusion of each visit, the Community Visitors prepare a report summarising the findings and indicating where action is required. A copy of the report is provided to the most senior staff member at the facility or the proprietor in the case of an SRS.

Where an issue cannot be resolved at facility level, it is usually taken to a more senior manager in the agency and/or the DHHS area office. Serious matters may be referred for action within OPA and dealt with as part of the Public Advocate's broader powers.

While the vast majority of visits are scheduled and unannounced, a significant number are in response to specific complaints. This includes referrals to the program via OPA's Advice Service. On occasions, repeated visits are necessary to certain facilities over a short period, in response to serious issues identified and at the discretion of the Community Visitors.

Panel Secretaries are Community Visitors responsible for planning, organising and reporting visits undertaken by their panel of two. Regional Convenors are Community Visitors who take on the team leader role for their stream, in their division or area.

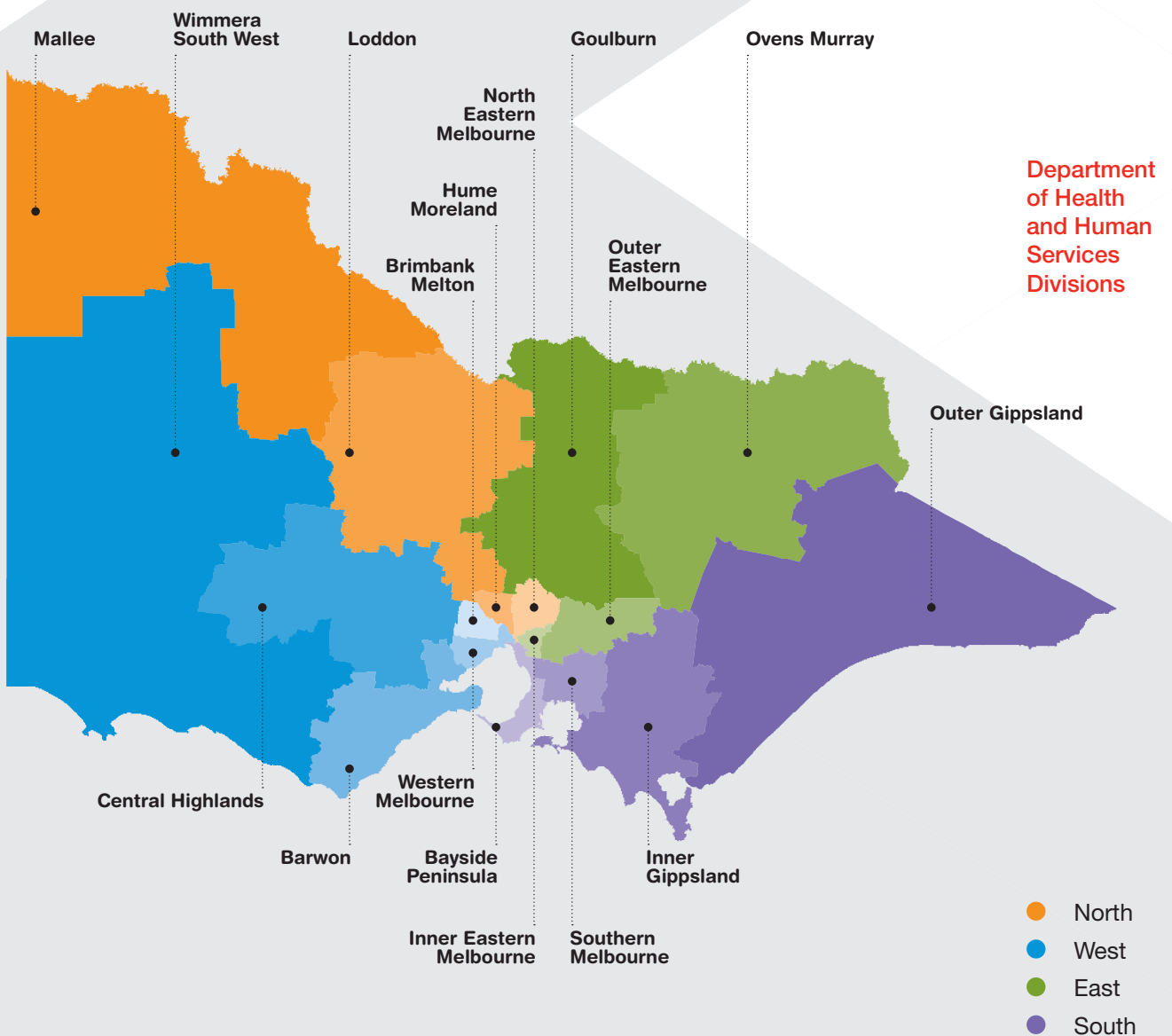
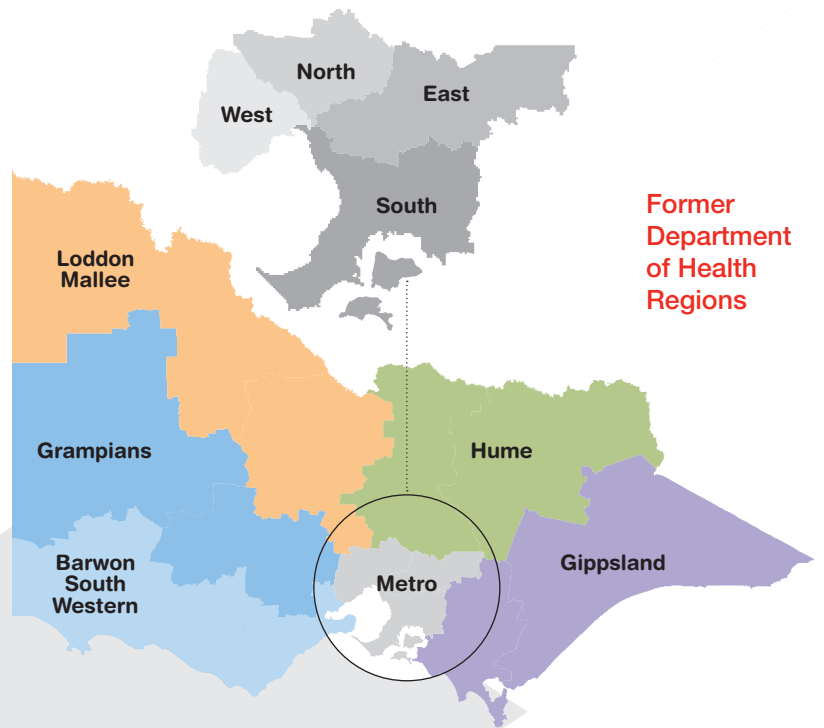
The ongoing support, training and recruitment of the Community Visitors and the boards is the responsibility of staff in the Safeguarding, Inclusion and Volunteer Programs Unit.

**Table 1. Community Visitors and visits by stream, 17/18**

Stream	CVs	Visits
Residential Services	76	764
Disability Services	255	2896
Mental Health	78	1601
<b>Total</b>	<b>409</b>	<b>5261</b>

# Reporting Regions/ Divisions

Department of Health and Human Services



# Residential Services

Statewide Report and  
Recommendations



## Recommendations

The Community Visitors Residential Services Board recommends that the State Government:

1. fund staff training in Supported Residential Services to manage excessive alcohol and illicit drug use effectively
2. audit Supported Residential Services staff attendance at Mental Health Training against the potential staff attendance pool
3. incorporate the recent Prescribed Reportable Incidents audit into the Department of Health and Human Services Annual Targeted Compliance Review Program
4. provide quarterly reports of Prescribed Reportable Incidents to the Community Visitors Program
5. ensure proprietors incorporate choice into the services provided to Supported Residential Services residents in line with the principles that underpin the *Supported Residential Services (Private Proprietors) Act 2010*
6. undertake a statewide project to review whether and how Supported Residential Services are meeting the needs of complex and aged residents
7. urgently act on the recommendations of the KPMG review of the Supporting Accommodation for Vulnerable Victorians Initiative and the Pension Level Project
8. expand the Resident Opportunities After Reform project model across the state to facilitate people with complex needs accessing National Disability Insurance Scheme and My Aged Care packages
9. review Supported Residential Services emergency management procedures to deal with increased numbers of people onsite, such as service providers
10. request Department of Health and Human Services Supported Residential Services branch negotiate a protocol for responding to incidents at SRS with Ambulance Victoria
11. advocate with the Australian Government for the retention and effective resourcing of the Community Visitors Program as an essential quality safeguard following full National Disability Insurance Scheme roll out.

# Statewide Report

## Introduction

Community Visitors reported 652 issues of concern found in Supported Residential Services (SRS), of which 22 per cent were serious physical or sexual assault.

Many issues were resolved at a local level but a significant number remain unresolved due to them still being processed.

This year, a regional and a metropolitan SRS closed, reducing the number to 128 across Victoria and the loss of 31 beds.

Pension-plus SRS constitute about 40 per cent of the sector where residents may pay more than \$1000 a week for their room, meals, care and support.

At the remaining 60 per cent pension-level SRS, residents are charged 85-95 per cent of the disability or aged pension. These residents are among the most vulnerable members of our community, often without family, and Community Visitors play an important role in protecting their human rights and advocating for their lives to be meaningful. They promote the rights of residents to live comfortably in their SRS with regular community engagement opportunities. One example, this year, was a resident who celebrated 21 years in her SRS with a party organised by the proprietor and fellow residents.

The Board is disappointed that, at the time of writing, it had not received the State Government response to the recommendations of last year's annual report, so this year's recommendations have been prepared without that feedback.

## Abuse, neglect and violence

This year, Community Visitors reported on the severity and impact of aggression between fellow residents as well as between staff and residents. This, combined with verbal altercations, regularly escalated to violence.

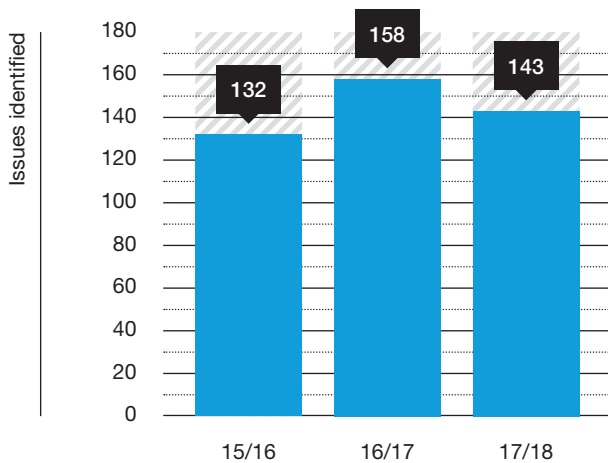
Community Visitors reported 143 issues of serious physical or sexual assault and, on several occasions, police were called. The prevalence of mental illness, combined with drug and alcohol use, often heighten tensions between residents.

In many instances, violent episodes led to resident evictions, pressure on people to move to another SRS or even homelessness.

The program commends Eastern Metropolitan Melbourne area DHHS for organising the local Centre Against Sexual Assault to conduct training for proprietors, Community Visitors, service providers and DHHS staff following allegations of resident sexual assault. This work built a comprehensive network of support and increased understanding of the protocols for responding to such allegations.

Table 2. Total visits Residential Services stream, 17/18

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	39	16	16	155	171
North Division	23	15	9	159	168
South Division	43	25	13	226	239
West Division	25	20	9	177	186
<b>Total</b>	<b>130</b>	<b>76</b>	<b>47</b>	<b>717</b>	<b>764</b>



**Figure 2.** Residential Services stream abuse, neglect and violence, 15/16–17/18

## Mental health issues

The 2013 SRS census documented 96 per cent of pension-level SRS residents having a disability, 59 per cent relating to mental health issues and 29 per cent having a mild intellectual disability.

These presentations may lead to increasingly complex, challenging and at times, risky behaviours. Over recent years, Community Visitors have highlighted the increasing impact of mental illness in SRS and this year is no different.

SRS residents gaining access to mental health services is one of the other key health issues facing the sector. The absence or paucity of these services, especially in rural and regional areas, places continued stress on SRS staff.

One persistent issue has been the lack of information provided by mental health services about those they discharge to SRS. The situation has been exacerbated by a widespread misperception in the mental health sector that clinical staff are employed in SRS. The

Board has repeatedly highlighted the need for better liaison and information sharing from mental health providers to SRS proprietors and staff.

Community Visitors welcome the finalisation of the DHHS Mental Health and SRS Interface Project in response to the repeated concerns they raised. The project aimed to ensure placements were appropriate, and that SRS staff understood, and could meet, incoming residents' mental health needs. The resulting *Guidelines for mental health services and supported residential services* and its distribution across the mental health and SRS sectors is applauded. The Board looks forward to reviewing the compliance data about guideline usage next year.

A coronial inquiry into the death of an SRS resident by their roommate during a psychotic episode led to a recommendation that all SRS staff undertake mental health training. DHHS is to be commended for accepting and implementing this recommendation over last year. It is particularly pleasing that 523 SRS staff, mainly in pension-level facilities, have attended a one-day training program. The majority of them report they now have an improved understanding of mental illness and how to manage the associated behaviours.

The challenge in the coming year is for DHHS to audit the uptake of the training against the pool of SRS staff who should attend. Further work is required by DHHS to ensure there is a greater uptake amongst pension-plus SRS. Community Visitors recognise the challenge this presents, particularly with the high level of staff turnover in the SRS sector. However, the large number of resident mental health issues reported, and their seriousness, demands a renewed focus on fully implementing this training across the sector.

## Incident reporting

Since the 2012 Act, Community Visitors have documented patchy compliance with incident reporting and that many proprietors and staff have a poor understanding of the difference between serious “prescribed reportable incidents” (PRI) and the less serious “recordable” incidents. There is an ongoing concern that SRS with very challenging and complex resident mixes have relatively few incidents documented.

The Board has raised these concerns repeatedly with DHHS over the year and urged it to take a more proactive regulatory response. DHHS confirmed that approximately 70 per cent of SRS have notified them of three or fewer PRIs since the 2012 legislation came into effect. The Board welcomes the DHHS decision to audit SRS with few or no reportable incidents over this time period.

Building this one-off DHHS audit of PRIs into its annual quality compliance framework will reinforce the importance of incident recording to proprietors and staff. This measure could contribute to the dynamic risk profile of every SRS and where inaction invites a stronger regulatory response from DHHS.

Ongoing monitoring of incident reporting remains a priority for Community Visitors but access to incident reports in some SRS remains an issue. The program will continue to identify SRS that do not comprehensively report incidents including assaults, neglect, death and falls or where the quality of reporting is poor.

## Resident choice

The Act enshrines 15 key standards one of which is ‘resident choice’.

Residents in some SRS have complained to Community Visitors that powdered milk is routinely served which they find unpalatable in hot drinks or on cereal. This has meant that some residents have resorted to buying their own fresh milk. DHHS advises that the practice of providing powdered milk is acceptable under the Act and commonplace across SRS. They found no issue with residents at one SRS being offered fresh milk in exchange for a small increase in their weekly fee.

Community Visitors reject the cost arguments related to fresh milk, particularly in the current economic environment, and view this as unacceptable by community standards. Proprietors should be required to inform potential residents prior to signing their Residential Agreement that only powdered milk is on offer. Failure to do so should be considered a breach of the agreement.

## Staff support

The regulations stipulate a minimum staff-to-resident ratio of 1:30 though staffing should be adequate to meet resident needs. A number of SRS are now catering to residents with complex needs, or aged residents who are becoming increasingly frail, so this ratio is often inadequate to the task.

At one SRS, two people, one using a walker and the other a walking stick, fell at the same time in the dining room. The staff member on duty was assisting another resident to dress. These two residents were helped up by their fellow residents, many of whom use mobility aids or have other physical limitations.

The Board understands the importance of the SRS sector remaining commercially viable but it must be within the context of meeting residents’ needs with dignity.

## SAWI and PLP funding

The KPMG review of the Supporting Accommodation for Vulnerable Victorians Initiative (SAVI) and the Pension Level Project (PLP) funding was finalised more than a year ago, however, Community Visitors are yet to see the DHHS response. One possible outcome is the combination of the two programs to be spread across all pension-level SRS, including those new to the sector.

Community Visitors would support such a change as it would better address need and sector viability.

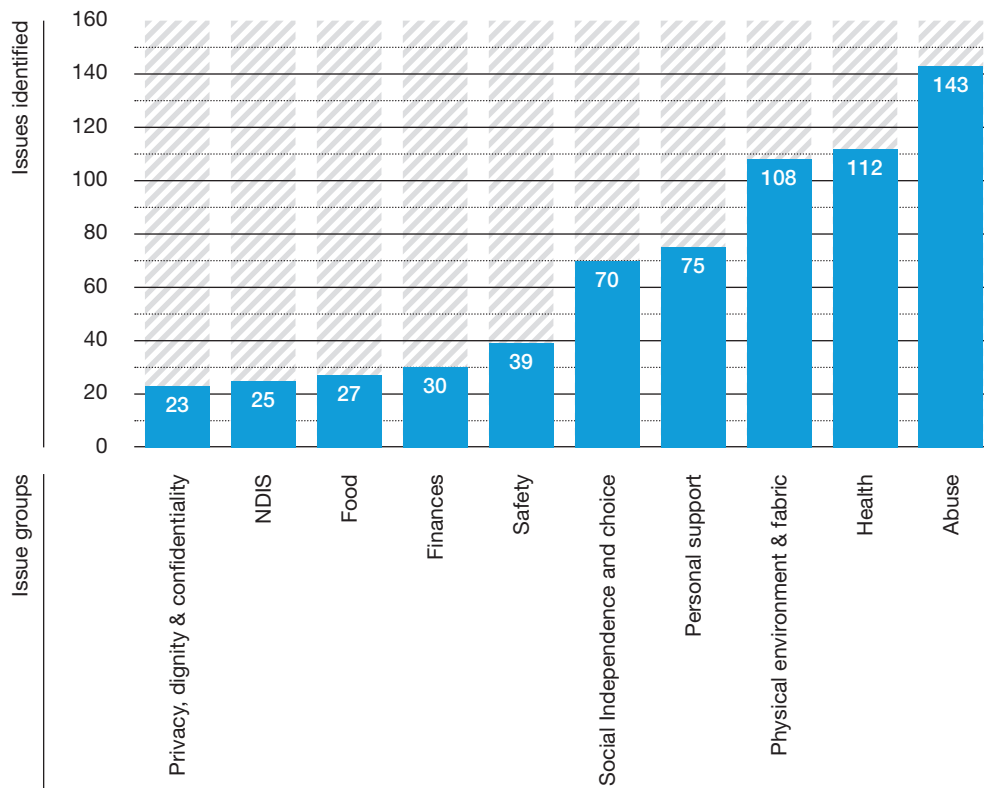
## NDIS

This year, the Community Visitors Residential Services Board undertook a project to assess the level of implementation of the National Disability Insurance Scheme (NDIS) across Victoria. Community Visitors asked five questions of SRS proprietors to assess the NDIS impact on residents. Fifty-one per cent of eligible SRS responded to the survey.

Community Visitors reported that most residents with NDIS plans were accessing services that enhanced their lifestyle, resulting in fewer behaviours of concern. However, there is concern about lengthy delays and a lack of responsiveness from the National Disability Insurance Agency (NDIA). They also reported residents experiencing difficulties in coordinating multiple funded services, and received negative feedback about the quality of some services.

Proprietors, however, point to the need to manage an increasing number of service providers entering their facility without any protocols to guide them in this changing service environment.

A positive this year has been the Resident Opportunities After Reform (ROAR) Project,



**Figure 3.** Residential Services stream by issue groups, 17/18

implemented in the Eastern Metropolitan Melbourne area, which supported SRS proprietors and staff to gain access to services for their residents with complex needs. The program prepares staff for NDIS planning processes and assists residents to articulate their needs. In addition, it facilitated residents over 65 years of age to gain access to My Aged Care packages.

This project has been an overwhelming success with a large number of residents aided to get additional supports. The program would like to see the project extended statewide.

An emerging issue has been SRS proprietors becoming NDIS providers. There is a potential for a conflict of interest when SRS are registered under State legislation to provide accommodation and support and also registered under the federal NDIS Act to provide similar or like supports.

One of the key tenets of the NDIS under its legislation is the separation of disability accommodation, referred to as Specialist Disability Accommodation (SDA), and independent living supports, referred as Supported Independent Living (SIL). This is to avoid potential conflicts of interests that could flow from a client having all their supports provided by one service provider.

Community Visitors have reported about quality of care issues over a number of years with one proprietor who runs several SRS. This proprietor is now able to

offer NDIS services to their SRS residents. Community Visitors have reported an example of residents of this SRS being signed up for NDIS service provision potentially for supports they should be receiving from the SRS.

Other long-standing and specialist providers have been displaced, so careful monitoring and oversight will be required to ensure these clients are not charged twice for the same service.

SIL and SDA-funded services under the NDIS require both State registration under the Disability Act as well as NDIS provider approval. These are different from SRS registration. Registration under the Disability Act brings the protection that complaints can be made to Victoria's Disability Services Commissioner.

DHHS advised that the proprietor had an application pending for registration under the Disability Act. Until an SRS proprietor is registered under that Act, the only safeguards applicable to their residents are visits by Community Visitors or any advocacy from services involved in resident care and support.

The potential conflict of interest issue was raised with the DHHS SRS Program. In response, they advised that the proprietor's registration as an NDIS provider was totally separate from the State SRS legislation and, therefore, the program had no oversight, nor could it act in relation to the issues being raised.

This concern was then escalated to the DHHS NDIS Transition team as well as the issue of whether the applicant was suitable to be an NDIS provider.

The Transition team advised that an SRS proprietor could not deliver a residential service under the Disability Act at its registered SRS premises. This proprietor has a large number of demountable buildings onsite at one of their SRS which they intend to offer as 'independent living' under the NDIS. Potentially, this could double the number of residents onsite.

Community Visitors remain concerned about the SRS residents as the proprietor appears to be increasingly focused on their new NDIS business model.

## Health

Community Visitors remain concerned about the health of SRS residents.

This year, they identified 20 issues about inappropriate medication management, the consequences of which varied widely. Several of these incidents involved staff, so proprietors should consider ongoing staff training in medication management to reduce such errors.

One resident's financial situation led to him refusing to take his medication for a chronic condition. He was reluctant to exacerbate his financial problems by purchasing new medication when he already had a large outstanding debt to the chemist.

A couple of issues were reported by Community Visitors this year about ambulance staff interaction with SRS residents. In one incident, a 120 kg man was injured following a fall in a bathroom. When SRS staff requested ambulance assistance they specifically stated his weight and that the SRS did not have lifting equipment. There were substantial delays until a third ambulance arrived with lifting gear to transfer the resident to hospital.

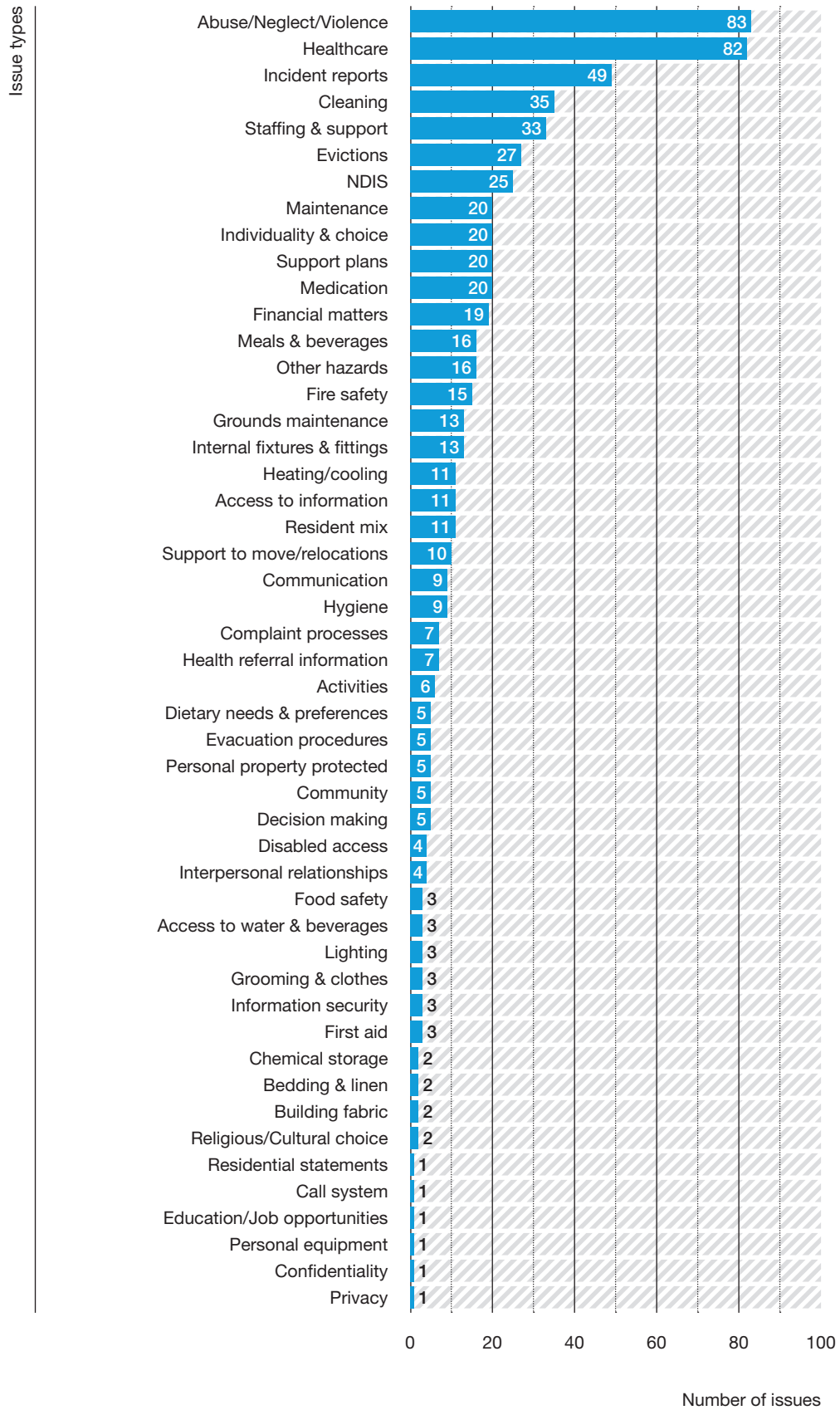


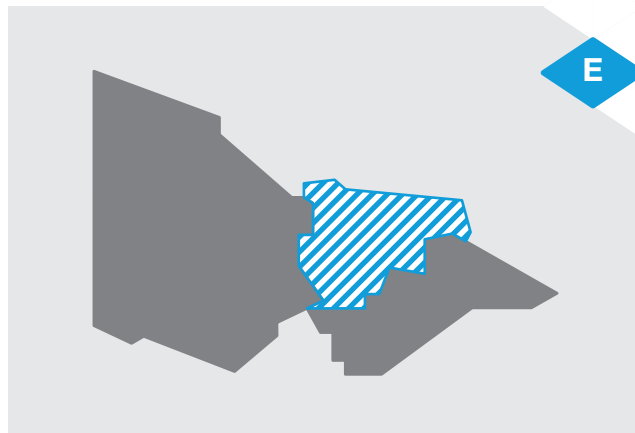
Figure 4. Residential Services stream number and types of issues identified, 17/18

# Divisional Reports



## East Division

EAST DIVISION INCLUDES EASTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF INNER EASTERN AND OUTER EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF HUME, COMPRISING THE DHHS AREAS OF OVENS MURRAY AND GOULBURN.



## Eastern Metropolitan Melbourne area

In the Eastern Metropolitan Melbourne area, there are 38 SRS of which eight are pension-level and 30 are pension-plus.

Community Visitors find that most facilities are heated or cooled according to the weather and many have built in water coolers, warm sitting or common rooms, television and sometimes pianos, computers and pay phones.

### Abuse

Community Visitors report many forms of abuse: name calling, arguments, physical violence between residents and towards staff including breaking furniture. Often violence starts over cigarettes or drugs; some people are evicted repeatedly for the same reasons from different SRS.

A man was evicted following verbal abuse of a worker and putting used needles in his washing that could lead to injury. At one SRS, police informed staff that a resident who had gone out in the morning had died from a drug overdose that night. Although residents are independent, the unexpected death of a resident

may be a catalyst for the SRS to reflect on whether their support plans are adequate to meet the residents' safety and wellbeing needs.

A resident's poor health may contribute to their distress and trigger violent behaviour toward other residents and staff. It may also cause behaviours that create discomfort for others such as night walking, calling out, self-harming, attempted suicide or an inability to control anger. In contrast, in one SRS, two men are supporting each other to stop drinking. A SRS may not suit a person and vice versa but, when the resident relocates, their behaviour changes.

In three facilities, there were reports of low key but constant violence, drug use and resident-on-resident abuse.

Residents in contact with their family are usually supported. Community Visitors, however, raised concerns at a pension-plus SRS where a resident's mother appeared to intervene in her daughter's care, against medical advice.



## Health

SRS maintain strong relationships with pharmacies and GPs, who visit at least fortnightly, and proprietors coordinate health services to support residents to attend off-site appointments. Medicine charts are usually well kept and medicine trolleys locked.

Community Visitors reported three examples of SRS which supported people who chose to die in their own home, providing care and comfort to the person's family and friends, often with the help of palliative care services.

## Personal support

Community Visitors have noted an improvement in staff responses to residents who display challenging behaviours. Staff report they feel better equipped to manage difficult behaviours since participating in a DHHS-funded mental health training session. Proprietors who receive a discharge summary from a mental health facility for a new resident are better able to support their complex needs during the transition.

Several facilities encourage residents to be involved in the care and upkeep of their own room and home. Participation in tasks such as gardening, sweeping, taking bins in and out, vacuuming, clearing tables and checking outing schedules, promotes an environment of mutual respect where people feel valued.

### Good practice



A pension-level SRS proprietor assisted a long-time resident who had lost contact with her daughter to search for her and re-establish contact.

Community Visitors were requested to visit one SRS on two separate occasions in response to concerns raised about hygiene and found no soap available for hand-washing in most bathrooms.

Community Visitors observed a resident's support worker sitting with her without any obvious form of communication or eye contact.

In another SRS, a support worker complained to Community Visitors that children were in the SRS, not realising they were a resident's family who visited twice a week.

## Social independence and choice

Many facilities have a variety of activities, ranging from bowling, art classes, swimming, visits to the library, walking, coffee or lunch, exercise and art classes. Many activities are organised by staff with EACH or Social Connections using SAVVI funding.

Community Visitors enjoyed talking with a resident who was proudly planning to celebrate 21 years in the SRS.

In one SRS, Community Visitors were told that several residents who gave powers of attorney to their children were relocated from the SRS without reasons being given.

Community Visitors are concerned that activities remain appropriate to residents' age and interests.

At one SRS, residents are concerned that council buses, which transport people to activities, will stop after 19 July 2018, limiting their social interactions and independence.

### Case study



Jack has several support workers. A hoarder, he obtains goods from the Salvation Army, which he then sells.

Jack recently acquired a cross trainer which takes up space in the communal area to the distress of the proprietor, disadvantaging other SRS residents.

As part of a TAFE student placement program, nine students and two staff attended an 18-bed SRS, two days a week for eight weeks.

They asked residents if they could view their records, and received agreement, however, Community Visitors were concerned that some residents may not have fully understood the request.

The Community Visitors were concerned that the large number of students might have been overwhelming for residents, and about what might happen to resident activity when the program finished.

## Incident reports

A concerned member of the public found a distraught and poorly dressed resident in parklands near the SRS. The resident was taken to hospital by police. There was no incident recorded.

## NDIS

Commencing in 2017, DHHS funded the Eastern Supported Residential Service ROAR Project, a partnership of a number of agencies. It aimed to assist residents in 18 SRS in the area to build knowledge and access funded programs such as the NDIS, My Aged Care and mental health services.

To date, the project has published an NDIS Practice Advice with resources, tools and guidelines to support people to become an NDIS participant and has been highly successful in facilitating this access. Community Visitors report that most SRS managers are helping residents to access the NDIS. Several proprietors have also registered to become service providers under NDIS. Many other residents, ineligible for the NDIS due to being over 65 years of age have also benefited from aged care packages.

## Finance

A staff member is reported to have persuaded five residents to move to the SRS operated by the previous owner.

Community Visitors were also told about a resident who borrowed money from other residents but did not repay them. The resident also acquired access to the bank account of their long-standing room-mate and regularly withdrew their money. When the proprietor offered to apply to VCAT for an administrator, both residents relocated to another SRS where the behaviour is reported to continue.

## Hume area

The pension-level SRS in the Hume area is the only SRS in the northern part of the state. It is owned by a company that also has a number of group homes and work sites for people with disabilities in the area. Occupancy has remained stable over the past 12 months with several short-term resident changes.

## Abuse

Verbal abuse among several residents is the most commonly reported incident. It is generally a result of unstable mental health. Police have been called on several occasions.

## Health

Mental health care is the most common need of residents. Several residents have spent considerable time in the regional mental health facility located 66 kilometres south of the SRS. A local mental health support worker visits the SRS weekly to administer medication and monitor residents with mental health concerns. One resident has had major hip surgery. Another had a knee replacement.

Other health concerns include residents with diabetes and epilepsy. A mobile optometrist and dental service attends the SRS annually.

## Physical environment and fabric

Interior painting and replacement of window coverings has been undertaken. Heating and cooling meet the environment conditions. Emergency exit signs have been upgraded throughout the SRS.

## Social independence and choice

A number of residents participate in SAVVI activities including bowling fortnightly and fishing. However some residents choose not to participate in any outside activities or attend the regular resident's meeting.

Nutritious meals are provided but not fresh milk as powdered milk is used. Kitchen staff report that fresh milk is too expensive.

## North Division

NORTH DIVISION INCLUDES NORTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF HUME MORELAND AND NORTH EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF LODDON AND MALLEE.



### Loddon Mallee area

There are four pension-level and one pension-plus SRS in the Loddon Mallee area.

#### Abuse

A number of residents reported resident-to-resident abuse. One resident said he was bashed on the head, another said he had his face injured. Other incidents include alleged assaults and repeated verbal abuse. There were at least two eviction notices served following allegations of abuse. One notice was later changed to a warning after the resident argued she had been verbally assaulted by her co-resident.

#### Health

Mental illness is a debilitating health issue in the area, which can involve depression, aggression, psychosis and self-harm often impacting a residents' ability to manage their own hygiene.

One resident complained that emergency treatment was not provided when they suffered a seizure.

#### Physical environment and fabric

Many cleaning issues were reported including dirty crockery, blinds, fans, vents and bathrooms, stained carpets, and issues with flies, cobwebs and a dirty outdoor shed.

## Personal support

At one SRS, residents complained staffing levels had been reduced. One resident said that showering support was not always available to those who needed it. Staff expressed a high level of frustration with the lack of help from DHHS and Outreach. Many residents wait far too long to access medical appointments and transport.

## Social independence and choice

At one SRS, Community Visitors have persistently reported that residents are denied their right under the Act to choose to have fresh milk in their tea or coffee; instead powdered milk is used in food and drinks. DHHS' contention is that, under the legislation, powdered milk is a satisfactory choice.

At the same pension-level SRS, many residents complained about substandard food. One resident showed Community Visitors a photo he had taken of left-over food which had been frozen and re-served. Some residents complained they were hungry and were buying food.

## NDIS

Twenty-three residents across three SRS had an NDIS plan.

At one SRS, 12 residents said they did not understand the NDIS. Another proprietor told Community Visitors that services for non-NDIS residents had been reduced.

### Case study

Geoff had a previous history of problems with alcohol.

Since the introduction of NDIS, he now works two days a week at a disability service and receives a small payment plus \$98 a month for taxi fares.

He is very happy with the outcome and said the NDIS has changed his life.

## Northern Metropolitan Melbourne area

There were 18 SRS operating in the Northern Metropolitan Melbourne area for most of the year: 14 pension-level and four pension-plus facilities.

### Abuse

Community Visitors remain seriously concerned about the safety of residents in some pension-level SRS. Assaults, fights between residents, sexual abuse, threats of violence and property damage were reported. One resident claimed he had been assaulted by a staff member but there was no evidence to substantiate it.

Police and ambulance officers were involved in some matters but often found residents reluctant to press charges. One resident was taken away by police in handcuffs after attacking another resident who had no clothes on. At the same SRS, another resident told Community Visitors he had hurt his hand punching a wall when he “went off his head.”

There are a large number of people with mental health issues who would likely be homeless if not living in these facilities. Shared rooms at some facilities can lead to tensions. Drug and alcohol issues often exacerbate problems in pension-level SRS.

All SRS have some system in place for recording incidents, and these records are a useful source of information for Community Visitors. At one SRS, Community Visitors learnt that a resident had drunk bleach after having suicidal thoughts. He was transported to hospital and on discharge tried living with his mother. When arrangements failed, he returned to the SRS. Community Visitors reported he now appeared more emotionally stable.

### Health

Health-related incidents included medication errors, an eye infection, the collapse of a resident, an ulcerated foot, and a number of mental health issues. Falls seem to be an ongoing issue at several SRS.

### Physical environment and fabric

Issues reported included unsafe power cords which was addressed, poor maintenance of outside areas, and insufficient cleaning at several pension-level SRS. On one visit to a pension-level SRS, Community Visitors noted sticky and dirty tables, floors, windows and chairs. Corridors had dead flies and cobwebs and there was a bathroom with a strong urine smell.

Community Visitors also reported a large number of unoccupied portable buildings on the vacant land adjacent to the SRS, some of which had windows

with jagged broken glass, as well as building debris and long, dry grass which was a fire risk, particularly if residents dropped a cigarette butt in it.

### Personal support

At one pension-level SRS, residents frequently wore dirty clothes. On one visit, Community Visitors reported that a resident had matted hair at the back of his head and very dirty clothes. The resident told Community Visitors that he only had two sets of clothes and he planned to go to Centrelink to get a loan to buy some more. The issues were discussed with the SRS manager and Community Visitors noticed, during the next visit, that the resident had had a haircut.

### Social independence and choice

Some SRS offer a variety of activities such as exercise programs, movie screenings, gardening, excursions, and a men’s shed. However, other SRS offer little in the way of activities. In one case, there are no activities offered apart from one hour of bingo a week.

### Incident reports

The quality of incident reporting remains an ongoing concern. Allegations of serious sexual and physical assault at an SRS have been investigated by police but the two incident reports related to them contained very little information. In another SRS, a death was not recorded in the incident record book. DHHS investigated to ensure an incident report was completed and appropriate actions taken.

### NDIS

Northern Metropolitan Melbourne area was the first metropolitan area to experience the NDIS roll out and, after a slow start, Community Visitors are pleased that many residents now have NDIS plans in place.

At four pension-level SRS and one pension-plus SRS, over half the residents have approved plans. Some proprietors and residents still seem confused about how the scheme operates or have complained that some NDIS staff have limited understanding of particular disabilities. Others are frustrated about delays in obtaining items in their plans such as equipment. For example, one proprietor was advised by NDIA there would be a 3-5 month wait for a resident needing a commode and another requiring a walking frame.

Community Visitors note that a group of pension-level SRS under the one proprietor has registered as a NDIS provider to offer accommodation and other supports like personal care and transport. Community Visitors have had ongoing issues about the quality and care provided over a number of years.

The staff member employed to facilitate NDIS services is based in the office of one of these SRS and there is the potential for existing residents to be charged twice for the same service.

Community Visitors are particularly concerned about the potential conflict of interest created when facilities are simultaneously registered under the Supported Residential Services (Private Proprietors) Act to provide accommodation and support and the National Disability Insurance Scheme Act (2013) to provide the same supports. This issue has been fully documented in the statewide report.

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## South Division

SOUTH DIVISION INCLUDES SOUTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BAYSIDE PENINSULA AND SOUTHERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF GIPPSLAND, COMPRISING INNER AND OUTER GIPPSLAND.



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## Gippsland area

Following the closure of a small pension-plus SRS in Sale in May 2018, the Gippsland area now has four pension-plus and one pension-level SRS.

### Health

Community Visitors are concerned at the poor communication and lack of support provided to the SRS staff by the hospital and mental health services. Further work is needed to prevent poor quality outcomes for SRS residents as the case study (below) documents.

### Case study

CS

Staff at a pension-plus SRS were concerned when a 94 year-old resident returned from Latrobe Hospital following hip surgery. While she was in hospital her medication for depression and anxiety was ceased. Following her return to the SRS, the resident's behaviour became increasingly erratic and disruptive. Staff at the SRS raised concerns with the local Area Mental Health Service, requesting a review on a number of occasions, however, no advice or assistance was received.

Staff at the SRS attempted to manage the resident's increasingly concerning behaviours. The resident was finally re-admitted to Latrobe Hospital following an incident where her anxiety escalated and resulted in her removing a toilet cistern from a bathroom wall. The resident's health rapidly declined in hospital and she subsequently passed away. This case was referred to the Coroner.

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## Physical environment and fabric

Community Visitors continue, at the request of residents, to advocate on their behalf to proprietors regarding a range of issues, including a faulty disability toilet in one SRS and faulty lighting in another. These issues have been addressed with positive outcomes.

## Personal support

Support plans, when checked by Community Visitors, mostly appear to be current. However, residents often need further support to follow through with their goals, as their motivation may be low.

The location of SRS can dictate the availability of low-cost or free, meaningful and interesting activities to their residents. A lack of low-cost transport affects the ability of residents to access services including activities.

## Incident reports

Lack of incident reporting continues to be a concern with one SRS having no such records since July 2017.

## NDIS

Some proprietors reported residents having difficulties accessing NDIS packages. They are also concerned about the time and paperwork involved in supporting eligible residents to access the scheme. One proprietor was assisting three residents who were declined plans by the NDIS because the paperwork from the doctor did not adequately address the scheme's eligibility criteria. Community Visitors spoke to one resident who has received NDIS funding, however, it is not sufficient to enable her to attend activities.

## Southern Metropolitan Melbourne area

There are 37 SRS in the Southern Metropolitan Melbourne area, 24 pension-level and 13 pension-plus. Community Visitors continue to enjoy an excellent collaborative relationship with DHHS Authorised Officers in the area.

### Abuse

Community Visitors raised concerns with a pension-plus SRS proprietor who had not followed correct protocols to report allegations of sexual assault of one resident on another within the prescribed timeframe. Community Visitors were concerned the vulnerable resident needed counselling and support to be able to engage with police.

A resident at a pension-level SRS, recently discharged from an acute mental health unit telephoned police and threatened to "blow up the SRS". The SRS was evacuated until the resident was re-admitted to hospital later that day.

Prior to this incident, the resident complained that he was finding it challenging recovering from alcoholism while exposed to other residents' alcohol use onsite. The agency managing the SRS works almost entirely with the homeless and substance affected clients on a harm-minimisation philosophy. Community Visitors have raised concerns with staff about the potential for tensions where recovering alcoholics co-habit with residents who drink on-site.

The incident also highlights ongoing concerns about the discharge practices of mental health services, particularly the burden placed on SRS staff when patients are discharged prematurely, often without proper documentation to assess suitability.

The incident was followed up with a notification to DHHS, which advised that resident mix was a matter for proprietors to address. Community Visitors will continue to monitor this SRS and the effectiveness of support provided to this very vulnerable cohort.

A number of violent incidents have occurred among residents at another pension-level SRS. Community Visitors noted that the use of synthetic cannabis by some residents appeared to have a disruptive impact at the SRS.

### Health

Community Visitors have voiced concerns regarding the lack of staff training in the administration of medication at some SRS and have noted incidents where incorrect medication was administered.

At one SRS, Community Visitors were pleased to find that one resident had quit smoking with the assistance of their SAWI-funded QUIT program.

### Case study

CS

Staff at a pension-level SRS requested an ambulance following an elderly frail resident's fall; she had a cut to her head, and acute pain in her right hip preventing her from getting up from the floor.

Ambulance officers arrived and reportedly criticised the staff for not having a lifting machine; they then made the elderly resident walk, despite her cries of pain, with her walking frame to the stretcher in the corridor. She was subsequently found to have fractured her hip.

The manager of the SRS made a formal complaint to Ambulance Victoria concerning the treatment of the resident by the officers. The manager was particularly distressed that the officers did not afford this vulnerable resident the care and dignity that she deserved. At one point, one of the officers put their foot under the resident's bottom in an effort to assist her to stand.

This incident highlights that the Ambulance officers do not appreciate the nature of an SRS being a low-level care environment with no lifting equipment.

### Physical environment and fabric

Lack of maintenance and cleaning remains an ongoing issue in a number of SRS. A strong smell of urine has been noted during visits to some SRS. Community Visitors have chosen to visit some SRS at different times of the day to obtain a better understanding of cleaning routines and practices. Rising damp is also an issue, putting some residents at risk.

One SRS allowed a resident to keep a cat. It brings pleasure, however, other residents complained of cat hair in their rooms and one resident was concerned because she is allergic to cats.

Bed bugs continue to be a problem at one pension-level SRS while, at another, accumulation of rubbish in outside areas is an issue.

At a pension-level SRS, Community Visitors noted several damaged outdoor steps leading from a fire exit. The critical importance of urgent repairs was highlighted to the proprietor as residents would not be able to safely evacuate the building in the event of an emergency. A notification to DHHS and numerous discussions between Community Visitors and the proprietor, clarifying the latter's responsibility for the safety of residents, eventually led to repairs being undertaken.

### Good practice



Crosbie Lodge, a pension-level SRS has installed solar panels for heating and air-conditioning. The proprietor reports that this has enabled air-conditioning to be turned on throughout the SRS when the temperature reached 26 degrees Celsius. Solar-powered heating will also make the home more comfortable in winter.

## Social independence and choice

A list of available activities is often placed on the noticeboard at many facilities, however, Community Visitors are keen to identify what efforts are being made by staff to engage residents and facilitate their participation in them. At one SRS, Community Visitors noted a survey conducted by ERMHA sought to identify what activities residents wished to participate, with the aim of increasing resident engagement.

### Good practice



Trentleigh Lodge SRS has an innovative approach to engaging residents with planned activities. A particularly delicious morning tea, including residents' personal preferences, is prepared on the day of the planned activity. All the residents eagerly come together for the feast, after which they appear much more motivated to participate in the activity.

## Incident reports

Community Visitors are concerned by the lack of or inadequate incident reporting at some SRS. At one SRS, the Incident Report Log is often not available when the proprietor is not on site. At another SRS, the Community Visitors sift through the daily issues book to identify incidents as there is not a separate Incident Report Log. At one pension-level SRS, Community Visitors queried the lack of information regarding reportable incidents.

## NDIS

NDIS information continues to confuse some proprietors. Community Visitors have been told that one SRS has been approached by small agencies, some from out of the area, and this is causing confusion. On a positive note, Crosbie Lodge has registered 13 of its residents with the NDIS. Some residents are already receiving services and the remainder are in the process of getting NDIS plans.

## Food

The quality and variety of food continues to be a concern for some residents. In a positive development, two SRS are utilising the OzHarvest Fruit Van Service, which delivers fresh fruit each week. Community Visitors have encouraged some SRS proprietors to enlist the assistance of local dieticians to transform menus.

### Good practice



An ongoing SAWI project has enabled Monash Health dieticians to visit SRS in their catchment area and work with both staff and residents to promote healthy eating habits.

Several proprietors speak very highly of this initiative, which involves a range of activities.

They take residents shopping to look at food labelling and discussing healthier and more cost-effective dietary options such as eating brown bread, more pulses and grains and homemade rather than pre-packaged soup.

## West Division

WEST DIVISION INCLUDES WESTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BRIMBANK MELTON AND WESTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF BARWON CENTRAL HIGHLANDS AND WIMMERA SOUTH WEST.



### Barwon and Wimmera South West area

There are four pension-level and four pension-plus facilities in the Barwon and Wimmera South West area. Geelong has three pension-level SRS and three pension-plus SRS. A further pension-level SRS is located in Warrnambool and another pension-plus in Portland.

#### Abuse

An incident report of sexual harassment noted that police were called but no further action was reported. The resident had moved out of the SRS by the time Community Visitors attended.

#### Health

Community Visitors witnessed an attempted suicide by a resident and identified the need for ongoing staff training in responding to mental health issues.

Community Visitors again reported concerns about medication errors.

In one SRS, medication was administered to, but fortunately not taken by, the wrong resident.

In another SRS, reporting of a medication error was unclear and there was no evidence of any follow up. These types of errors can be minimised by an SRS

having good procedures in place. One SRS with many elderly residents successfully applied the following strategies to reduce medication errors: the staff member administering medications is “uninterruptable”, there is daily management monitoring of medication administration, and there is follow-up to determine the causes of all errors.

#### Physical environment and fabric

Community Visitors remain concerned about many issues with SRS fabric throughout the area. When the SRS proprietor does not own the building there is often a dispute between landlord and proprietor about responsibility for serious fabric issues resulting in delays to action them. At one SRS, Community Visitors have repeatedly advocated, at residents’ request, for a handrail on a steep driveway.

This matter has not been resolved because the responsibility for the hand-railing is unclear.

#### Personal support

Good personal support plans are a critical tool to record and action appropriate agreed support for residents. Community Visitors have observed that, in some SRS, plans are limited or residents are unaware of them, making it difficult to assess if the residents are being effectively supported. The Act does not require residents to be provided with a copy of their support plan, however, it is evidence of good practice when they are furnished with one, or are at least aware of its contents.

#### Incident reports

Community Visitors noted poor levels of detail recorded in incident reports, especially in relation to action taken by staff, during or after the incidents.

#### NDIS

Some residents who have NDIS packages report difficulties in accessing reviews of their plan or timely reassessment of packages. For example, when funding for taxis finishes, many residents will not have the financial means to attend activities.

#### Food

Residents in one SRS have frequently reported being unhappy with snack-like evening meals, despite the input of a SAWI-supported dietician. Community Visitors continue to advocate for residents preferences and their right to choice.

## Potential unregistered SRS

Community Visitors are concerned about four Geelong houses that appear to be operating as an unregistered SRS. The person running them previously operated an SRS in the same street, however, flood damage to that facility a number of years ago led them to relocate the residents temporarily to the houses while repairs were carried out. Eventually, the proprietor's Geelong SRS license was cancelled but they have continued running these houses.

When Community Visitors notified DHHS about this issue, they were told that the houses do not constitute an SRS and the Authorised Officers were unable to monitor them. The officers asked local government to apply the 'rooming house test' and liaise with Consumer Affairs regarding tenure arrangements.

## Grampians/Central Highlands area

There are seven pension-level SRS and two pension-plus in the Grampians/Central Highlands area. Good rapport exists between Community Visitors, SRS proprietors, DHHS and support services in this area.

### Abuse

An SRS resident disclosed to Community Visitors an alleged sexual assault that occurred when they were living in another type of accommodation.

This information was shared with the proprietors, who linked the resident with sexual assault support services. Following this disclosure, and with appropriate support, the proprietors reported that the resident seemed to be a lot more at ease.

### Health

For some residents, healthcare remains a concern. At times, staff and proprietors are not able to support a resident to make good choices.

Community Visitors reported the circumstances of a resident in a pension-level SRS who had complex health issues as a result of his lifestyle. The resident underwent major surgery and was required to maintain a healthy diet in order to reduce complications post-surgery, and maximise his recovery and wellbeing. Despite proprietors working with healthcare services, the resident remains non-compliant. This issue highlights the complexity of respecting a person's right to make their own choices versus the impact of their decisions.

Medication errors at an SRS resulted in one resident being taken to hospital and another being monitored closely. Proprietors acted swiftly and appropriately around both these incidents. Disciplinary action was taken as well as providing staff with urgent directives about proper medication management.

In another SRS, Community Visitors noted that a medication trolley left in a hallway unlocked with medication accessible.

One health service expected the proprietor would attend appointments with a resident to learn how to adjust the resident's brace. This indicated a misunderstanding from a healthcare professional as to how much support an SRS can provide.

### Personal support

Community Visitors commented on the lack of detail and accessibility of residents' support plans at some SRS. They noted that many updated and reviewed plans consisted merely of a date change with very little change to ensure personal and support goals were specific and measurable. Interim support plans at one SRS were electronic and staff were unsure how to access them on the computer.

### Social independence and choice

In one SRS, a proprietor evicted residents without providing notice to vacate or notifying the DHHS within the required timeframes.

Community Visitors are concerned that, in some cases, a resident may go from one SRS to the next with little information about their personal and medical needs. This makes it challenging for proprietors to provide appropriate supports. It was reported that, within a month, a resident left one SRS and was evicted from another for being drunk and aggressive towards staff. Community Visitors were told that he became homeless. Community Visitors note that, in several SRS, proprietors are very good at connecting residents with community service organisations that engage the residents in a variety of activities.

### NDIS

There are large differences in the level of support provided to residents transitioning to the NDIS. Some proprietors appeared to lack initiative in helping residents access the scheme while others have been extremely proactive in providing information and helping residents liaise with relevant support services.

Some proprietors reported difficulties in getting providers to implement the packages. Despite much encouragement from staff, some residents do not want to enter the scheme.

## Western Metropolitan Melbourne area

There are eight SRS in the Western Metropolitan Melbourne area, six pension-level facilities and two pension-plus.

Community Visitors have enjoyed a very positive collaborative relationship with the Authorised Officers in the area. They also acknowledge that, generally, SRS proprietors and staff are willing and open to working with Community Visitors to improve the quality of their residents' lives.

### Abuse

Community Visitors highlighted concerns about an elderly male resident who was sexually harassing female residents. The Authorised Officer was contacted and Community Visitors note the concerns were followed up very quickly. The proprietor had not notified DHHS of any reportable incidents relating to this resident. The resident was issued a Notice to Vacate and moved to more suitable accommodation.

In another SRS, Community Visitors reported an incident of bullying. They were very concerned that the proprietor did not manage this issue or document it appropriately. After follow up from DHHS, the proprietor put strategies in place to build positive relationships between the residents involved.

Community Visitors remain concerned about the resident mix at some SRS in the area. In one SRS, there are ongoing issues relating to the mix of residents who range from 19 years of age to 89 and live with a variety of disabilities including dementia, acquired brain injury, mental illness and intellectual disability. Residents described their lived experience in the SRS as chaotic, unpredictable and fearful. Ongoing discussions have been held with residents, the proprietor and DHHS. Community Visitors have increased their presence and are visiting regularly in an effort to monitor this situation.

### Personal support

Community Visitors are concerned about the lack of information when residents move from one SRS to another. At one SRS, the proprietors received limited information regarding a new resident from another SRS. This resulted in staff not being adequately briefed which affected the quality of support available.

A new personal care coordinator working four days a week at a pension-level SRS has made a significant positive difference for residents. She is skilled in building rapport, listening and communicating effectively and appropriately with residents. All staff at the SRS are supportive of residents, however, the social isolation of some prior to the personal care coordinator's arrival was significant simply because they could not be understood.



# Disability Services

Statewide Report and  
Recommendations



## Recommendations

The Community Visitors Disability Services Board recommends that the State Government:

1. provide Community Visitors with electronic access to all serious impact incidents in the new Client Information Management System
2. clarify the arrangements to advise Community Visitors of new residential accommodation services as soon as they open to ensure they are aware of their obligation to visit
3. adequately fund the Community Visitors Program to undertake a minimum of four visits a year to disability residential services
4. support the implementation of electronic visit reporting for Community Visitors
5. clarify with the Australian Government the service-provider-of-last-resort arrangements as an essential safety-net during crises and ensure access to accommodation and services for people whose behaviours of concern threaten their tenancy or service arrangements
6. undertake a project to document access for, and the demand of, people with disability to the respite service in areas both prior to and after the National Disability Insurance Scheme roll out
7. advocate with the Australian Government for the retention and effective resourcing of the Community Visitors Program as an essential quality safeguard following full National Disability Insurance Scheme roll out.

# Statewide Report

## Introduction

Disability Services Community Visitors remain the primary safeguard for those at risk in the disability accommodation sector.

As this report evidences, their work, this year, has contributed statewide to improving the lives of residents and eliminating abuse and neglect. They continue to provide outstanding service, safeguarding the lives of Victorians with disability.

This year, Community Visitors identified 3914 issues impacting on residents. These ranged from reports of abuse to concerns about rights, quality of staff support and physical wellbeing. Issues that are resolved during visits are not included in these figures, as these are not reported for further follow-up. Of the issues reported, 37 per cent were addressed and closed. This is a decrease from the preceding year but is likely to be related to changes in the data collection and recording.

The Community Visitors annual report is prepared using information gathered from services across the state and aims to provide a comprehensive, relevant and independent review of how the sector is operating on the ground for clients. So, the Board is disappointed that, at the time of writing, the State Government's response to the recommendations made in the *Community Visitors Annual Report 2016-2017* is yet to be tabled in Parliament.

This year's recommendations have been developed without this input.

## Abuse and neglect

A total of 160 issues of abuse and neglect were recorded by Community Visitors and 13 notifications to the Public Advocate involving the most serious issues they identified.

Consistent with the patterns of abuse reported in recent years, most were serious incidents of resident-to-resident and staff-to-resident abuse. The Board remains concerned about this level of abuse. The inability of Community Visitors to access incident reports often limits their capacity to report on serious incidents that occur in residential settings.

Key factors that contribute to situations of abuse include resident incompatibility, inadequate staffing and training, a lack of resident advocacy and difficulties associated with police follow-up after reports are made. Houses where there are intervention orders between residents create challenges for staff attempting to provide support to all residents, particularly if there are severe restrictions imposed on the interactions between particular residents.

The reporting of abuse matters by Community Visitors is one of the most important aspects of their role. It is, however, a complex area for a variety of reasons. Residents may be unable to report what has happened or they may not perceive what has happened to them as abuse due to previous experiences. There may be a culture of secrecy around abuse or concern that reporting will lead to a loss of services or eviction.

Table 3. Total visits Disability Services stream, 17/18

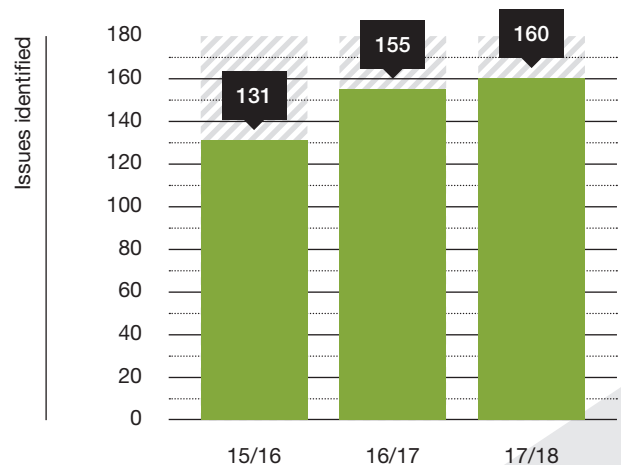
Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
North Division	292	49	29	469	498
East Division	353	82	36	861	897
South Division	287	70	32	708	740
West Division	263	54	10	751	761
<b>Total</b>	<b>1195</b>	<b>255</b>	<b>107</b>	<b>2789</b>	<b>2896</b>

These factors highlight why it is so important that Community Visitors document and report abuse and ensure those incidents are referred to the appropriate body for investigation.

The important safeguarding role played by Community Visitors was recognised with additional State Government funding this year. The additional funding assisted Community Visitors to refer 105 abuse and neglect issues to the Disability Services Commissioner. Another initiative supported by the additional funding is the development of a training module to enhance Community Visitors abuse detection skills which will be piloted with volunteers prior to its roll out.

It is anticipated that these two initiatives will build on Community Visitors' work over many years towards building a 'zero tolerance' approach to abuse.

The abuse matters reported this year are similar to those documented in previous reports. Community Visitors have reported several positive responses to incidents of abuse and neglect where they have reported appropriate management and successful outcomes.



**Figure 5.** Disability Services stream abuse, neglect and violence, 15/16–17/18

**Table 4. Breakdown of issues included in notifications to the Public Advocate in Disability Services, 17/18**

Issue	Number
Physical assault – resident-to-resident	7
Physical assault – staff-to-resident	3
Physical assault – resident-to-staff	7
Sexual assault – staff-to-resident	1
Psychological/emotional abuse – resident-to-resident	3
Psychological/emotional abuse – staff-to-resident	1
Psychological/emotional abuse – resident-to-staff	4
Property damage	2
Financial abuse/exploitation	1

## NDIS

The NDIS support model changes the existing Victorian practice substantially as it is premised on the splitting of services to avoid conflicts of interest.

Currently, in Victoria the majority of people with a disability living in residential accommodation have the same service provider owning or leasing the house and providing independent living supports.

Under the NDIS, there is a separation between the physical building ownership or lease by one provider, termed 'Supported Disability Accommodation (SDA)', and another provider offering the personal care necessary for everyday living, termed 'Supported Independent Living (SIL)'.

This year, Community Visitors reported 186 issues relating to the NDIS.

The NDIS safeguarding regime will not apply in Victoria until 1 July 2019. In the transition from the state disability system to the NDIS, some important gaps in the safeguarding system have emerged. For example, there are new service providers seeking to become registered as NDIS providers that have not previously operated in Victoria. These service providers are not currently registered under the Disability Act, so existing state safeguards do not apply to them, meanwhile, the national regime is not yet operational. Another risk is that, if there are allegations of abuse against those providers, they may become 'lost in the system' between the state and national safeguards.

The roll out of the NDIS adds another layer of complexity. Consequently, Community Visitors have documented a number of important transition issues this year.

### Vacancy management in transition

The new vacancy management and coordination process under the NDIS involves website advertising opportunities, followed by an 'open house' and then applications to the relevant SIL service provider.

There are reports that, while this system provides choice for the new resident, existing residents have not always been consulted and compatibility with existing residents has not always been considered.

Community Visitors are concerned that this process has the potential for service providers to prioritise more tenants who do not have high-support needs and complex behaviours of concern over those that do.

### Provision of 'last resort' accommodation and support

Community Visitors are also perturbed about the lack of both short and long-term accommodation options for people with high-support needs and complex behaviours of concern. There is an urgent need for an agreement on the provider of last resort for such tenants. Community Visitors have advocated for DHHS to retain this role.

### Case study

CS

Community Visitors expressed concern about a resident with vision and hearing impairments walking in the middle of a busy road near his group home.

The resident had an obsession with aligning wheelie bins in his street. Attempts to redirect his movements led to staff assaults, community confrontations and complaints. Strategies to minimise risks were tried for some years.

This year, the resident's hearing and vision declined and independent assessments found he never looked before crossing roads and railway tracks. After he was twice hit by vehicles, he was temporarily relocated to a reception property with over 40 hectares of farmland.

He now receives his daily support from a community service organisation (CSO) and DHHS has maintained its involvement with him. DHHS convenes regular case conferences and staff from his previous home are working with his case manager to find alternative accommodation for him in a rural setting via the Housing Hub website.

Three properties have been viewed but were unsuitable. DHHS has also engaged behavioural specialists and paid for over \$15,000 of property damage caused by the resident after he was moved to his current accommodation.

The resident is yet to complete an NDIS plan, but how will he and other residents with complex needs fare in an NDIS world where there is no agency of last resort for coordinating an emergency response when accommodation breaks down.

### Residents over 65 years of age

Residents in group homes who are over 65 years of age are ineligible for the NDIS but are to have their existing disability services funded and maintained through the national Continuity of Support (CoS) program.

One of the concerns for this group of residents has been the delayed implementation of this federal program. It has created uncertainty and fear on the part of affected residents and their families and confusion for service providers.

Residents over 65 years of age may be disadvantaged by comparison to NDIS participants living under the same roof. This is because the entitlements for NDIS residents may be greater than for those who will

only be maintaining their current entitlements under CoS. NDIS participants' supports will be subject to regular reviews and potentially increased. This may create disparities between residents based on their entitlements under different schemes.

An older resident who needs to transition out of day services and stay at home may not be able to if all other residents are out at day placements, or attending external activities. Their CoS package may be insufficient to enable this transition to retirement as it does not fund a model of care that meets the needs of an ageing person with a disability living in a group home. Older residents may be left with no choice but to move to aged care which is often ill-equipped to deal with people with disability.

Community Visitors have already reported instances of this inequity in group homes.

### Case study

CS

Two older residents in a CSO house indicated that they wished to spend more time at home, as they were struggling to attend the day service five days a week. The service provider supported them to apply for an NDIS plan that included sufficient funding so they could stay at home a day a week as a transition to retirement.

However, when they received their second NDIS plan, it had removed this funding, despite their need for it continuing. These participants will now need to seek another plan review to reinstate the funding they lost which enabled them to stay at home once a week.

The CoS guidelines are unclear and are yet to be tested. So what entitlements a resident in a similar situation over 65 years of age, ineligible for the NDIS and covered by CoS would have is uncertain. There is no clarity, for example, as to whether they have similar review rights to NDIS participants.

### Access to NDIS Plans

Community Visitors are entitled to inspect NDIS participant plans of residents in group homes. However, the ability of Community Visitors to exercise their functions and duties under the Disability Act are limited by service providers. Service providers are unclear about the authority of Community Visitors in the current environment and use the requirement for the consent from participants, or their representatives, to deny them access to NDIS plans.

As the NDIS moves to full scheme roll out, there will need to be further clarification between the Australian and State Governments to enable Community Visitors to perform their important safeguarding and social inclusion role.

### Equipment

As in previous years, Community Visitors have raised concerns across most of the state about long waiting times for essential aids and equipment for residents.

The transition to the NDIS is adding a further level of complication to these delays. In the areas where the NDIS has been rolled out, residents who had already experienced long delays for equipment from the Statewide Equipment Program (SWEP), experienced further delays as it was unclear whether NDIS would fully fund certain items. In some cases, delays in accessing occupational therapy assessments have also contributed to lengthy waiting times.

Delays in accessing equipment via SWEP and NDIS significantly impact on the health and wellbeing of many residents. Residents have been denied timely access to equipment such as wheelchairs, which would facilitate their independence enabling greater participation in community activities; and special beds, which enables better health management of pressure areas.

### Respite care

An emerging issue concerns access to respite care. Community Visitors have identified decreased occupancy rates in facility-based respite care. There is some evidence that the reason that families are being charged extra fees is to cover the additional staff when the person needing respite has complex needs.

Overnight respite services in NDIS roll out areas are also being underutilised, while families also seem reluctant to use the respite funding allocated to the participant they care for until absolutely necessary, due to inadequate funding in individual plans.

Community Visitors query the weight given to participant complexity when NDIS allocates respite funding for an individual.

### Incident reporting

Incident reports are essential for capturing information and identifying appropriate responses to client wellbeing issues.

For many years, Community Visitors across the state have highlighted difficulties in accessing incident reports. These difficulties continue, as disability services appear either unclear or neglectful of their obligations in this regard. Section 130 of the Disability Act obliges service providers to cooperate with

Community Visitors and provide incident reports as requested. While some disability service providers comply, significant numbers do not fully meet the requirements of the Act. DHHS has agreed to issue a direction reminding service providers of their obligation to provide Community Visitors with incident reports.

The new Client Incident Management System (CIMS) for incident reporting was implemented in CSOs in January 2018. The implementation was linked to internal management systems which are different in each agency. Community Visitors are concerned about the categorisation of incidents under the new system, particularly the recording of resident-to-staff assaults and 'near misses' as 'non-major incidents'. Reduced reporting requirements may inhibit the development of strategies to mitigate the impact on residents who have witnessed such incidents. Also, if a staff member is a victim of an assault and takes leave, staff consistency and continuity of care is compromised, thereby affecting residents.

The Board has asked for CIMS incident reporting system information to be routinely forwarded to the Community Visitors Program to enable cross-referencing with information gathered by Community Visitors. This would ensure Community Visitors get the information they need and were entitled to receive under the Act, thus, assisting them to perform their role more effectively. This would also strengthen the existing safeguards ensuring all serious incidents were captured, reported, managed and classified correctly. It would also help address concerns about under-reporting of incidents. However, DHHS has advised that this access is not currently possible.

## Visits

The funding to the Community Visitor Program covers two visits a year to disability Shared Supported Accommodation.

The Board has always advocated the funded visits to be set at four a year.

Community Visitors believe the current visiting regime is inadequate because it does not facilitate the rapport necessary for residents to confidently report issues of concern and ensure the residents' human rights are protected.

Two visits a year is also insufficient to support a 'zero tolerance' approach to abuse. Some residents are at greater risk and may benefit from additional visits to ensure their rights are protected.

This needs to be factored into any visit regime.

## Nutrition Project

Community Visitors in the Eastern Metropolitan Melbourne area conducted a small but important project in the first quarter of 2018.

It arose in response to concerns about residents' nutrition and healthy eating and was initiated by Community Visitors, drawing on their skills and experience and supported by program staff.

It is hoped that its results will inform and assist Community Visitors in their visiting, and service providers to better meet residents' nutritional needs.

## Appropriateness of residential environment

A number of homes are being refurbished to meet NDIS accommodation standards and it is anticipated that this will occur across all houses prior to the full NDIS roll out. Community Visitors welcome these improvements in residential amenity and believe these refurbishments are substantially improving residents' lives.

On the other hand, delays in maintenance have perpetuated hazardous and unhygienic environments for residents. Regional reports document flooding in bathrooms, poor sanitation, mould and broken toilets as well as unhygienic and uneven carpets that can be a falls risk.

## Residential safeguards

Community Visitors visit gazetted residential services in accordance with the Disability Act. In the NDIS environment, these homes are known as Specialist Disability Accommodation (SDA), and new models of SDA will likely develop over time in response to the funding incentives being offered under the NDIS.

The Bilateral Agreement for Transition to the NDIS between the Commonwealth and State Government established that the existing Victorian safeguards would continue to operate. Therefore, the independent oversight and advocacy provided by Community Visitors to residents of group-home (now referred to as SDA) continue unaltered during transition.

However, Community Visitors have not always been advised about the opening of new SDA. There is the need for clearer communication and information-gathering processes around SDA identification between DHHS and NDIA in Victoria.

This will ensure that the safeguarding function provided by Community Visitors is available to every SDA resident during transition.

## Quality of staff support

Community Visitors again raise concerns about the increasing casualisation of the disability workforce and the negative impact this has on the provision of high-quality, person-centred active support (PCAS).

There are no minimal training requirements for staff employed through Supported Independent Living (SIL) funding in the NDIS. This has the potential to further erode the quality of care and support to residents.

Community Visitors will continue to monitor these issues over the coming year.

## Self-determination

Concerns about Person-Centred Plans (PCPs) and the need for better individual planning has been highlighted in successive annual reports. Community Visitors continue to see PCPs that are out-of-date or not reviewed regularly, are not reflective of residents' needs or wishes and lack meaningful goals.

Service providers are required to continue to meet the requirements of the Disability Act and DHHS' Human Service Standards (July 2012). Accordingly, all DHHS-funded service providers are required to demonstrate that residents have a goal-oriented plan that is implemented and reviewed regularly.

Community Visitors noted last year that industrial work bans impacted on the completion of key worker reports and the provision of active support, which may have affected the quality of PCPs. As the industrial action is now finished, Community Visitors want to see a commitment from service providers to meaningful engagement with residents in the development of high quality PCPs, based on individualised planning principles.

Many residents, particularly those with complex support needs, have never had the opportunity to take a holiday. Holidays should be accessible to all residents. Brief holidays, supported by existing disability residential staff, should be considered when residents cannot access formal holiday packages or programs.

## Physical wellbeing

Community Visitors continue to report multiple concerns about poor medication administration and, in some instances, medication errors that have resulted in hospitalisation. More needs to be done by service providers to reduce the frequency of such incidents such as improved training.

Community Visitors have reported numerous cases where residents' physical wellbeing has been impacted by a lack of access to timely and appropriate medical and dental treatment or allied health assessments. These situations are preventable and may, in some instances, constitute neglect.

## Case study

CS

In October 2017, Community Visitors visited a house where all residents were ventilator-dependent.

A resident and his wife told Community Visitors they believed his life was at risk because the ventilator malfunction alarm had been sent for repair a month earlier and it was unlikely it could be repaired.

A baby monitor had been set up in the resident's room and speakers located in the office to enable staff monitoring. At the time, Community Visitors visited, however, no staff member was in the office.

Five months later, Community Visitors were assured by a casual staff member that the alarm was working. However, the resident on the ventilator was very anxious and upset because the new alarm system had been purchased but no date set for installation.

The issue was escalated to the service provider also highlighting that the October report response was long overdue.

The current report, a supplementary report and further emailed questions elicited a phone and email response from the provider. Community Visitors were assured a new alarm system would be installed later in February and, in the interim, an additional registered nurse had been employed to ensure the resident's safety.

In late May, OPA was advised by phone that a new alarm system had been installed. No formal written responses were ever received.

## Liaison with DHHS

Last year's report expressed the hope that there would be improvements in the continuity of DHHS staff in attendance at liaison meetings.

This has continued to be an issue at some regional and statewide liaison meetings between DHHS and Community Visitors because of staff movements associated with DHHS restructures. Hopefully, this situation will improve over the coming 12 months.

It is vital that the Board meets regularly with the same staff as the issues are complex and often take considerable time to resolve.

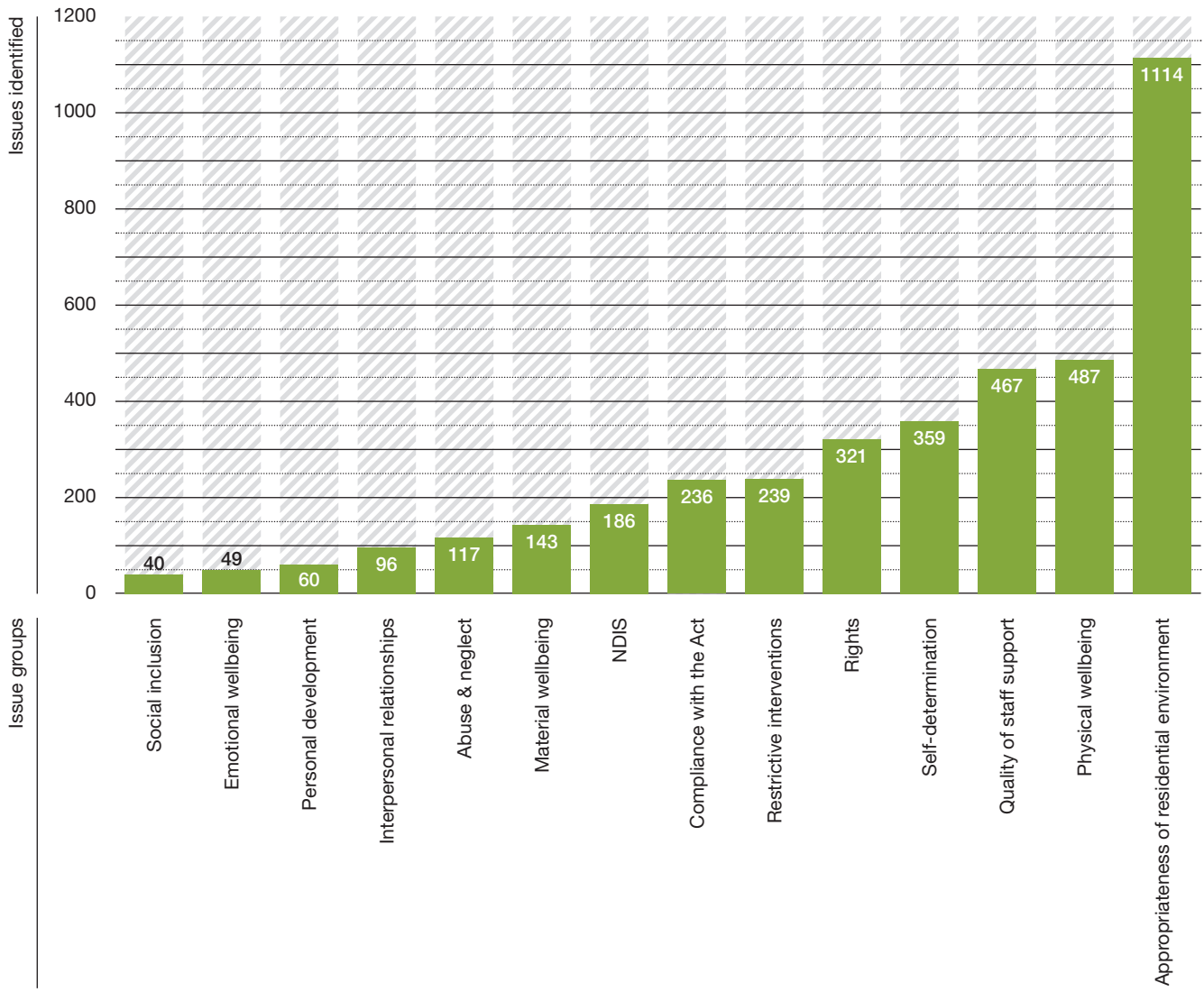


Figure 6. Disability Services stream by issue groups, 17/18

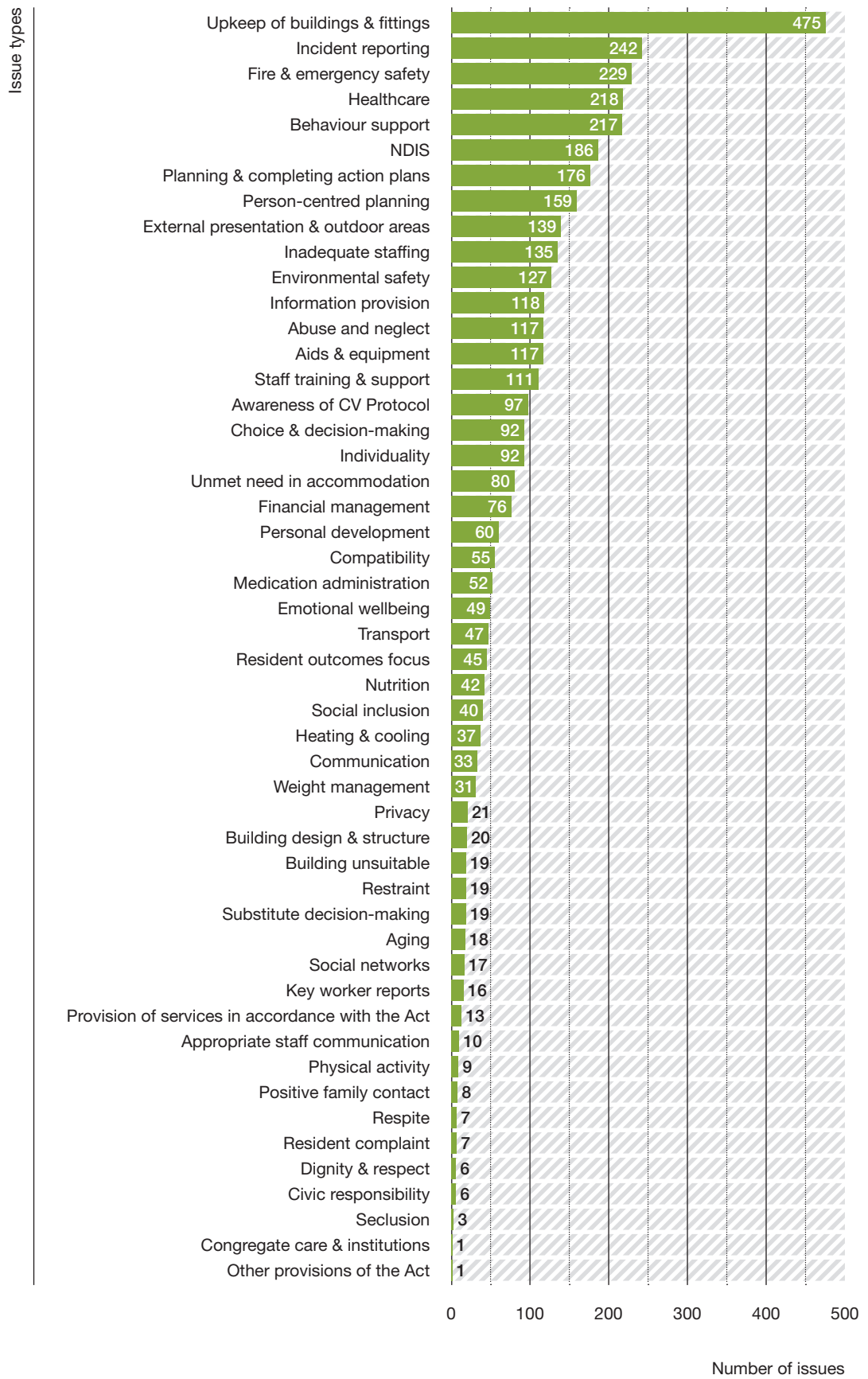


Figure 7. Disability Services stream number and types of issues identified, 17/18

# Divisional Reports



## East Division

EAST DIVISION INCLUDES EASTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF INNER EASTERN AND OUTER EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF HUME, COMPRISING THE DHHS AREAS OF OVENS MURRAY AND GOULBURN.



## Eastern Metropolitan Melbourne

### Abuse and neglect

Community Visitors continue to report on client psychosocial health issues that result in aggressive verbal and physical behaviour toward other residents and staff including property damage, physical assault, threats and heightened sexualised behaviours.

In one case, a highly agitated resident who slammed doors and punched windows was unable to access a psychiatrist appointment for over six weeks. Positive engagement activities were introduced to help the resident feel safe, secure and to reduce her agitation. Similar activities were designed for all residents so they would also feel safe and secure.

In many houses, these behaviours are well-managed by consultation with relevant support services. Health practitioners also assist by developing behaviour support plans, which minimise the negative impact of the behaviours on other residents.

A resident at a respite house was hospitalised after staff failed to administer morning medication. Unfortunately, this was the first time the resident had used an overnight respite service.

### Case study

CS

A resident in a CSO house alleged that she had been bullied by management and threatened with eviction.

When Community Visitors failed to receive a response from the CSO, they organised to meet with the senior service manager. The CSO agreed to seek an independent advocate to facilitate communication between the resident and management but have yet to follow through with this undertaking. These concerns have been escalated to the Public Advocate and DHHS for further action.

A resident's relative reported to staff unexplained bruising at a Community Service Organisation (CSO) house, which was promptly followed up by the service provider and a police investigation was initiated. The service is now monitoring interactions within the house more closely and has introduced additional staffing, including an active night shift.



A CSO resident was assaulted by a stranger in the community for the third time in a year. Subsequently, police and Victims of Crime Victoria were involved. Despite concerns that the resident was being targeted by the alleged perpetrator, police chose not to take further action.

A resident's violent interaction with a bus driver resulted in the resident being banned from the service. He is now obliged to use taxis or private transport to attend day placement.

## Appropriateness of residential environment

Delays in resolving issues related to the upkeep and maintenance of buildings and fittings impacts significantly on the lives of residents. Community Visitors report that, due to DHHS budget limitations, little work, except for the most urgent, is undertaken.

Community Visitors identified many group homes in need of painting and refurbishment. There are numerous examples of poorly maintained carpets, which are a potential source of infection and a tripping hazard. Maintaining or replacing carpet will enable floors to be kept in a clean and hygienic condition. A resident in a CSO house tripped over loose carpet and injured herself, despite the hazard being identified by Community Visitors previously.

Broken clothes dryers in multiple locations result in carers spending more time attending to laundry and hanging clothes to dry rather than participating in activities with residents.

At one CSO house, bathroom pipes leaked into two bedrooms causing damage that took several months to repair. Works not being completed to a satisfactory standard raised further concerns for the health and safety of residents.

At a rundown, five-bedroom Disability Accommodation Services (DAS) house, the one bathroom contained the house's only toilet. Community Visitors requested that management cap the number of residents to four.

Cleanliness concerns were highlighted at two DAS houses where Community Visitors observed mouldy shower curtains, filthy walls and floors and noted the need for better household cleaning.

For two years, Community Visitors have raised concerns regarding the safety of an outdoor play area at a CSO children's respite service. Community Visitors were subsequently delighted to observe that the above-ground trampoline had been replaced with an in-ground unit bordered by ample rubber flanges and an appropriately thick layer of tan bark. This trampoline should contribute to a safe and enjoyable outdoor environment.

In a DAS house with ageing residents, where one resident requires a walker while the others also have mobility issues, three separate groups of concrete steps were installed in the rear garden. Community Visitors reported that the steps pose a falls risk without rails installed and some residents are restricted from accessing all of their garden.

Community Visitors report that comprehensive assessment of residents' behaviours, support needs and preferences are crucial when transitioning a new resident into a group home. In one house, inadequate assessment resulted in compatibility issues and placed further pressure on staff to provide adequate care for all residents.

A young male who previously resided with his parents moved to a group home. The resident displayed aggressive behaviours—smashing windows, kicking doors, and destroying other residents' property, as well as assaulting other residents and staff. Kitchen cupboards and drawers now have locks installed to prevent further damage. More suitable permanent accommodation is being sought by DHHS for this resident as other residents were traumatised by his behaviour. In the short-term, other behaviour management strategies are being implemented. Insufficient assessment contributed to this inappropriate placement.

## Case study

CS

A young woman with an intellectual disability and known history of disruptive conduct was placed in a DAS house with three older men.

In addition to this risk to her safety, after moving in, she increasingly engaged in a range of risk-taking behaviours, including staying out all night, drinking heavily and shoplifting. She also allegedly engaged in prostitution. Staff were placed under immense pressure as they tried to manage her escalating behaviours.

The woman was eventually moved to an all-female house with increased supervision and a strict curfew.

Community Visitors report that she is settling in well and the staff at the new house have noted a reduction in risk-taking behaviours.

Two residents with particularly challenging behaviours moved into a CSO house. Community Visitors understood this move was to be into two separate units within the one house. Although a partition was later installed to increase privacy for each resident, many altercations still occur due to shared bathroom and living areas. Community Visitors have highlighted the incompatibility of these residents and queried whether the accommodation promotes their safety and wellbeing.

Community Visitors report that the closure of the Oakleigh Centre congregate care facility and the relocation of residents to new homes has made a considerable difference to their quality of life.

Recently, three residents in a DAS house were relocated to a more suitable home with an additional bathroom and more spacious living areas.

## Case study

CS

Two male residents were temporarily relocated to a serviced apartment, leaving another resident to live independently.

Community Visitors observed a transformation in the men in their new environment, as they conversed and joked with them in a manner previously unobserved. The men have developed skills in personal responsibility, respect and mutual support.

Their personal confidence has soared, and with the support of family and the service provider, they now engage in activities at home and in the community.

## Physical wellbeing

Community Visitors frequently report one or more aspects of residents' physical wellbeing that requires additional support. In some cases, the challenges of supporting ageing residents are apparent, with some exhibiting behavioural changes due to dementia. Appropriate communication between support staff at houses and day services is crucial to maintaining client health, as some residents require special diets.

Concerns about residents' access to dental services were reported. A resident with complex physical health needs required dental work under sedation, possibly with the support of an advocate. Subsequently, Community Visitors were advised that the house supervisor would liaise with a special needs dental service and family to ensure that consent was provided so that treatment could proceed.

Community Visitors frequently report that residents wait extended periods for aids and special equipment. DHHS advised that a resident was not on the priority list of the State-wide Equipment Program (SWEP) so he may have had to wait another year for a wheelchair. Another resident does not have his own wheelchair so cannot participate in extended community access until one is provided. In another house, the resident waited months for a specially designed bath to be repaired.

## Case study

CS

At a DAS house, Community Visitors noticed a lack of physical activity among residents and a tendency to remain at home during the day and sleep.

Management responded that staff were encouraging residents to exercise while respecting their right to choose.

One resident naps due to seizure medication combined with mobility issues; another now walks regularly with the house supervisor, while another is starting to increase his physical activity following a reduction in medication.

Another sleeps during the day and reminds staff it is his right to choose if he wants to stay in his pyjamas.

## Nutrition Project

The Nutrition Project was initiated by Community Visitors in the Eastern Metropolitan Melbourne area to explore how nutrition was delivered to residents of group homes. It was conducted from the January to April 2018.

The objectives of the project were to consider:

- a) nutritional value of food provided in group homes
- b) staff training and knowledge in meal planning
- c) choice and involvement of residents in meal planning.

Due to a lack of available resources and expertise, it was beyond the scope of the project to examine the first objective. This could be the subject of further inquiry should these obstacles be overcome in the future.

Information was obtained on routine visits from staff, residents and Community Visitors about staff knowledge of residents' diets, menu planning, staff training and qualifications in nutrition and resident involvement in menu planning.

A relatively large random sample of 118 CSO and DAS houses was selected for the project and questionnaires were returned from 81 houses (an excellent response rate of 69 per cent). Service providers were notified about the project prior to commencement and informed that the information gathered would be de-identified and a report provided on completion.

The project report has not yet been finalised, however, the preliminary findings were very positive with respect to staff knowledge and accessibility of information regarding residents' special dietary requirements or preferences. In addition, the findings highlighted resident consultation and involvement in menu planning, including perceptions of their ability to influence menus. Commonly, menus in the house detailed a variety of meals for the week.

The final report will include recommendations for service providers, Community Visitors and the Community Visitors Disability Services Board.

The Nutrition Project Team thanks everyone involved in the project including service providers, residents, Community Visitors, and OPA staff.

## Quality of staff support

Community Visitors consistently report examples of outdated residents' plans, including Behaviour Support Plans (BSP), Client Support Plans, PCPs and Health Management Plans. They are concerned that the care provided to residents does not reflect their complex needs or personal goals.

Some plans were unavailable during visits due to difficulties accessing digital information, hindering Community Visitors' ability to assess what happens in residents' lives. It is also challenging to determine if plans for residents with little or no verbal communication skills are being actioned. Some houses are creative and innovative using iPads, photo albums and other tools to engage residents in the planning process.

Inadequate and inflexible staff rosters, reliance on casual and on-call staff and difficulties with attracting and retaining quality staff continue to be reported as issues of concern. All these factors negatively impact the continuity and consistency of services and relationships with residents, resulting in a lack of high-quality, personalised support and an inability to flexibly meet the changing needs of some residents.

Behaviour management strategies should be regularly reviewed and additional support provided to ensure that residents' right to independence is balanced with the need to protect them from harm. A resident in a DAS house diagnosed with diabetes had a gambling problem and frequently accesses inner-city nightclubs. On occasions, he runs out of money and may not return home in time to receive his medication. Community Visitors are concerned that missed medication may lead to him being hospitalised.

Concerns were raised by Community Visitors regarding the disruptive impact of a new resident with complex needs—they asked what was being done to support staff and residents over the short and long-term. DHHS advised that the resident had settled considerably with positive behaviour strategies to provide structure and reduce boredom. Staff were offered positive behaviour support training and a roster review will be considered.

Community Visitors queried the quality of support at a DAS house, noting that residents were being fed packet lasagne and stale bread was observed in lunch boxes. There was no toilet paper for residents, while the furniture was dusty and Christmas decorations had not been removed from the lounge. Community Visitors also queried that bruises on residents were not included in house documentation.

Community Visitors acknowledge that service providers are investing resources to improve the quality of staff through training. They report that staff are clearer regarding what is expected of them as a result of constant quality assurance reviews.

Staff at one house provided excellent opportunities for residents to access community activities including live theatre, music festivals, swimming, drawing, holidays on cruise ships, Girl Guides, horse riding, yoga, massages, a trip on the Indian Pacific railway, a conference and greyhound race meetings. In many houses, staff encourage residents to undertake household tasks and there are regular well-attended house meetings where residents are actively encouraged to make household decisions.

While a new enterprise agreement was being negotiated with DAS employees, union bans meant that staff did not complete keyworker reports, asset registers, vehicle logs, or participate in roster reviews. This presented a range of difficulties for Community Visitors trying to access the information they needed.

## Rights

Some services do not keep paper records of incidents, however, electronic access for Community Visitors may still not be available. Some service providers have been asked repeatedly to provide access to incident reports, yet the responsiveness is very patchy. In particular, Community Visitors have had ongoing difficulties accessing incident reports from a CSO, whose response to concerns indicates a limited understanding of its obligations under legislation.

A CSO resident fell out of bed on multiple occasions, injuring himself and requiring ambulance support. Community Visitors were unable to access reports documenting these incidents.

Community Visitors were told of a resident's assaultive behaviour towards staff and clients. They requested access to a particular incident report relating to assault of a staff member by the resident. In response, DHHS management noted efforts to train staff, review behaviour management strategies and seek support from mental health and specialist services, however, they did not clarify if an actual incident had occurred or where it was recorded. Without this information, the circumstances of the assault may not be adequately identified or assessed.

Several residents in a CSO house complained that there was no resident consultation in the house and no 'paperwork' for the new rules. One resident was upset when a manual handling assessment was conducted without her consent and felt her privacy had been invaded.

## Restrictive interventions

Community Visitors reported that three residents' Occupational Violence Risk Assessment and Management Tools appeared to be out-of-date. Following their intervention, DHHS advised that all three had been updated.

Residential statements have been updated to include restrictive interventions in the house, which have been imposed in response to a resident's behaviours arising from a medical condition. Staff engagement in person-centred active support of residents has had a positive impact on residents' behaviours and increased their involvement with activities.

## NDIS

Most services have been very supportive of residents and families and provided information to inform and prepare them for NDIS meetings. Anecdotally, Community Visitors report residents with a strong support network have received better outcomes from the planning process, compared to those with fewer supports.

Many residents have little or no contact with family and it is unclear what support they will receive to access the NDIS. Community Visitors are keen to ensure that they are not unduly disadvantaged as a result. DHHS is still waiting for advice regarding the engagement of advocates for these people.

In one house, non-verbal residents received letters from the National Disability Insurance Agency (NDIA) indicating that they would receive phone calls to discuss access to the scheme.

There is a lack of clarity regarding the NDIS with many residents and their families requesting more information to better manage the services they are receiving.

Some service providers are reluctant to provide Community Visitors access to residents' individual plans.

Where residents are 65 years of age and over and ineligible for the NDIS, Community Visitors believe they are entitled to 'age in place', and be supported to remain in their homes for as long as possible. Despite the provision of Continuity of Support funding, Community Visitors believe that some older residents may be vulnerable to premature placement in residential aged care facilities.

One resident, with NDIS funding for one-on-one activities spent their funds in the first four months. The funding shortfall was unlikely to be addressed quickly through a plan review due to the reported NDIA backlog of them. Without funding, the service was unable to continue supporting the resident's activities. Resident access to transport affects participation in activities and, it is hoped that, access to NDIS funding may help to solve this issue in future.

At a CSO children's respite house, Community Visitors queried reduction in demand from children and their families. The CSO responded that occupancy rates remained at around 85 per cent but there were issues with the transition to NDIS, for instance, use of respite during the week is impacted when there is insufficient funding for transport to schools in NDIS plans.

# Hume

## Abuse and neglect

With the support of Community Visitors, some residents are advocating for themselves to stop abuse.

### Case study

CS

A resident at a CSO house wrote a letter to Community Visitors detailing 15 separate allegations of verbal and physical abuse against staff. Community Visitors were unable to view the incident reports that related to the allegations.

A staff member was stood down in response to the allegations pending an internal investigation and a notification made to the Disability Worker Exclusion Scheme. Residents' families were informed of the allegations and the processes for responding to such allegations.

Community Visitors applauded the resident for his courage in raising concerns on behalf of himself and other residents. All residents were provided with the contact numbers of senior service managers and offered advocacy. The CSO has committed to monthly resident meetings to support residents to speak up about issues they may be having with staff.

Since September 2017, a CSO house has not met the conditions of a fire audit and has been deemed unsafe. Active nights have been rostered to mitigate the risk to residents.

Community Visitors frequently report maintenance issues associated with the upkeep of building and fittings, for example, in the Goulburn area it took three months to replace a broken dryer at one house.

## Physical wellbeing

In the Ovens Murray area, Community Visitors report concerns about hygiene, safety and the dignity of residents at a purpose-built home which is two years old. The main bathroom, located directly opposite the kitchen and dining area, compromises the privacy and dignity of residents. Since August 2017, Community Visitors have reported that three toilets linked to a water treatment system are intermittently blocked. Staff use buckets of water to assist in flushing waste. Community Visitors were advised by DHHS in June 2018 that the repair has been escalated for priority attention.

For many years, Community Visitors have raised concerns about a CSO resident with complex support needs and queried the appropriateness of his accommodation. Following advice from a GP, the CSO issued this longstanding client a Notice to Vacate. It could no longer meet his support needs due to his multiple and complex medical conditions. The resident is being assisted by a NDIS Support Coordinator to find alternative accommodation and the notice period has been extended.

## Appropriateness of residential environment

Respite services are too-often used for crisis situations. In the Goulburn area, 30 families using a respite service had their bookings cancelled for up to nine weeks when the house was used for one high-risk client who posed a serious safety risk to other residents and staff in a group home. Regular users of the respite service were redirected to an alternative service, which normally caters for children only.

Children's respite services were cancelled two days a week to accommodate adult clients during this time. One family considered applying for full-time care as they were struggling to cope without access to regular respite.

Behavioural assessments needed to explore more suitable permanent housing options for this high-risk client would take several months. Subsequently, the client was detained within a justice facility following a serious incident so the respite service could resume.

## Quality of staff support

In one house, Community Visitors noticed that Client Information Sheets were last completed in 2014.

Community Visitors recorded examples of the positive ways staff manage incidents. In one case, staff were commended for their response during an incident where a resident threw knives and forks at staff and residents.

Over an extended period, police regularly visit a house to de-escalate situations and prevent staff and residents being harmed. Police worked with staff to provide ongoing support. This model has proven effective in decreasing the frequency and intensity of incidents involving a young male resident with autism. During episodes, staff took residents out to protect them. Incident reports were well-documented and discussed at care and house meetings. Despite the dynamics between residents at this house being very challenging, staff have worked hard to maintain a good balance and support all residents.

At meetings with two CSOs, Community Visitors were informed about new policies, procedures and training to reinforce the need for maintaining professional boundaries.

## Rights

Community Visitors' inability to access incident reports in most houses remains an ongoing and serious issue.

At one CSO house, a Community Visitor observed skin grazing on a vulnerable resident confined to a wheelchair. As there was no incident report available for Community Visitors to view, they spoke to staff, who explained that the resident was pushed in her wheelchair by another resident, down a steep driveway and onto a road where the injury occurred.

The client was assessed by a doctor to have superficial injuries. A traumatised staff member was offered support and access to the Employee Assistance Program. Community Visitors raised their concerns at a meeting with the service provider in March and June 2018, however, the incident reports are still not available to view onsite.

Some houses have established a process to ensure Community Visitors can access incident reports. The inability of staff to access or log into the Client Incident Management System (CIMS) consistently limits access to incident reports.

## Restrictive interventions

In the Goulburn area, Community Visitors report the construction of a three-metre fence on the boundary between a DAS respite facility and a private residential property. Other boundaries have a standard 1.8 metre fence and the rest of the property is open. Community Visitors felt the fence was out of character with the neighbourhood and may stigmatise the house and its residents.

A resident regularly chooses to remain in her room as she feels bullied by another resident who recently moved to this house. Tensions between the new client and some staff created an unpleasant environment. The service manager and staff assisted the residents to develop house rules and structured talk time to reinforce positive relationship-building. The resident now feels more comfortable using the communal areas of the house and participating in activities.

## NDIS

NDIS is being rolled out across Ovens Murray and is scheduled to be rolled out in the Goulburn area in 2019. Staff and consumers are still learning about the scheme, and Community Visitors report confusion about the role of the Support Coordinator as distinct from a Case Manager.

## North Division

NORTH DIVISION INCLUDES NORTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF HUME MORELAND AND NORTH EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF LODDON AND MALLEE.



## Loddon Mallee area

### Abuse and neglect

Community Visitors noted several serious incidents involving resident-to-resident aggression.

In one instance, six police, two ambulance officers and mental health personnel attended a group home when a resident became violent.

At another house, both residents and staff were traumatised following assaults.

Community Visitors observed positive improvements in behaviour following interventions such as support from other agencies, medication reviews, staff training and the consistent application of management strategies.

In one house, residents were temporarily relocated until alternative accommodation could be found for a resident with destructive and threatening behaviour.

## Case study

CS

Community Visitors were informed that a staff member was verbally abusive towards residents and staff, including making sexualised comments and innuendos.

He monopolised the television remote control, choosing programs without consulting residents, and telling them where to sit so he could have his favourite chair.

The residents did not like him and did not want him to care for them.

Following a report to DHHS, the staff member was immediately stood down pending a full investigation.

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In April 2018, Community Visitors were told that a resident with an acquired brain injury (ABI) and severe physical disabilities was being verbally abused by a staff member.

The resident was allegedly abused when he had difficulty chewing and swallowing his medication. Only one member of staff was routinely rostered on in this house where all residents needed a high level of care and support.

Community Visitors discussed these and other issues with the CSO and will continue to monitor the house.

## Appropriateness of residential environment

Community Visitors identified numerous building issues impacting on the safety and wellbeing of residents and staff. Some newer houses had deficiencies evident on occupation. In one house, ongoing shower drainage problems caused widespread flooding whenever it was used. While this issue remains problematic, other issues identified at the same house have been addressed.

## Case study

CS

In April 2018, Community Visitors noted a resident's broken television/DVD player had not been replaced in a CSO house.

The resident, who enjoyed his television programs and DVDs, lived without entertainment at home for many months. Staff advised that the old television would be replaced by the end of July.

Community Visitors think this should have been replaced sooner.

At the same house, carpet in another resident's bedroom was unhygienic due to them urinating on it.

Following Community Visitor advocacy, the CSO agreed the flooring should be replaced and would include it in the resident's NDIS application under 'home modifications'. If this was unsuccessful the agency would need to explore alternate funding options.

The resident is still waiting.

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A DAS house in Echuca has large cracks in the walls and ceilings in two bedrooms and on an exterior brick wall. Eight months later, the cracks had not been repaired. The house was inspected by an engineer and reported to be safe. Until underpinning works have been completed, the cracks will not be repaired. Community Visitors are concerned about the time taken to repair the walls, particularly as funding is a factor in the delay.

## Quality of staff support

In most houses, Community Visitors are warmly welcomed by staff or residents. It is pleasing to note staff regard Community-Visitor reporting as complementary to their own work in ensuring resident wellbeing.

Several CSO houses with residents with complex needs or a history of offending, have one staff member rostered on. Community Visitors query whether this is sufficient staffing to cater to the needs of the residents.

Following the death of one long-term resident, there was no professional debriefing of other residents for more than six months. Many months later, the daily duty list still showed the deceased resident's duties. A staff member said that the person's name had not been removed because one of the other residents "did not like change".

## Rights

Community Visitors still have difficulty accessing incident reports. With the CIMS rolling out, hard copies may not be available and Community Visitors are rarely given computer access. This is an ongoing issue that needs to be addressed urgently.

Community Visitors are frustrated with CSOs that do not provide timely written responses to reported issues.

## Northern Metropolitan Melbourne

### Abuse and neglect

This year, staff-to-resident, resident-to-resident, and resident-to-staff assaults were all recorded. Unexplained injuries or allegations of staff-to-resident abuse led to staff being stood down promptly and investigations commenced by police, DHHS and independent investigators. Where allegations could not be substantiated, staff returned to work, sometimes to other facilities.

#### Case study

CS

In November 2017, Community Visitors noted day placement staff had reported a resident having significant bruising on multiple parts of their body.

Police, family and DHHS management were notified and the resident was examined by two independent medical officers within 24 hours.

Both examinations confirmed that injuries were consistent with physical abuse and not accidental.

Two staff were stood down on full pay while internal and independent investigations were undertaken. One staff member has returned to work but the other remains suspended as at June 2018.

Resident violence included a resident charging another resident with a wheelchair, a resident stabbing another with a fork, objects being smashed and threats of violence.

Sometimes resident incompatibility or inconsistent staff approaches have triggered resident outbursts. In one DAS house, Community Visitors were pleased to note a reduction in incidents and a positive improvement in the house atmosphere after staff training in person-centred

active support and encouragement to consistently implement these strategies.

Serious neglect was also reported. One resident told Community Visitors she was forced to spend all night in her chair because unskilled staff were unable to put her to bed. Medication errors and poor bowel or personal care practices have placed residents at risk. In one case this led to a hospital admission.

Financial abuse was also reported.

#### Case study

CS

A resident tearfully told Community Visitors she did not want to see her private guardian, who was “bossy” and had imposed a diet and exercise routine on her.

The resident said the private guardian and her boyfriend took her to luxury hotels, but stayed in the penthouse and dined out while she stayed in her room. The resident also alleged that the private guardian used the resident’s funds to buy gifts for her boyfriend.

DHHS organised for an independent advocate to meet with the resident in response to Community Visitor inquiries.

A VCAT hearing was held and an OPA guardian and independent administrator were appointed for the resident.

### Appropriateness of residential environment

Housing Choices Australia (HCA) is the landlord for 14 houses in the area responsible for the building and its fabric.

Its houses, that are two storey or cramped, are unsuitable for ageing residents with mobility problems and present a fire risk. Maintenance issues take an extraordinarily long time to fix. In 2017, one house was identified as needing ramps at both entrances; neither have been installed as of May 2018. For more than two years, a side fence in a poor state of repair enabled the neighbour’s dog to access the property, rendering the backyard unsuitable for unsupervised resident activities.

Since 2014, Community Visitors have reported that part of the residents’ lounge room has been used as an office, with clutter and confidential files exposed. Entry to the room by the residents is restricted when the office chair is used and blocks the door. Plans for an extension have finally been approved but it has taken an unacceptable four years to address the situation.

Carpet at one DHHS house was reported as “unhygienic and revolting” due to a resident frequently urinating on it. Support strategies were implemented and the carpet cleaned fortnightly, however, the odours persisted. This remained a problem for two years. At another DHHS house, the bathroom had holes in the walls and the shower seat was unusable.

While the upgrades in many DHHS houses have been generally well-received, one family was upset that curtains they paid for were replaced with blinds without consultation. DHHS offered to replace or reimburse them.

## Physical wellbeing

Long waits for equipment and health services can have extremely serious implications.

### Case study

CS

Two residents at a CSO house were sometimes left in soiled beds overnight as there were not enough staff rostered on at the house to allow residents to be regularly turned or changed during the night.

One resident had a severe rash and another reported back pain from being left in the same position all night.

The CSO engaged with health professionals to find solutions and is hoping the NDIS may fund active night staff or assist with the purchase of a special rolling bed to address these longstanding issues.

One resident is confined to bed or a ‘princess’ chair as he is unable to access funds for a wheelchair. He was assessed as needing a wheelchair in May 2017 and an NDIS application was lodged in October 2017. In June 2018, DHHS hired a wheelchair as an interim measure. NDIS funding has now been approved.

At another house, Community Visitors sighted infected sores, bruising and scratches on a resident’s arms as a result of protruding screws and a clip on a wheelchair.

Long waits for dental care and medical assessment have also been reported.

### Case study

CS

In June 2017, Community Visitors noted that a resident required teeth extractions under general anaesthetic at the Royal Dental Hospital of Melbourne.

In October 2017, Community Visitors were informed there were issues relating to consent as the resident had no next-of-kin to sign for the anaesthetic.

In November 2017, Community Visitors were told that consent issues had been followed up with OPA and the resident needed to be assessed by a cardiologist before she could have the anaesthetic.

In May 2018, the resident’s GP said she could have the anaesthetic without seeing a cardiologist and the dental hospital agreed. However, they advised that the procedure would need to occur at a general hospital as she was not in pain and did not require urgent treatment.

She could wait for up to two years for this treatment.

## Quality of staff support

Reports of high levels of casual staffing, and staff without adequate training to support residents with complex needs, are concerning.

### Case study

CS

Community Visitors became aware that a resident had choked to death but could not find documentation relating to the incident.

They were told the resident had entered another resident’s bedroom (accidentally left unlocked), eaten food he found there and was later found on the floor by staff.

Community Visitors understand that the documentation relating to the incident was forwarded to the Coroner.

## Case study

CS

The behaviour of a resident in a CSO house deteriorated over time; the bathroom nearest his room was reserved for his exclusive use because of his lack of personal hygiene.

His late night returns to the house woke other residents.

His hoarding of rubbish led to his room being industrially cleaned weekly. His inattendance led to care meetings being cancelled. Staff attempted to engage him in activities during the day and one-to-one staff were employed through NDIS funding. Staff are commended for their efforts in accommodating his behaviour.

The resident has since moved to alternative accommodation.

There are examples of exemplary staff support and record keeping.

## Good practice

Community Visitors found a resident with a bleeding tooth who, in distress, had broken a bottle and cut her foot.

She has autism spectrum disorder, is non-verbal and screams intermittently.

Staff swept up broken glass and supported her and another resident, called an ambulance and contacted the resident's family. Her emergency information was photocopied to accompany her to hospital.

Paramedics recommended she go to hospital.

Staff transported the resident in the house bus and paramedics triaged her in advance to reduce her distress. Staff were calm, purposeful and efficient and a difficult situation was handled professionally.

Lack of activities and support to engage residents remains a problem in some houses.

As a result of industrial action in DAS houses, roster reviews were delayed and key worker reports not written for most of 2017 and 2018.

## Rights

Community Visitors are frequently unable to access incident reports and other documents in both CSO and DAS houses. Some staff assist with electronic access to documents, however, Community Visitors feel this sometimes impacts on staff duties. Casual staff often cannot assist at all.

## Good practice

The Tipping Foundation provides electronic incident report summaries to the Community Visitor volunteer team leader and OPA each month.

Copies of serious incident reports are usually attached or they can be requested.

Staff often facilitate family contact, including the provision of transport. At one house, a family cooks a meal every Tuesday. Residents and staff assist and everyone eats together.

## Restrictive interventions

Community Visitors are concerned about an adolescent resident living in a locked area of a CSO house who cannot access educational activities.

In other cases, residents with a history of violent behaviour live alone in locked facilities with 24-hour staffing.

In some houses, locked cupboards and doors have been reported.

## NDIS

The NDIS has made a positive difference to some residents' lives, enabling them to participate in activities or achieve long-standing goals.

## Good practice

Two men shared a bedroom for many years, with one expressing his desire to move out because of the living arrangements.

NDIS-funded renovations for an extra bedroom, which was completed in May 2018, resolved this long-standing issue.

Residents sometimes endure delays in accessing services due to the shortage of support coordination. Others experienced a decrease in funding when they received their plan or when it was reviewed. One resident's supported recreational outings were halved with a loss of approximately \$45,000. One resident said she is concerned that reduced funding for outings may cause her to overeat and smoke again.

Respite usage has decreased at some facilities. This may relate to NDIS-funding reductions or people being approved for different types of respite in their NDIS plans.

Case management is not funded under the NDIS and some residents do not have support coordinators to assist them to manage their packages. There is confusion about who will pay for non-standard items like behaviour specialists and home modifications. The promised Continuity of Support Program for residents over 65 years of age is still not operational.

There are serious challenges in accessing emergency housing and support for people where a resident needs to be quickly relocated after violence.

### Case study

CS

Tensions between two residents sharing a unit supported by a CSO boiled over and a resident with significant anxiety, autism and schizophrenia was admitted to hospital after an assault by a fellow resident.

He remained in a mental health unit for seven weeks. He wanted to return home but not if the resident who assaulted him and three staff members remained there.

An NDIS plan review for the resident took months. Eventually, it was accepted that he should move, however, the NDIA said that it could not fund housing.

Meanwhile, DHHS said that, in an NDIS environment, it was not its responsibility to rehouse the co-resident.

To facilitate his discharge from hospital, NDIS funding was utilised for temporary accommodation for the assault victim, however, this reduced the amount available to him for other purposes.

## Transport

Community Visitors are concerned about how access to vehicles, now shared between two or three houses, will be managed after full scheme roll out so residents can continue community participation.

Another problem is that staff cannot drive resident-owned vehicles due to insurance issues.

## Disability Forensic Assessment and Treatment Service

The Disability Forensic and Treatment Service (DFATS) is a statewide forensic facility that accommodates and treats offenders with a disability subject to orders under the Disability Act 2006 or the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997. The outcome of the review of the DFATS' model of care is not yet known.

DFATS had two new admissions this year and three residents exited. Resident dynamics can be challenging and residents move between units to manage compatibility and safety issues. Residents can only remain at DFATS for a maximum of five years but they can move to a supervised house for the last period of their treatment.

DFATS also provides clinical support and case management to residents in the Long Term Residential Program, a facility providing support for up to five people with an intellectual disability needing longer-term treatment.

In addition to offence-related treatment, DFATS residents engage in sport and various activities delivered onsite by Melbourne Polytechnic.

Two residents admitted under the Crimes (Mental Impairment and Unfitness to be Tried) Act are deaf, so staff and residents were trained in Auslan and strategies introduced to assist communication.

Staff have been working with residents to prepare them for NDIS-planning meetings.

## South Division

SOUTH DIVISION INCLUDES SOUTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BAYSIDE PENINSULA AND SOUTHERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF GIPPSLAND, COMPRISING INNER AND OUTER GIPPSLAND.



### Gippsland area

#### Abuse and neglect

A resident at a DAS house assaulted other residents and staff on several occasions. Despite the involvement of specialist services, the resident continues to display behaviours that impact on other residents. Community Visitors query what is required to create a safer living environment for the residents.

Community Visitors were disturbed to hear of an attempted suicide by a CSO resident.

She was admitted to the acute mental health unit for assessment but was soon discharged as she did not meet the criteria for treatment under the *Mental Health Act 2014*. Her behaviours had escalated and were impacting other clients.

Community Visitors were seeking clarification about the behavioural support strategies that were in place and whether they needed to be reviewed.

#### Appropriateness of residential environment

There were significant delays in responses to maintenance requests across both DAS and CSO houses. In one DAS house, toilet seats were broken and residents sat directly on porcelain for a number of weeks. A water leak led to the carpet being removed from a resident's bedroom, leaving only a bare concrete floor for two months.

These maintenance issues have now been resolved.

#### Restrictive interventions

At a CSO house, Community Visitors were unable to access residents' BSPs. They observed that a resident's bed was removed each day to prevent him from remaining in it, however, they were unable to see a BSP supporting this strategy.

#### NDIS

The use of facility-based respite services appears to have declined with the roll out of the NDIS. A respite house in Morwell closed for a week, partly due to participants and their families receiving insufficient funding in their NDIS plans. Similar issues were reported at other respite facilities where occupancy rates have reduced significantly.

Participants seeking reviews of plans are experiencing long delays. Community Visitors are concerned about the impact this will have on many families.

### Southern Metropolitan Melbourne

#### Abuse and neglect

A new resident in a CSO house punched another resident who called him "a dog". He told staff this was an extremely offensive term in his culture. Medical assistance was sought for the victim of the assault who, fortunately, did not sustain a significant injury. The victim met with her sister and staff and decided to report the assault to police, but not to press charges. The perpetrator's care team from the Transport Accident Commission were also notified.

The new resident is significantly younger than the other residents who are frail, elderly or have very high care needs. The incompatibility of the new resident with the other residents may compromise what has been a safe and peaceful living environment.

## Notification to the Public Advocate

i

A four-bedroom DAS house had only one resident as the other residents moved out in the previous 12 to 18 months due to his aggression.

The resident had autism, mild intellectual disability and severe anxiety plus a history of severely challenging behaviours.

When Community Visitors visited, they found the house in 'lock-down' as the resident's behaviour had escalated. The sole worker had locked herself in the office as two other staff had been assaulted that day. She informed Community Visitors that the arrival of police and ambulance was imminent.

Mechanical and chemical restraint was needed when emergency services attended the house to take the resident to hospital. Staff report that the resident's behaviour deteriorated despite the efforts of a number of agencies involved.

The reliance on frequent intervention by emergency services was unsustainable and likely to contribute to the resident's acute levels of distress and trauma. There was a lack of clarity regarding the resident's mental health status, with differing diagnoses from two mental health services.

The constant exposure to challenging behaviours took its toll on the support team which further compromised support. DHHS planned to move the resident to a purpose-built house, arguing there would be greater flexibility around staffing and transport as a bus was based at the house.

Numerous incident reports at a CSO house detailed a resident's aggressive behaviour towards other residents and staff. Community Visitors could not view an updated BSP and queried whether the resident required a medication review, as well as consultation with specialist behaviour services. The CSO confirmed an updated BSP was in place and the resident was regularly reviewed by his psychiatrist. It agreed to a referral to specialist services.

An assault involving two other residents took place at the same house. Furniture was thrown and one of the residents wielded a knife. Community Visitors advocated for staff to receive support and training in behaviour management strategies as previously recommended by specialist services. Subsequently,

they noted there had been no further incidents between the two residents and that the staff at the house were more consistently applying the recommended behavioural interventions.

A young female resident at a CSO house fell while unattended in swimming pool change rooms. The only medical treatment given was the application of a small adhesive bandage. A few days later, her GP noted swelling and bruising. An X-ray revealed a fractured shoulder. The resident underwent surgery and spent a number of weeks in hospital followed by a lengthy rehabilitation.

A resident at a DAS house called the OPA Advice Service claiming a fellow resident had attacked staff and other residents on several occasions. Despite police intervention, he was concerned that staff were afraid of the resident and could not protect him and wanted to move to another house.

Community Visitors discussed the concerns with both residents and the staff. Staff consulted extensively with residents and their families to identify ways to enhance safety in the house. The mother of the resident who wished to move wanted him to stay. He was offered treatment from his psychologist but declined further support. Community Visitors felt that the incident had been appropriately dealt with and there was positive consultation with residents and family in developing the response.

Despite his objections, a CSO resident had his underarms shaven by a staff member. The staff member was stood down following the incident.

Community Visitors were concerned about frequent serious resident-on-resident assaults in a DAS house. They noted differences in opinion and approach between some staff and management. In response, DHHS outlined measures being implemented including regular care team meetings, consultation with specialist behaviour services, regular incident report reviews and environmental modifications to create two separate 'zones' within the house.

For three years, Community Visitors have reported and advocated for a young male resident of a DAS house with dual disabilities and complex needs. The house is locked because of another resident's behaviour. A number of requests to intervene at the house have been received by Community Visitors and they query the suitability of the environment and effectiveness of staff support for the resident.

The resident's behaviours have regressed to the point that hourly toilet training is now required. They need more appropriate support and a different environment to allow the young man to reach his full potential and have a better quality of life.

### Good practice

Residents and staff at a DAS house attended Zero Tolerance training run by VALID, focusing on promoting the rights of residents and protecting them from abuse and neglect.

During the residents' training session, examples of abusive behavior were discussed as well as how to identify the people they would trust to speak to, if subjected to abuse.

There was also discussion of resident-to-resident abuse and encouragement not to tolerate abuse from anyone.

### Good practice

At a DAS house, staff implemented an innovative 'restorative justice' approach to residents' behaviours of concern.

Residents are supported to understand the consequences of their actions on other residents.

They also take responsibility and pay for any property damage, write an apology letter to the 'victim' and other residents and meet with those affected to discuss the impact of their behaviour.

There was a lack of consultation with staff and residents at a DAS house, where the bathroom and toilet facilities were upgraded to meet NDIS-readiness requirements. Recently, Community Visitors observed that the renovations were incomplete and the toilet area cannot be satisfactorily accessed by a wheelchair-bound resident. The overall quality of the upgrades was unsatisfactory. As renovations are planned for a number of houses to comply with NDIS requirements, more effective consultation with staff and residents will ensure residents' needs are given primary consideration in these processes.

### Case study

In early 2017, Community Visitors reported on the poor state of the bathroom in a CSO house. The woodwork was rotting and the tiles and surrounds were mouldy.

They continued to raise the issue, photographing the shower and contrasting it with the clean, modern state of the staff bathroom.

Some residents were being treated for tinea and Community Visitors queried whether bathroom hygiene had contributed to this condition. The CSO organised bathroom renovations; now the shower has been replaced and the residents are much happier with their facilities.

## Appropriateness of residential environment

Service providers can be slow to respond to maintenance issues. In one house, Community Visitors advocated for the replacement of old, stained carpet for five years. In another house, maintenance of an air conditioner was overdue.

Fire safety checks and fire evacuation drills are not done regularly in several houses. Consequently, some staff have a limited understanding of these procedures.

Kitchen and laundry renovations at a CSO house were undertaken without consultation with residents or staff. Some works were inappropriate and residents in wheelchairs had difficulty accessing kitchen areas to assist in food preparation. The laundry trough was too small and difficult to access.

These issues were raised with management who subsequently met with residents to seek their advice on what worked well and their concerns. The agency wanted to reflect on and apply the learnings to future house renovations.

### Good practice

A movie-loving resident's bedroom window looked onto an untended, narrow area at the side of the house.

Staff worked with a sibling and a friend of the resident to redevelop this area into a colourful movie-themed garden full of interesting features including a yellow-brick road, a small tin man and a pair of red shoes.

## Physical wellbeing

Community Visitors advocated for physiotherapy, massage, occupational therapy services, and flu vaccinations. They also suggested further support to increase residents' physical activity.

In 2016, an urgent request was made for a CSO resident to be assessed for a new wheelchair. The resident chose to be assessed by the CSO allied health service, which took two years to complete it. In another house, residents were concerned about whether their wheelchairs were covered under the NDIS.

## Quality of staff support

Agencies have difficulty finding or retaining suitably qualified permanent staff resulting in a high use of casual staff that impacts on resident care. Casual staff have restricted access to documents, which can hinder Community Visitors' attempts to gather information during visits. In one house, an extra staff member was provided to support a resident during the morning peak which worked well.

### Good practice

Staff at a CSO house were commended for supporting a terminally ill resident to remain in her home.

The local palliative care service assisted staff at the house, who worked 24-hour shifts to ensure that the resident was comfortable and cared for during her last weeks.

Staff received an award from their service provider for their advocacy work on behalf of the resident and promoting her human rights.

### Good practice

One resident at a CSO house requiring close supervision attended the Formula 1 Grand Prix, including a short helicopter ride over the racetrack.

Staff did extensive risk assessment planning to enable all this. The photos show he thoroughly enjoyed both experiences.

DAS staff have continued to support a resident during acute admissions to hospital and rehabilitation. This support was to prevent premature discharge and address the inability of hospital staff to provide appropriate care for ill patients with special needs and disabilities.

A young resident of a DAS house was visiting a shopping centre with her carer when her wheelchair tipped forward. The wheelchair was not faulty and the brake was on at the time of the incident. She suffered facial trauma including loss of front teeth and, subsequently, developed aspiration pneumonia. Staff supported her extended recovery in hospital. Her loss of teeth exacerbated prior swallowing difficulties and she is likely to require PEG feeding in the future.

WorkSafe Victoria issued compliance orders to the house for weekly maintenance of wheelchairs and a formal assessment of community destinations for safe wheelchair access. So, staff have been trained in these aspects of care.

A CSO house has five male residents with complex needs living in separate units. There was disquiet about the safety of one resident including whether clearer behaviour management strategies were needed. The resident indicated he wanted to move into alternative accommodation but needed support to do so. Another agency is providing support for him to achieve this.

Despite staff reassurances, Community Visitors believe that behaviours of concern among residents are escalating and query the compatibility of this group.

## Rights

Community Visitors are frustrated by the inability to view incident reports including monthly summaries. They believe that, in addition to readily accessible individual incident reports, each house should have a central log of incidents available for inspection. Some staff may not have access to the house computer or know how to locate either the electronic or hard copy incident reports in a client's file.

During one visit, even permanent staff could not access this information. In some CSO houses, the transition to the CIMS incident reporting system has created challenges. It is commendable that some service providers provide a monthly hard copy of incidents for Community Visitors to view.

### Case study

Community Visitors observed a resident walking naked in the house during visits.

They noted that bathroom doors remained open while residents were using it.

House staff took the view that these behaviours did not negatively impact the house. However, Community Visitors believe that it adversely affects residents' dignity and privacy.

## Restrictive interventions

Community Visitors report improved quality of life for a resident who has lived in the locked rear section of a DAS house for ten years.

They believed that the resident was secluded and requested a specialist review of this arrangement. Management disagreed, arguing that he chose to have the door locked because he felt safer and he could request that staff unlock the door.

A key has now been provided for the resident's use and, with consistent staff support, he is also engaged in activities.

## NDIS

A CSO resident who is an NDIS participant has a long-standing history of serious behaviours of concern including property damage and assault of residents, staff and the public.

The resident was issued with a Notice to Vacate and an eviction application was made to VCAT. However, it was subsequently dismissed. Two families removed their sons from the home for their safety and the alleged perpetrator was relocated.

The resident has moved to accommodation that is outside the Disability Act safeguards or tenancy protection.

Community Visitors are concerned that NDIS plans make no provision for urgent relocation of residents in a crisis situation.

## West Division

WEST DIVISION INCLUDES WESTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BRIMBANK MELTON AND WESTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF BARWON CENTRAL HIGHLANDS AND WIMMERA SOUTH WEST.



## Barwon

### Abuse and neglect

Community Visitors were informed of incidents involving resident-to-resident and resident-to-staff assaults, and property damage.

In one house, when a male resident sexually assaulted a female resident, charges were laid and an intervention order taken out on behalf of the victim.

Staff managed this difficult situation well as the residents continued to live together while a long-term solution was found. The perpetrator was eventually moved to more suitable accommodation.

At another house, two staff members were assaulted when they attempted to transport a resident. The vehicle has undergone modification to make it safer for staff to transport the resident perpetrator.

Referrals for assessments and external resident supports helped to manage both these challenging situations.

## Appropriateness of residential environment

Most maintenance issues were resolved.

In some houses undergoing renovation, residents and staff were unclear about timelines for the completion of works and alternative accommodation arrangements.

The upkeep of carpets and floors is sometimes neglected and, as a consequence, some carpets present a tripping hazard, particularly for ageing residents or those with reduced mobility.

Other environmental issues such as mould could also present a health risk.

## Physical wellbeing

A significant number of falls-related incidents were noted.

The risk of falls increases as residents age and their health declines. Service providers have taken action to respond to these incidents, however, more could be done to promote prevention strategies.

## Quality of staff support

Staff attempt to support residents with behaviours of concern without neglecting the needs of others.

Residents displaying challenging behaviours often have comprehensive assessments and plans in place to guide staff. The intensive support provided to residents can impact on staff ability to engage other residents in meaningful activities.

A resident displayed increased behaviours of concern as a result of early-onset dementia. Staff were proactive in referring the resident to dementia specialist services, assisting them to better meet the resident's changing needs.

## Restrictive interventions

Incidents involving restrictive practices have been reported by Community Visitors. One involved seclusion and the other the use of a mechanical restraint. In both cases, BSPs, relevant notifications and approvals were in place.

## NDIS

Some NDIS participants experienced lengthy delays in receiving equipment and services, as well as delays in processing plan reviews when their needs changed.

One resident did not get funding for a shower chair, while another resident has been waiting over 18 months for a special type of mattress and couch.

A resident in a CSO expressed disappointment that her new wheelchair had taken so long to be delivered and the "initial excitement" of finding out she would get a new chair had dissipated.

A resident was only alerted that his funding for community access ran out when his support worker did not show up for an outing.

Staff were often unfamiliar with a resident's plan or had no access to it. This was frustrating for staff trying to resolve issues on behalf of their residents.

## Rights

There have been numerous occasions where Community Visitors have not had access to incident reports, which give them a more complete picture of residents' lives and enable them to better perform their role.

A staff member in one house did not understand the role of Community Visitors and denied them access. In two other houses, the service providers' Community Visitor folders, containing reports from previous visits, could not be found.

## Central Highlands

### Abuse and neglect

A resident with complex physical and mental health issues and behaviours of concern was relocated.

Incidents continued to occur in his new home. On two occasions, a staff member grabbed him and pulled him to the ground in response to the resident yelling that he wanted to go to bed early.

The alleged offender was suspended pending police and internal inquiry. Despite being witnessed by another staff member, both inquiries concluded that the allegations were unsubstantiated.

Subsequently, staff told Community Visitors they were concerned for the safety of residents and carers due to two instances of assaults on staff by the same resident. DHHS was considering alternative accommodation for the resident when he passed away in April 2018.

Community Visitors understand the death was referred to the Coroner.

In a CSO house, a staff member forcefully pushed a resident in her wheelchair which hit a wall. When staff checked the resident they found her unharmed. The incident was originally classified as poor quality of care but re-classified as a staff-to-client assault when queried by Community Visitors. The staff member was stood down and an investigation found the allegations substantiated.

Community Visitors questioned the appropriateness of a resident's accommodation after they learned he had previously displayed inappropriate sexual behaviours. The vulnerability of the other residents was of great concern. In July 2017, Community Visitors were advised that the resident indecently assaulted another resident in their bedroom and was subsequently arrested and charged by police and removed from the house. He is now supported in a DAS house better suited to his needs.

A DAS resident alleged that a staff member physically assaulted her on two occasions by grabbing her arm and pinching her, resulting in bruising. The resident also alleged that the cause of the bruising was a fall in the bus at day placement. The incident was reported to police and the staff member stood down. After nine months, the matter has not been finalised.

## Physical wellbeing

At another CSO house, a resident is waiting for the supply of a special mattress which will provide relief from worsening bed sores.

Lengthy and unreasonable delays for basic and essential equipment like wheelchairs are unreasonable and have a deleterious effect on residents' lives.

### Case study

CS

In September 2017, Community Visitors reported that a resident's wheelchair needed urgent replacement as "he is unable to operate it himself and is very restricted in movement". An initial occupational therapy assessment reported that a new wheelchair was "not urgent", however, a second assessment, two months later, approved funding.

In March 2018, with a new wheelchair yet to arrive, the resident injured his eye on his wheelchair headrest. Community Visitors noted that he was less motivated to attend outings and queried whether this was due to the discomfort he experienced in his wheelchair.

The CSO reported that the State-wide Equipment Program has a massive backlog of equipment applications. At the end of May 2018, the issue has not been resolved.

The resident has waited two years for a new wheelchair.

## Restrictive interventions

When a CSO house was changed from a respite facility to a group home, door locks and keypads were removed, and there was nothing to alert staff if a resident left the house.

The house is located on a steep block with the road sloping down to a busy intersection. A neighbour found a resident in a wheelchair in a drain near a busy road at 5.30pm. The same resident was found outside twice more that evening.

The resident surprised staff one morning when he rang the doorbell at 6.00am. Keypads were subsequently reinstalled for resident safety.

## NDIS

Occupancy rates in the four respite houses have decreased. Many participants and their families have reduced respite funding, with some having their funding reduced from 90 to 40 days, resulting in families 'saving their days' until they really need them.

NDIS plans are slowly being completed but some residents are still awaiting advocacy while others are frustrated when day programs that they enjoyed have ceased, reportedly due to NDIS funding changes.

Day program providers can choose who they accept and some clients may have difficulty finding an alternative provider. In the interim, house staff provide support during the day for residents who cannot attend day programs.

Residents are being charged high rates for physiotherapy services with NDIS providers. While community health centres are often cheaper for the same service, they generally have long waiting lists.

## Western Metropolitan Melbourne

### Abuse and neglect

In a DAS house, a temporary decline in a resident's health resulted in behaviours that disturbed other residents. One resident reacted aggressively to the resident's behaviour. The targeting continued despite the implementation of various behavioural strategies, extra staffing and an active night.

A transition plan is in place to move the resident to another house.

There have been several allegations of sexual abuse across a number of CSO houses:

- a female resident's friend allegedly sexually assaulted her in her bedroom
- a female resident was allegedly assaulted by another resident's boyfriend
- a staff member was stood down and placed on the Disability Worker Exclusion Scheme following an allegation he sexually assaulted two female residents.

All cases were reported to police though no charges were laid.

### Case study

CS

A transition plan was in place for a young woman living in a CSO house to enable her to live independently with her boyfriend as he displayed behaviours of concern and regularly manipulated others at another residence run by the same CSO.

The service provider had serious reservations about the transition proceeding. The boyfriend had displayed some controlling and manipulative behaviours such as using the bed himself so she had to sleep on cushions on the floor, isolating her from family members and attempting to gain control of her finances.

Following an application to VCAT, an independent guardian was appointed for the young woman, to make decisions relating to accommodation and access to services.

## Appropriateness of residential environment

Community Visitors queried whether glass in a DAS unit should be replaced with safety glass, after windows were broken in an adjacent unit. Initial responses indicated that safety glass would only be installed if the windows were broken or damaged, in line with a DAS environmental assessment report. At a recent liaison meeting, management reported that they would look at costings to get the glass replaced.

A CSO house has multiple, ongoing maintenance issues including rust and mould in the bathroom, leaking pipes in the rear garden, and an unstable fence. A resident was reportedly very upset about the maintenance issues in the house.

In a DAS house, an unattractive sensory room has not been utilised. Community Visitors have been

reporting on this disused room for several years and were told that an upgrade depended on occupational therapy assessments being completed for all residents. Recently Community Visitors were advised that the space was being converted to a second lounge room as a sensory room was no longer required.

## Physical wellbeing

A resident of a CSO house has been awaiting an occupational therapy assessment since December 2017. This resident has complex behaviours which appear to have been exacerbated by the delayed assessment.

Staff at a CSO house were concerned about the declining health of a resident who refused to be examined or treated by medical professionals due to an acute phobia. The CSO applied for a guardian to be appointed to make decisions regarding her care.

An OPA investigation led to VCAT appointing an independent guardian to make decisions about healthcare and access to services.

## Quality of staff support

Medication errors have been noted in several different facilities.

In one DAS house, medication was administered to the wrong resident. Documentation of the incident indicated a failure to follow protocols.

Remedial action included a review of duty of care and medication administration procedures. In a CSO house where multiple medication errors occurred, staff efforts to eliminate errors appeared to be successful. Another CSO has not responded to ongoing issues of medication errors.

Staff at a CSO house were unable to locate documentation for a resident with complex behaviours including incident reports. Staff turnover appears to have contributed to poor understanding of procedures.

Community Visitors were concerned about the lack of documentation available for staff to support residents during transition from one service provider to another. Missing information included PCPs, BSPs and critical incident reports.

## Rights

A DAS resident has experienced considerable delays in getting his financial administrator to pay for equipment and services including a wheelchair and day program fees. The administrator also appeared resistant to providing funds for a holiday. Staff say they have to balance the financial needs of the resident with maintaining a good relationship with his administrator.

Concerns have been raised about the wellbeing of a young man who resides in a CSO house as he has not been to school for over 18 months and has little community interaction. His verbal communication skills have deteriorated and he is experiencing educational and social skill deficits. Despite this issue being raised with the CSO and DHHS, there has not been an adequate response to date.

The suitability of a resident's bed has been questioned because it is hard to position him to avoid aspiration. Plastic sheeting is used instead of proper incontinence sheets. An occupational therapist recommended a safer, more appropriate bed. The resident's guardian disagrees with the purchase and is seeking a second opinion even though funding has been approved. The issue remains unresolved.

A CSO resident did not want her health and other personal information shared with a family member. The staff were unable to facilitate a meeting between the resident, family member and her healthcare professional. The service provider has been unable to clarify if there are lawful grounds for the family member to access the resident's personal or health information.

Access to incident reports has been an ongoing concern for Community Visitors. The transition of CSOs to the CIMS has added another layer of complexity. Community Visitors commend the initiative of a house manager at one CSO house who prints the incident reports and places them in a folder to enable easy access by Community Visitors during visits.

## NDIS

It is hoped that the NDIS will facilitate opportunities for some residents to relocate closer to their families, particularly in regional Victoria.

## Wimmera South West

### Abuse and neglect

Community Visitors have noted a number of incidents involving resident-to-resident and resident-to-staff assaults. One respite house has a regular client who is very aggressive towards staff, impacting on the wellbeing of other residents.

Often only one staff member is on duty in houses. In a CSO house, a resident has attacked a housemate on a number of occasions resulting in an intervention order being taken out by the affected resident's family.

Community Visitors note the positive work by the CSO to deal with this complex and difficult situation.

## Appropriateness of residential environment

Newer homes are spacious, have modern amenities and privacy, while older houses, increasingly, require maintenance. In some houses, maintenance issues are regularly reported on but little progress or improvement is seen. Other houses have had significant maintenance and improvement work, making them far more comfortable and appealing.

## Physical wellbeing

Good nutrition is a focus in many houses. Residents in one DAS house are receiving support from a dietician at South West Healthcare, resulting in healthier diets. Sugar in food and drink has been reduced with positive results and residents are supported to make healthier choices.

Medication errors remain an issue. In one respite house, medication for the same client was missed twice on the same day. Community Visitors query whether new procedures in place are working.

Four residents with very complex needs required dental treatment involving a general anaesthetic. Refusal by the hospital anaesthetist to administer the anaesthetic resulted in the dentist being unable to perform the treatment. Previously, the residents had undergone this procedure and Community Visitors questioned the reasons for the refusal of treatment.

Community Visitors have highlighted confusion and delays around diagnosis and treatment of seriously ill residents. Examples included delayed diagnosis of a leg fracture and a serious hip infection that was initially diagnosed as a urinary tract infection. They are concerned this represents a lack of understanding on the part of health professionals about treating people with disabilities.

Concerns have been raised about long delays for some residents acquiring new wheelchairs.

## Quality of staff support

Houses with regular staffing provide a consistent caring and professional environment. Community Visitors witnessed how staff knowledge and care enabled them to respond well to a volatile situation in a house.

Community Visitors queried staff numbers in a house where a new resident regularly requires a specific procedure. This was problematic for the care of other residents when there was only one staff member on duty. Extra staff have now been rostered for such occasions.

Houses provide a wide range of sporting and leisure activities. A number of residents now participate in weekly in-house individual and group music sessions. This is relatively new and is proving very successful.

## Good practice



Community Visitors commended staff at a group home situated on a large block in a rural town.

When no one answered the doorbell, they followed the sound of music and voices, past the free-range chickens, and found everyone in the 'camp-site' complete with a giant woodpile, a kiosk, a picnic area and a barbecue where the residents and staff were enjoying themselves.

It is a favourite meeting place for families.

## Rights

A resident with complex needs attended a holiday program in Tasmania.

Unfortunately, the organisation running the program refused to accept that resident again. People with complex needs often struggle to find programs that cater to their needs.

A resident who regularly attended annual conferences and games was unable to this year due to inadequate planning to ensure wheelchair access on transport, in accommodation and at other facilities.

In one country town, the lack of local day services has meant that residents have either been unable to attend or forced to travel to access these services.

Some residents who attend the remaining local day services are being transported back home or to another facility to access toilet facilities.

## NDIS

Some residents under 65 years of age are paying to attend day programs while waiting for their NDIS plans to be implemented.

Other residents over 65 years of age have not been able to attend day programs as they are waiting for Continuity of Support funding to commence.

A decrease in the use of local respite houses by participants funded through NDIS has been noted.

# Mental Health

Statewide Report and Recommendations

## Recommendations

The Community Visitors Mental Health Board recommends that the State Government:

1. continue to invest in and expand strategies such as the Safewards program to keep consumers safe and create positive, recovery-focussed environments
2. implement the recommendations of the Mental Health Complaints Commissioner's report, *The right to be safe*, to ensure sexual safety in acute mental health inpatient units
3. increase the number of mental health beds, particularly those designed for short-stay and drug treatment and rehabilitation
4. replace all shared inpatient rooms with single occupancy accommodation
5. develop more long-term supported accommodation options for consumers with complex needs to reduce inappropriate discharges to Supported Residential Services
6. ensure 24/7 mental health triage services are available at all major hospitals so consumers are assessed within four hours of arrival at emergency departments
7. investigate the reasons for the increased use of restraint and seclusion in adolescent beds, and implement strategies to reduce it
8. urgently review the model of care in the two statewide Transition Support Units to ensure it is meeting the needs of consumers with both mental illness and cognitive disability
9. ensure Community Visitors have unfettered access to incident report documentation, including incidents within 28 days of discharge
10. lobby the Australian Government for increased advocacy services to assist those with a psychosocial disability to gain access to the National Disability Insurance Scheme
11. advocate with the Australian government for the retention and effective resourcing of the Community Visitors Program as an essential quality safeguard following full National disability Insurance Scheme roll out.

# Statewide Report

## Introduction

Community Visitors are empowered by the *Mental Health Act 2014* to serve as a safeguard to protect and promote the rights, wellbeing and safety of consumers in prescribed public mental health facilities providing 24-hour care.

They visit unannounced and observe what is happening at the time of their visit, as well as talk with residents and staff about their experience of the mental health system. They can immediately seek a resolution to identified issues. If issues cannot be resolved locally, they are documented in their reports and can be escalated through the Community Visitors Board to the Office of the Chief Psychiatrist (OCP), Department of Health and Human Services (DHHS) or the Mental Health Complaints Commissioner.

This year, 78 appointed Community Visitors undertook 1601 visits to 143 mental health units across Victoria.

The units include adult and aged person's acute inpatient units, aged person's residential units, community care units (CCU), secure extended care units (SECU), child and adolescent units, eating disorder units, mother and baby units, prevention and recovery care (PARC) and transition support units (TSU).

The Board acknowledges the dedication of the Community Visitors and thanks all staff in mental health services demonstrating compassion and care for people at a difficult time in their lives.

## Serious incidents, assaults and safety

The safety of consumers and staff in mental health facilities remains a major concern.

Serious incidents reported by Community Visitors include:

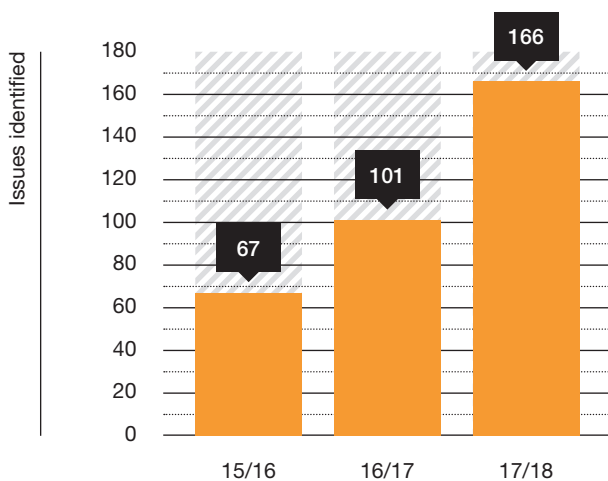
- assaults
- sexual assaults
- suicides and self-harm
- property damage

The incidents of assaults and violence in units appeared to significantly increase this year.

Incidents reported by Community Visitors increased from 101 last year to 166 this year, a 64 per cent increase. Part of this increase could be explained by greater access by Community Visitors this year to incident reports in some services, but it remains a very troubling increase.

Table 5. Total visits Mental Health stream, 17/18

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	33	14	20	343	363
North Division	36	12	18	306	324
South Division	41	29	30	413	443
West Division	33	23	18	453	471
<b>Total</b>	<b>143</b>	<b>78</b>	<b>86</b>	<b>1515</b>	<b>1601</b>



**Figure 8.** Mental Health stream assaults and violence, 15/16–17/18

### Assaults, aggression and property damage

Consumers who are experiencing acute symptoms of mental illness sometimes exhibit aggressive behaviour and cause damage to people and premises. This can be very traumatic for other consumers, visitors and staff.

For example, during one visit to an acute unit, Community Visitors noted the incident reports included:

- two consumers found with drug paraphernalia
- two consumers had engaged in consensual but inappropriate conduct. The female was transferred to an extended care unit (ECU) because of her vulnerability.
- an alleged (strangulation) assault in courtyard
- a consumer broke a bedroom window and “went AWOL” (absconded)
- several medication errors.

Aggression is not limited to acute inpatient units. In a CCU in Northern Metropolitan Melbourne, a resident stabbed a co-resident who later died. At another CCU in Western Metropolitan Melbourne, ambulance and police were called after one resident punched another. At St Vincent’s Health acute aged care unit, a volunteer Community Visitor was injured by a consumer during an unpredictable outburst.

St Vincent’s Health has introduced metal detectors as part of the admission process to acute units to reduce the risk of prohibited items on the ward. One consumer admitted from police custody was found to have a knife in his sock.

### Gender safety

In 2018, the Mental Health Complaints Commissioner released ‘The Right to Be Safe’ report which found “significant numbers of women report experiencing sexual activity, harassment, intimidation and assault while accessing acute mental health inpatient treatment in Victoria”. According to the report, “in some instances, staff responses to sexual safety breaches are guided by assessment of the illness of the perpetrator rather than the impact of the behaviour on other people accessing treatment.” Community Visitor reports support this finding.

#### Case study

CS

At Monash Health’s Casey Hospital, a female consumer alleged that she was sexually assaulted by a male consumer who had entered her bedroom. The female was in a women-only corridor in the unit. She was encouraged to lock her bedroom door if frightened, but was reluctant to do so as she felt she was being secluded. The male consumer was closely monitored. The female was supported to report her allegations to police.

In another instance, a female patient at Inner West Sunshine Hospital's adult acute unit alleged that a male patient entered her room, exposed himself and sought intercourse.

Men can also be victims of sexual assault. A male consumer was sexually assaulted in the High Dependency Unit (HDU) at Latrobe Regional Hospital's acute unit. Police investigations and charges are unlikely to be laid unless there is substantiating evidence.

While women-only corridors have been created in most acute units, they are not always used solely for women due to consumer gender imbalances and high bed occupancies.

### Assaults in aged care

People with dementia account for 52 per cent of all residents in residential aged care facilities. Managing unpredictable behaviour in the least restrictive manner with vulnerable and frail residents is challenging for staff working in these facilities.

At the Lyndoch Living's Audrey Prider Center in Barwon South West, a residential facility supporting consumers with dementia, a resident held a pillow over the face of another resident. Following this incident, fellow residents reported feeling intimidated and unsafe.

A male consumer at Goulburn Valley Health's Wanyarra Aged Care Unit perpetrated a series of assaults on other residents.

A complaint to the Aged Care Commissioner concerned staff-to-resident bullying and intimidation at St Vincent's Hospital Riverside House. The hospital investigation found allegations against staff were unsubstantiated.

Residents with bruising were discovered at Blackwood Cottage, managed by North East and Border Mental Health Services. Investigations by the OCP and review by the Australian Aged Care Quality Agency, cleared staff of misconduct, neglect and abuse but found deficiencies in appropriateness and safety of care. The investigations highlighted the value of Community Visitors' unannounced visits, particularly for those residents who do not have family or significant others who visit them regularly.

### Suicides and self-harm

As in previous years, some consumers attempted suicide while in mental health units or shortly after being discharged. Sadly, several took their own lives, despite attempts by facilities to reduce risk by, for example, trying to remove all ligature points.

Community Visitors report they are concerned that some consumers are discharged before they are fully

ready, with services constantly under pressure to discharge people quickly due to bed shortages.

One consumer from a Bendigo Health unit suicided immediately after discharge, during unsupervised travel to Melbourne. Another patient suicided while on leave from an acute unit. A third suicided on the day after he was discharged from an older persons unit. Such incidents appear to be thoroughly investigated by hospital quality and review committees after they occur but these reviews often take months to complete.

## Treatment and care

Aspects of treatment and care were the most frequently reported concern, with 304 issues this year. These included issues relating to the admission process, all aspects of psychiatric care, medical care, discharge, food, availability and suitability of beds, and restrictive practices.

### Bed shortages

There are 2471 funded mental health beds in Victoria. In some areas (Dandenong, Glenelg and Inner South East), there was more than 100 per cent occupancy of adult beds during the year, according to Victorian Health Services data. Services are constantly under pressure to discharge people quickly. This can affect patient care.

The Department of Health and Human Services (DHHS) monitors the number of consumers readmitted within 28 days. In the last eight months, various facilities met the state-wide target of 14 per cent or less readmission rate. However, Gippsland, North West and Northern Mallee adult acute units each had at least one quarter where at least one in five consumers discharged were readmitted within 28 days.

Additional investment by government and a range of strategies are needed to both prevent the need for admissions and to provide effective treatment to those admitted into care.

### Transitional support units

Last year, Community Visitors expressed concern about delays in the opening of two TSUs which provide specialist assistance to people with a cognitive disability and mental illness. It is now some years since these two facilities, managed by the Austin and Monash hospitals were built but they are still not fully occupied. Community Visitors would have expected to see a broad range of consumers supported by these services by now. The model of service and referral pathways need urgent review. Community Visitors welcome reassurance that they will be included in the refinement of the model.

## Case study

CS

Stella, a woman with an intellectual disability and mental health issues, living in a rural region, can be aggressive and abusive towards others.

For five years, Community Visitors have watched her move between her group home and regional mental health facilities. In January 2018, Stella was again taken to a mental health service for assessment. It was decided that she should be admitted, however, there was no bed for her. She was not admitted until three days later.

Stella spent about 90 days living at the group home and the remainder of the year living in an acute mental health unit or PARC.

Although Stella is still very unwell, it is planned that she will eventually transition back to shared supported accommodation. Stella's access to appropriate treatment for her dual disability and the safety and wellbeing of other residents and staff are the primary concerns of Community Visitors.

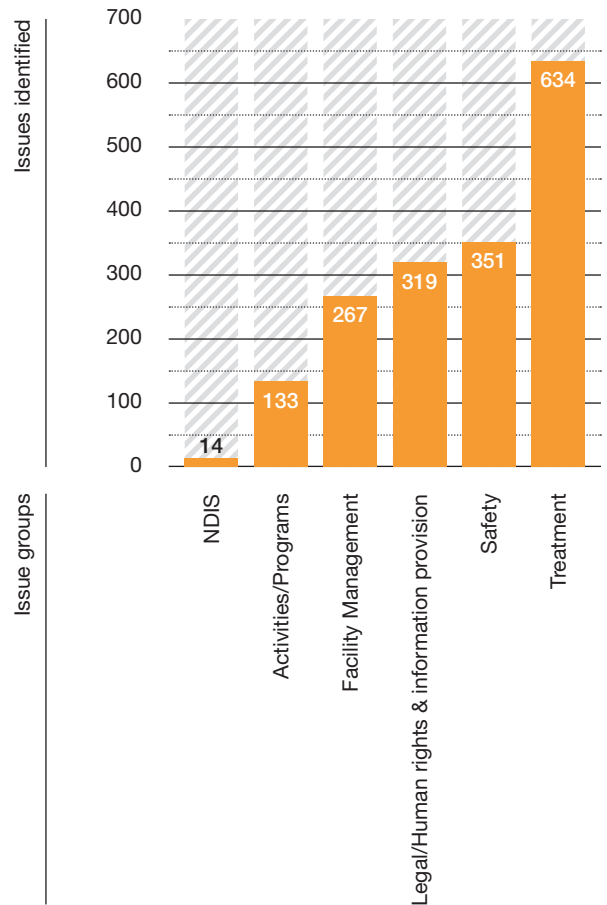


Figure 9. Mental Health stream by issue groups, 17/18

## The acuity of PARC residents

Community Visitors have raised concerns about the acuity of consumers in PARCs. PARCs are step-down facilities, but Community Visitors believe the bed pressures in acute units have contributed to this issue. This can affect the therapeutic atmosphere of a facility and not all staff have the training and experience to manage very challenging situations. A solitary staff member on overnight shift at Ringwood PARC allowed an ex-resident, who had been sent to an emergency department because of aggressive behaviour, to re-enter the unit later that night. A consumer at Clayton PARC attempted self-harm by overdosing with medication, then tried to asphyxiate herself. Two days later, she again overdosed.

## Dignity issues

While the majority of consumers report they are satisfied with their treatment and care, examples of staff intimidation and bullying have been reported. Some patients allege staff are patronising. One PARC resident said she did not like being called "sweetie" and "love". Others have claimed staff are rude or insensitive.

## Case study

CS

A female consumer told Community Visitors that she had attempted self-harm while in Sunshine Hospital adult acute unit. She was discovered by a male nurse who in an allegedly aggressive manner demanded "What the F--- are you doing?" The female patient started crying and the nurse in an unsympathetic manner reportedly said "don't give me that crying bull---t". Sunshine Hospital stood down two staff while an investigation was conducted.

## Restraint and seclusion

Physical restraint and seclusion are sometimes used after patients place themselves or others at risk.

## Case study

CS

At an acute unit in the Eastern Metropolitan Melbourne area, one consumer, upset by his mother's poor health and an upcoming court appearance, twice climbed onto the roof. He was placed in seclusion. The second time in seclusion, he covered the window and set fire to the urinal.

Victorian Health Services performance data, at the time of writing, shows that seclusion events in child and adolescent units had doubled in the last nine months. This is concerning because any seclusion event for a young child is traumatising.

## Legal rights and information provision

Community Visitors recorded 319 issues in relation to legal rights and provision of information.

At St Vincent's, restraint and seclusion were used as part of the management of a resident with autism, who had been admitted several times and exhibited aggression and inappropriate sexual behaviours. At Thomas Embling Hospital, one female patient has spent a large part of the last year in seclusion because of her aggressive behaviours.

## Information

Some consumers, particularly those on treatment orders, complained about inadequate or unclear information. Particularly concerning were reports from consumers who complained about a lack of information regarding medications and possible side

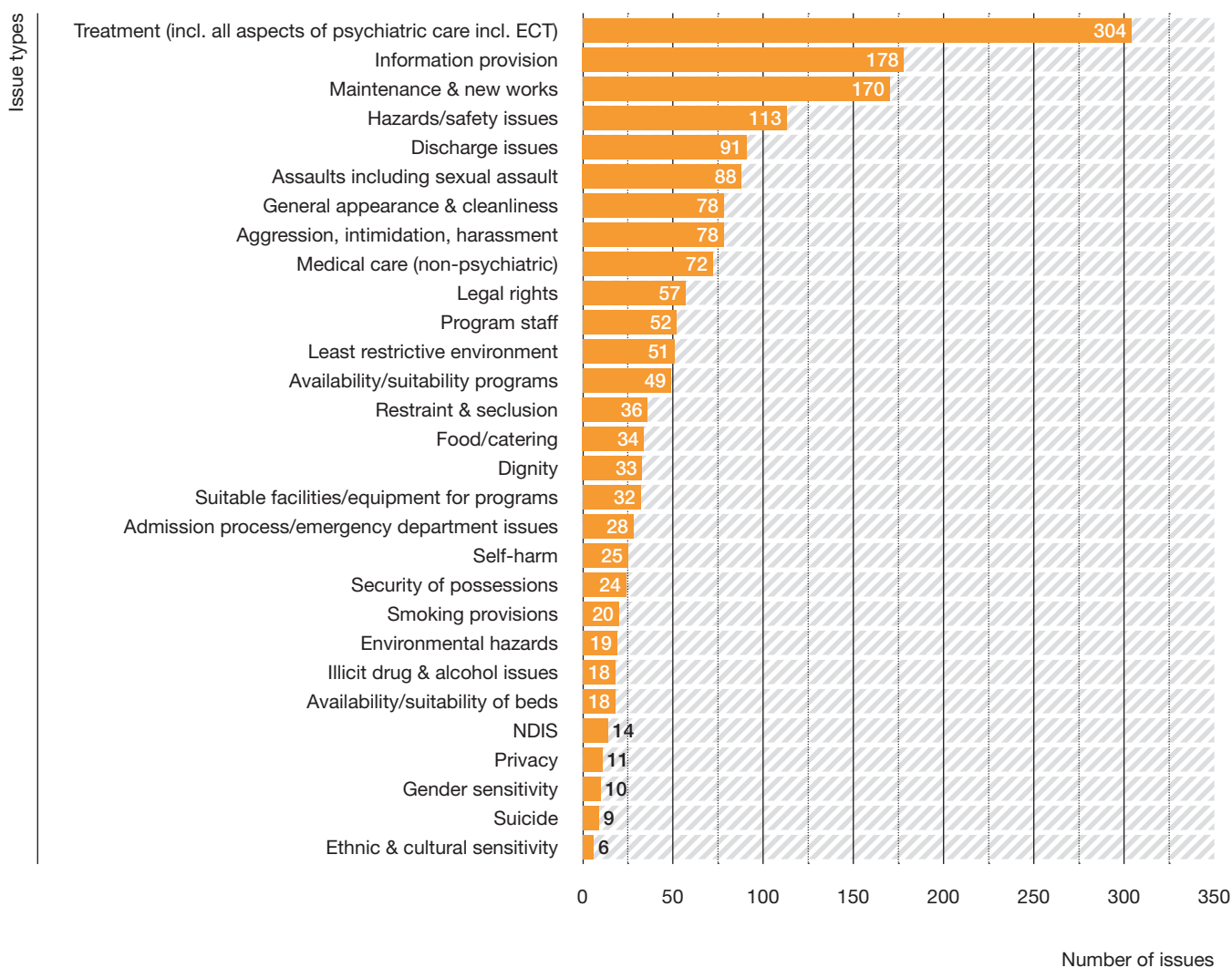


Figure 10. Mental Health stream number and types of issues identified, 17/18

effects. Community Visitors received frequent queries from consumers regarding access to Mental Health Tribunal hearings, rights to appeal, and right to second opinions. They provided information where appropriate to consumers. Some facilities did not display posters and brochures about the Community Visitors Program. It is imperative that consumers and patients are provided with this as Community Visitors are a vital safeguarding mechanism in the system.

## Access issues

There were a number of issues reported about access to phones. Consumers were distressed about having their mobile phone confiscated, the absence of an operational public phone or when the only phone available was within close vicinity of the nurses' station where they could be overheard.

Consumers also raised issues about:

- finances and State Trustees' administration of their money
- access to pyjamas, clothes or sanitary pads
- access to the internet
- access to drinks
- smoking provisions
- safety of belongings
- discharge and leave issues
- advanced statements and nominated persons
- family visits and access to children.

These issues were documented and discussed with services.

## Facility management

Delays in attending to maintenance issues continue to be reported by Community Visitors across the state. Maintenance works are required to address environmental and safety hazards in bathrooms, bedrooms, communal areas, and gardens and courtyards.

At Goulburn Valley Health Grutzner House, an out-of-use bathroom impacted upon the number of beds available for several months. At St Vincent's Hospital Footbridge CCU, a large amount of water collecting on the bathroom floor is a safety hazard. Latrobe Regional Hospital's Agnes Unit has had problems with heating and cooling since it opened.

At the Swanston Centre in Geelong, there is no window in the door to the aged care and seclusion units, restricting visibility to consumers. The service advised that no action was initially taken as it had had a client with complex needs accommodated in this room for seven months.

Unit 2 at Dandenong Hospital requires replacement or repair of its 'flexi-care' unit doors. Monash Medical Centre's P Block has had major issues with the cleanliness of the kitchen and central courtyard.

At the Maroondah Hospital, the PAPU courtyard is unsuitable when it is raining as the sail coverings are not waterproof. Alfred Health Baringa has shade cloth missing from the main outdoor area and the smaller outdoor area remains unused.

The Royal Melbourne's Norfolk Terrace has considerable amounts of rubbish on the verandas and garden beds outside Units 2 and 3.

Improvements in facilities were noted:

- construction at Thomas Embling Hospital's Argyle Unit to create additional beds and extend a bathroom, laundry, and dining room
- Ballarat Health Services obtained some new well-overdue furniture
- renovations to Broadmeadows CCU activities room have significantly improved its ambience.

## Activities and programs

Many consumers are dissatisfied with a lack of meaningful activities.

Community Visitors report that Goulburn Valley Health-Wanyarra Unit has limited activities, and note there are regular incidents of aggression reported. Latrobe Regional Hospital's Child and Adolescent Unit has no activities except for puzzles. Maroondah Hospital's Unit 1 has an art room that appears to be underused and undersupplied.

Consumers at Box Hill Hospital complained they viewed a drug and alcohol prevention video which was outdated and not helpful, and the Peter James Centre had feedback from consumers that they would prefer to have planned activities instead of daily activities written on the day.

Community Visitors reported disparity across the state of the availability of activities. St Vincent's Hospital's aged care facility staff are not engaging with residents and they use their mobile phones during work hours. Dandenong Hospital's Unit 3 had no permanent occupational therapist for more than six months while Mercy Health's Ursula Frayne Centre only has an occupational therapist available twice a week. The Willows, managed by Northern and Border Mental Health Service, also had no activities officer for a large part of the year.

Community Visitors also noted some facilities had positive activities. Art therapy and tai chi classes are provided at Eastern Health's Upton House. Thomas Embling Hospital has an art therapist working with patients to create a wall mural. Bendigo Health's Simpkin House has a violinist visiting monthly and a dog regularly visiting. Music is also part of the program at the Royal Melbourne Hospital's Banksia unit, and yoga is held at the Burnside PARC.

In Ballarat, Sovereign House CCU, which has weekly BBQs and take-away meals, has a positive atmosphere. The Steele Haughton Unit's Extended Care has regular outings and activities.

## NDIS

Community Visitors are increasingly reporting National Disability Insurance Scheme (NDIS) issues. Staff in mental health services report great frustration with the NDIS application processes, particularly when a planning meeting can take seven months to organise from when the application form is lodged. Planners do not necessarily have mental health training or experience, and some are reluctant to meet face-to-face. The organisation of family meetings can also be time-consuming.

Draft plans are not provided to applicants or services for comment before finalisation. Plans can take three to four months to change if they do not accurately address the applicant's needs. Frequent follow up is often required to ensure matters are progressing and staff can spend very lengthy periods of time on hold when they phone the National Disability Insurance Agency (NDIA).

One occupational therapist told Community Visitors that hospital staff must follow up NDIS planners at least monthly which, for 25 SECU consumers, is very time consuming. If the consumer does not engage with the NDIS within three months, their application lapses.

The length of time involved in obtaining a plan and engaging a support coordinator to manage it can result in lengthy delays in consumers obtaining appropriate accommodation and support to leave facilities. This leads to delays and beds blockages in CCUs, PARCs and acute units.

Where people have been able to obtain extra hours of support through the scheme, it has made a difference to their lives. At the Bendigo Health SECU, residents are now able to undertake community activities with one-on-one support.

## Service provider responsiveness

Community Visitors are frustrated that some staff lack an understanding of their role.

At 19 facilities, Community Visitors recorded difficulties in gaining access to incident reports at the time of their visits. Some services provide monthly electronic incident summaries and specific reports on request. Others print out hard copies to be viewed during visits. These measures are helpful. Other services have introduced procedures to allow electronic access during visits but these procedures have not always worked in practice.

Access to incident reports at the Royal Children's Hospital has been problematic for several years. Procedures agreed to last year required a senior manager to be contacted when Community Visitors wanted to view the reports at the time of a visit. This proved difficult on occasions due to senior managers being absent or unavailable for a lengthy period.

Discussions between the Board, the Chief Psychiatrist, Neil Coventry, and the hospital have led to a positive change in practice.

Apart from this ongoing issue and delays in obtaining written responses from some services, Community Visitors mainly report good working-relationships with facility managers and staff.

The Board appreciates the support of DHHS' Mental Health Division and the Office of the Chief Psychiatrist this year. Liaison meetings held with these parties have been transparent and collaborative, and a variety of actions have been undertaken by the OCP to address issues identified by Community Visitors.

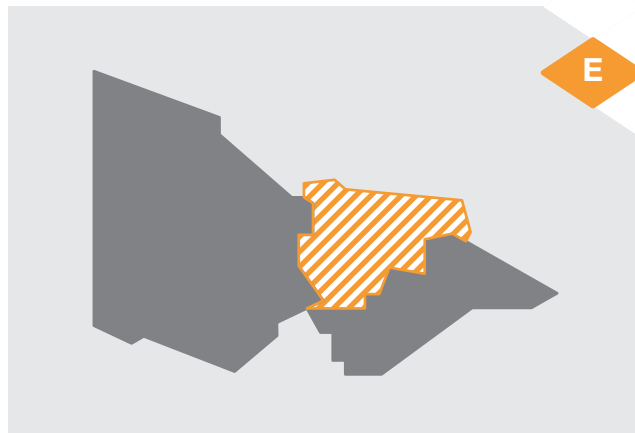


# Divisional Reports



## East Division

EAST DIVISION INCLUDES EASTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF INNER EASTERN AND OUTER EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF HUME, COMPRISING THE DHHS AREAS OF OVENS MURRAY AND GOULBURN.



## Eastern Metropolitan Melbourne area

### Introduction

Eastern Health and St Vincent's Health (which includes St George's Hospital and St Vincent's Hospital, Melbourne) manage services visited in the region. Services include five adult acute units, two aged acute units, four aged persons' residential units, one adolescent unit, three CCUs, one PAPU and three emergency departments. Three PARCS are jointly managed by MIND Australia, Wellways and the two health services.

### Serious incidents, assaults and safety

Ensuring the safety of patients, staff and Community Visitors remains a challenge at all services. An unprovoked attack on a Community Visitor by an older consumer at St Vincent's Normanby House led to enhanced Community Visitor safety training.

The safety of frail residents is paramount in aged mental health care and Community Visitor reports reflected concerns within this setting, acknowledging the unpredictability of aggressive behaviour in an

environment of least restraint. At Peter James Centre's Mooroolbark facility, one consumer was hospitalised following aggression by another consumer and, at the Burwood facility, one male consumer was responsible for 18 reports of aggression towards others. At St Vincent's Auburn House (a psychogeriatric service), inappropriate sexual contact between a male and female resident was reported.

Strategies have been introduced in acute units to address consumer and staff safety. At St Vincent's, in addition to drug detection dogs, clinical staff now use metal detectors to search consumers for prohibited and dangerous items. Staff detected a knife in a consumer's sock during the admission process despite them transferring from police custody. At Eastern Health Maroondah Hospital, security guards are stationed on the wards. In a search to remove prohibited items, an inpatient complained he was inappropriately handled by security staff as they removed a cigarette lighter and 'strike anywhere' matches.

Violence between consumers is reported regularly by Community Visitors; the attempted strangulation of a female consumer by a male consumer at St Vincent's adult acute, and the attempted sexual assault of a male consumer by another male consumer at St Vincent's are examples.



### Case study

CS

Young adults from Eastern Health’s Upton House adult unit were placed into its Child and Youth Mental Health Unit where vulnerable children as young as 13 years old are admitted.

Community Visitors reported an 18 year old consumer caused a disturbance among the younger consumers that required security staff assistance.

Due to admission pressures on beds in the Intensive Care Areas (ICA) at Upton House, patients were prematurely moved to the open ward with security present.

### Good practice



Eastern Health’s Linwood House PARC invites previous residents to stay and be supported during at-risk periods, extended public holidays and significant anniversaries.

The out-dated design of older hospitals like St Vincent’s and Eastern Health’s Upton House, places consumers and their visitors at risk; vulnerable mental health consumers share rooms and visitors must walk through the open ward to the family/visitors’ room. A male consumer became aroused by two young female children visiting their mother at St Vincent’s inpatient unit. Rather than risking a repeat of the situation, the mother chose not to see her children again until well enough to be granted day leave.

Community Visitors raised concerns about a vulnerable female resident at an Eastern Health CCU who left her accommodation at night without staff knowledge and was brought back by police.

In July 2017, at Peter James’ South Ward, Community Visitors noted a critical incident report of a resident having their fingers amputated by a door closure; this was later updated to “broken finger tips”. In 2018, Eastern Health is trialling a soft-closing mechanism on bedroom doors to prevent consumer injuries.

## Treatment and care

Consumers and residents have praised the treatment delivered by both services, notably the tailored service model of sub-acute care provided by PARC facilities. However, Community Visitors note increasing demand for inpatient beds and report the growing acuity of Eastern Health PARC consumers. The PARC is not resourced as an acute setting.

In 2017, one PARC resident overdosed and self-harmed and actively concealed this behaviour from staff. For this reason, Community Visitors were concerned about overnight safety when only one worker is rostered on. A written response was requested but not received.

## Legal rights and information provision

At Upton House, the women-only/ gender sensitive area was compromised by the presence of males due to bed shortages and there being more male than female consumers. The door to the area was propped open and one female consumer commented she felt unsafe.

A female consumer at St Vincent’s inpatient unit waited 14 days for an independent second opinion, which occurred two days after her Mental Health Tribunal hearing.

Two consumers were found in consensual but inappropriate sexual contact in the bathroom at St Vincent's inpatient unit. The female consumer deemed vulnerable was transferred to the ECU.

On numerous visits to Maroondah Hospital inpatient units in 2017, Community Visitors reported the absence of consumer rights information. On one occasion, they were informed by a nurse in charge that the consumer rights booklets were confusing for consumers and were, therefore, not distributed. This situation was rectified in 2018.

Critical incident reports are often unavailable to Community Visitors if the visits occur outside usual business hours of Monday to Friday and if the unit manager is not present.

## Facility management

At Eastern Health Upton House, a trolley with mechanical restraints was stored in a corridor outside the seclusion area, which consumers might have found intimidating. Community Visitors successfully requested the removal or covering of the trolley.

Delays in the maintenance or replacement of washing machines and clothes dryers disadvantages consumers, notably at Eastern Health Upton and Linwood facilities. Similarly, at Upton House, extended delays in replacing hazardous metal-pegged artificial turf in the courtyard prompted the presence of a security guard in the consumers' outdoor space.

For more than a year, residents at St Vincent's aged care facility, Riverside House, were at risk from hazardous material thrown over the fence from a neighbouring housing estate, and then from building debris as a high-rise apartment complex was constructed at the rear of the property. Safety concerns curtailed residents' access to fresh air and sunshine in the garden until a staff member was available to accompany them.

## Activities and programs

Children from the local childcare facility regularly visited St Vincent's Riverside House aged care facility. This uplifting experience for residents was organised by the activity officer to engage a resident who was a former early childhood educator.

Quarterly liaison meetings continue as a useful exchange between Community Visitors and Health Services Management. Recently, Eastern Health informed Community Visitors about an outreach Suicide Postvention and Prevention Project Community Response and Recovery Plan initiative.

## NDIS

At St Vincent's Footbridge CCU, staff work with residents to develop independent living skills. Some residents, however, are disadvantaged because they minimise their personal needs during NDIS planning meetings when they actually need ongoing funded support.

## Hume area

Services include Goulburn Valley Health (Goulburn Valley Area Mental Health Services) and Albury Wodonga Health (North East and Border Mental Health Services).

There are two acute inpatient units, two aged acute inpatient units, two aged residential units, two CCUs, two PARCs and two emergency departments.

## Serious incidents, assaults and safety

Verbal and physical threats and assaults continue to be reported in all acute mental health units. Community Visitors reported an alleged assault of a consumer by a staff member at the North East and Border Mental Health Services Kerferd Unit. The staff member claimed to have used reasonable force in an escalating incident where the assault of a female staff member was occurring.

The staff member has now participated in aggression prevention and response training, however, further systemic training of all staff is being undertaken. In addition, a senior mental health nurse educator will work with staff to refresh the Safewards program.

## Treatment and care

Shepparton PARC is managed by Wellways with clinical management provided by Goulburn Valley Health. Consumers complained to Community Visitors of frequent delays of several hours to receive medication. Every day, for at least a week, 80 per cent of medication arrived late. Community Visitors advised clinical management, and a mental health nurse consultant provided additional support, leading to improvements which have been maintained.

On almost every visit to a Goulburn Valley Area Mental Health Service, Community Visitors reported a shortage of staff. Despite ongoing recruitment efforts, senior management are perpetually challenged to attract suitably qualified and interested candidates, with few or no responses to advertising. This is a critical concern across the area with care requirements placing additional pressure on staff, particularly when experienced nurse practitioners retire from the profession.

## Legal rights and information provision

Community Visitors at Wanyarra Acute Inpatient Unit clearly heard discussions taking place in the Mental Health Tribunal hearings room and reported that soundproofing was required to maintain consumer privacy and confidentiality. Senior management of Goulburn Valley Health are investigating these concerns.

## Facility management

Poorly designed and maintained facilities significantly impact the treatment and care of consumers. At Wanyarra Acute Inpatient Unit, consumers easily kick and punch holes in an external security fence. The outside area of the women's section remains unused due to a low wall. Staff concerns at the risk of consumers' absconding has prevented access to a large grassed outdoor open area for most of the year.

A secure, women-only unit opened at Goulburn Valley Health's Wanyarra Unit. However, damaged and lost access passes require the door to remain open at all times, defeating its purpose.

Between March and May 2018, at the Wanyarra aged persons unit, the television room remote control was misplaced and not replaced. Frail and aged consumers were unable to independently use the television and relied on staff to assist them.

## Activities and programs

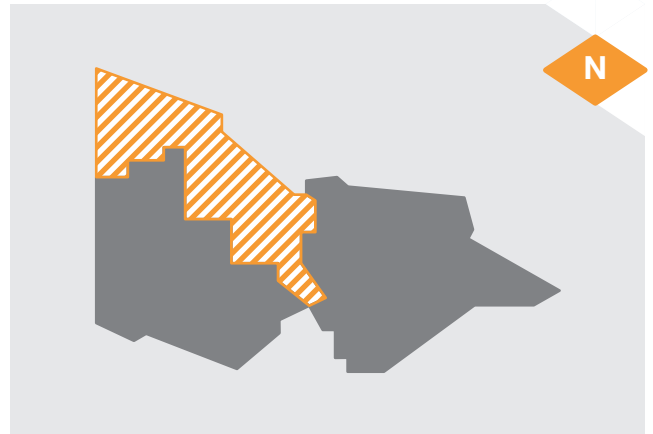
There continues to be a lack of indoor and outdoor therapeutic consumer activities at Wanyarra acute units. Since July 2017, Community Visitors observe that advertised activities in the adult acute unit are not always conducted, television is frequently inaccessible and consumers complain of being bored. In February 2018, Goulburn Valley Health advised an occupational therapist would be recruited to ensure activities are more readily available, however, the position description is still being developed. New gym equipment has just arrived.

### Good practice

At Goulburn Valley Health aged residential unit, Grutzner House, tai chi classes are being trialled as a falls minimisation strategy.

## North Division

NORTH DIVISION INCLUDES NORTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF HUME MORELAND AND NORTH EASTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF LODDON AND MALLEE.



## Loddon Mallee area

### Introduction

Bendigo Health and Ramsay Health provide services to eleven mental health facilities and two emergency departments. Community Visitors are now regularly visiting the acute inpatient unit and a new PARC in Mildura. All non-residential mental health clients have transferred to the new Bendigo Hospital, with an increased capacity that has mostly relieved critical bed shortages in the region.

### Serious incidents, assaults, and safety

Despite Bendigo Health's acute care efforts, three clients recently discharged or on short leave took their lives. Rigorous internal reviews relating to these incidents have been undertaken. Community Visitors enquired about the attention given to contributing factors. Reassurances have been provided by management on the standard of training in suicide prevention.

Medication administration incidents have continued to occur across Bendigo Health acute units. Difficulty in administering medication to non-compliant clients and isolated cases of inappropriate methods of delivery (secreting in food) occurred. Bendigo Health conducted a trial with a pharmacist on the acute unit with the favourable results and learnings under consideration.

Several occurrences of incorrect meal service for a client with a food allergy occurred, despite unit staff requests. Bendigo Health identified the matter as serious, and is tightening special meal administration.

## Treatment and care

Consumers expressed satisfaction with care at both Ramsay Health and Bendigo Health units. There were instances of delays in mental health consultations in the Bendigo Health extended care unit, leading to the arrangement of regular future visits by psychiatrists. The older persons unit's fall prevention efforts have resulted in a substantial reduction in falls. Community Visitors have monitored consumer feedback on electroconvulsive treatment (ECT) and Bendigo Health has given reassurances of best practice.

Bendigo Health residential units, PARC and CCU, have had a number of instances of consumer intoxication. The recent establishment of a Dual Diagnosis Residential Rehabilitation Unit on the former SECU site provides a referral path for consumers with those care needs.

Ramsay Health has finalised a model of care for the new PARC in cooperation with their Wellways partner. Community Visitors discussed with Ramsay Health ways of enhancing the discharge planning aspects of the model. The model of care will be updated on completion of the renovations of Ward 5.

## Legal rights and information provision

Access to incident reports summaries at Bendigo Health units has improved in the last year. Ramsay Health is reactivating Community Visitor access to incident report summaries. Bendigo Health confirmed it provides Community Visitors with access to full incident reports and findings of investigations.

Second psychiatric opinions advocated by Community Visitors are generally provided internally by Bendigo Health professional staff, but have also been arranged by video link with the city-based service.

## Facility management

Renovations to Ramsay Health's acute unit are expected to be completed by the end of 2018. The new PARC at Mildura is now operational and Community Visitors observed a very well-appointed facility on a recent visit.

Bendigo Health has reviewed the Bendigo PARC with the aim of either upgrading or building a new purpose-built facility. Redevelopment of the aged care facility, Simpkin House, is proceeding, including a memory support unit, expanded activity area, and a hairdressing salon.

## Activities and programs

Community Visitors continue to receive comments from consumers about the lack of suitable activities. Group meetings and therapy sessions are arranged in Bendigo Health acute units. Pet therapy visits are also organised, however, Community Visitors advocated for more individual activity resources and are encouraged by the introduction of resources such as iPads.

## Service provider responsiveness

Quarterly liaison meetings with Bendigo Health continue to be well-attended and productive. Nurse unit managers were generous with their time and information for Community Visitor reporting, and mostly provide timely written responses. Ramsay Health management has kept the Community Visitors Program advised of their plans and developments.

## Northern Metropolitan Melbourne area

### Introduction

Three health networks provide mental health services in the Northern Metropolitan Melbourne area:

- Austin Health manages a mother and baby unit, acute unit, SECU, children's unit, adolescents unit, brain disorder (BD) unit, veterans' post-traumatic stress disorder unit, a Community Recovery Program, a PARC, TSU and an emergency department with co-located Psychiatric Assessment and Planning Unit (PAPU).
- North West Mental Health (NWMH) provides the North West Area Mental Health Service and Northern Area Mental Health Service (NAMHS) which has a PARC, CCU, two adult acute units, an aged acute inpatient unit and four mental health beds in the Northern Hospital emergency department.
- Forensicare manages Thomas Embling Hospital (TEH), a seven-unit forensic mental health hospital.

### Serious incidents, assaults and safety

#### Assaults and aggression

A male resident at Northern CCU died from multiple stab wounds allegedly inflicted by another resident. The alleged perpetrator was arrested by police and is in prison awaiting trial. Appropriate teams responded and counselling for consumers and staff was provided. The incident report was provided to Community Visitors and arrangements made for a root-cause

analysis. Victoria Police, Worksafe and the Coroner are investigating. An incident of this seriousness is unusual in a CCU where consumers are on the way to recovery and reintegration into the community.

A serious harassment incident involving a contractor and a female consumer occurred at the Austin PARC. Once reported by the consumer, the incident was promptly handled by management with counselling provided to the consumer and action with the firm to remove the contractor from the service. The incident highlights the risks inherent in dealing with contractors and outsourcing arrangements where personnel screening may not equal the standards expected of hospital staff.

Acute units continue to experience a high level of aggression, both consumer-to-consumer and consumer-to-staff. This reflects the acute nature of mental illness and the high turnover in acute units where the average length of stay is around 14 days, and there is a constant influx of new and seriously ill consumers requiring a period to come down from their high level of agitation.

The admission of consumers with a history of violence and assault has required special measures including the placement of security guards in these units. One manager organised debriefing for other consumers who were upset at seeing others being restrained by several security guards.

## Suicides

A female patient in TEH suicided by asphyxiation. TEH had previously reported it had removed all practicable ligature points and it periodically inspected for potential ligature points. The patient had a history of multiple previous attempts and used her own clothing. None of the usual triggers in the patient's behaviour were apparent. Follow-up counselling to patients and staff was provided. The incident was properly reported to the appropriate authorities and copies of the investigations and reviews were made available to Community Visitors.

A female consumer in the Northern Hospital suicided by asphyxiation. The incident reporting, staff responses and notifications to the authorities and family were appropriate. Follow-up counselling to consumers and staff was provided. Community Visitors were provided with copies of the incident report and will be provided a copy of the more detailed root-cause analysis when completed.

## Drugs

There were several reports of consumers or their visitors importing drugs. Illicit drugs are sometimes traded or exchanged for favours, which can have a very serious impact on consumer health and welfare.

Preventative and response measures include posted warnings, consumer and visitor education, targeted and random inspections, searches by drug dogs and unit lockdowns.

## Treatment and care

Community Visitors observed a generally high standard of treatment and care. Treatment issues were promptly responded to, including concerns about medication, restraint, ECT treatments, staff behaviours, requests for second opinions, security of belongings, and access to leave. Care concerns included issues relating to accommodation and discharge arrangements, family matters, and access to finances through State Trustees. Satisfactory resolution of such issues is a key factor in recovery.

Last year's report included a case study of an adolescent with a dual disability who had lived in an adolescent acute unit for more than two years. In August 2017, he was successfully discharged to appropriate accommodation and care. Multiple state and federal agencies were involved in resolving this matter. High-level departmental attention is required to address and refine processes in such cases so bureaucratic processes do not prolong the inappropriate detention of consumers.

Community Visitors welcomed the opening in mid-2017 of the TSU, a purpose-built, ten-bed facility for people who have both a mental illness and cognitive disability. However, the beds have never been fully occupied. Community Visitors understand that the current consumer profile does not reflect the designated target group. Direct referrals from disability services are not accepted and, to date, the unit has only accepted clients from within the Austin Health's catchment or TEH rather than operating as a statewide facility as designated.

One patient at TEH has been in seclusion for most of the last two years because of her volatility and frequent violence. Community Visitors were advised that her seclusion episodes are documented and in accordance with Chief Psychiatrist advice.

## Facility management

Construction is underway to expand TEH's capacity from 116 to 124 forensic patients. Currently there are 13 forensic patients managed in prison because there are no beds available in TEH.

In addition, the hospital is building a ten-bed secure psychiatric intensive care unit which will provide short-term intensive treatment of prisoners admitted from the general prison system.

The new facilities will include four two-bedroom units that will provide an additional eight forensic

beds, as well as expanded dining room, laundry, and shower facilities and interview/counselling rooms. The construction has led to a loss of campus space and severe disruption to both patients and staff, however, everyone has responded well to the challenges.

## Service provider responsiveness

Where Community Visitors have requested written responses to visit reports, they are generally provided within the week of request. Incident reports are provided on request.

Quarterly liaison meetings between mental health hospital managements and Community Visitors continue to be effective and informative.

Some hospitals display statistical reports in their facilities and others provide them at quarterly meetings. Summaries of incident reports are still in development and will be very helpful in providing context to the statistical reports.

## Clinical Governance

The Community Visitor Regional Convenor attends the Forensicare monthly Safety, Quality and Risk Committee as an observer.

The committee is the senior clinical review authority in Forensicare Victoria. It provides oversight of all mental health clinical activity in TEH and Victorian Corrections establishments where Forensicare provides mental health care. This has been beneficial in observing the notification, review, classification, investigation and responses to incidents of all types.

The Austin Mental Health Clinical Service Unit has made a similar arrangement for the Regional Convenor to attend their monthly committee meeting.

## South Division

SOUTH DIVISION INCLUDES SOUTHERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BAYSIDE PENINSULA AND SOUTHERN MELBOURNE, AND THE REGIONAL VICTORIAN AREA OF GIPPSLAND, COMPRISING INNER AND OUTER GIPPSLAND.



## Gippsland area

### Introduction

The Latrobe Regional Hospital manages mental health services in the Gippsland Region. Community Visitors visit an acute inpatient unit which includes an HDU, child and adolescent beds, aged persons inpatient unit, CCU, emergency department, mother-baby unit and PARC.

### Serious incidents, assaults and safety

Serious safety concerns are raised by consumers in La Trobe Regional Hospital acute unit: one consumer alleged he had been raped during a previous admission. Police investigated. Police were also called after a consumer attacked another consumer, causing a bloody nose and bruising. Another consumer alleged he was choked by a co-consumer. He didn't want police involved as he understood the other person was unwell. The alleged offender was moved to the HDU where he was involved as a victim in another incident. Staff intervened.

In March, a cleaner was knocked to the ground while in the acute unit. They have not returned to work. This was an unprovoked incident and out of character for the consumer. A requested incident report was yet to be received at the time of writing.

In February, Community Visitors reported broken road-guttering within the CCU grounds. In May, a staff member and resident suffered injuries while negotiating this guttering. Staff at the CCU reported this issue for action but it is still to be addressed.

## Treatment and care

Although the general feedback about staff is very positive, several consumers commented that some night staff do not treat consumers with respect.

One consumer was discharged to a motel for four nights. Community Visitors were concerned about his housing beyond that and were told he was being linked with a housing service. The shortage of appropriate accommodation in the area is well-known.

## Legal rights and information provision

Distribution of information packs for consumers was a concern, with consumers reporting they have not received information or orientation to the unit on admission.

## Facility management

Long-standing problems including lack of suitable curtains and blinds in the adult acute and SECU, a broken door into the women's-only corridor, access by consumers to treatment rooms, and replacement of the slip strips to shower recesses, have now been resolved. It took over two months for the drawing of a penis and testicles on the ceiling of a unit kitchen to be painted over.

Still outstanding are lack of curtains for privacy and climate control in the child and adolescent unit, and lack of signage to the mother-baby unit despite being open for more than three years. Consumers and other service providers find it extremely difficult to locate this unit, particularly as it is the only unit that cannot be accessed from within the hospital.

On occasions, doors to outdoor courtyards have been locked. This seems to be due to staff oversight, rather than intent.

New furniture and activity resources have been purchased for all units providing consumers with a more stimulating and therapeutic environment.

Plans for refurbishment of the CCU have been approved and funding sourced, but, at the time of writing, minimal work had been completed.

In November 2017, a new emergency department was opened including a behaviour assessment room. This room is not operational as there are problems with the way the door opens into the room. This has been reported to the contractor. Mental health triage staff are located within the emergency department.

## Activities and programs

Activity programs within units have expanded and are invaluable to consumers. Two occupational therapists and an enthusiastic diversional therapist work across the Macalister and Flynn Units to help engage consumers in meaningful activities.

## Service provider responsiveness

Quarterly liaison meetings are well-attended, enabling Community Visitors to discuss issues with senior hospital staff directly. A new protocol for access to incident reports by Community Visitors has commenced. It is still in the early stages but will hopefully resolve previous ongoing access issues.

Senior hospital staff also have a new reporting process to ensure issues reported by Community Visitors are addressed in a timely manner.

## Southern Metropolitan Melbourne area

### Introduction

Three health networks (Alfred Health, Monash Health and Peninsula Health) provide seven adult and four aged persons acute inpatient units, four aged persons residential units, four CCUs, three child and adolescent inpatient units, one eating disorders unit, one mother and baby unit, one SECU, one TSU for people with an intellectual disability and mental illness and seven PARC facilities.

### Serious incidents, assaults and safety

The Monash Health Women's PARC was left without communication or personal alarms for over 12 months due to a Telstra issue. Vulnerable consumers were at risk due to staff relying on mobile phones, having no access to personal alarms, and using a courier service for consumer records. The PARC has been listed for capital works to network the system.

There is some confusion in relation to the responsibilities of PARC staff access to Monash Riskman and the recording of incidents. This issue needs to be clarified with all PARC staff by the responsible body, Monash Health.

Community Visitors reported that the behaviour of a female diagnosed with a dual disability placed in an aged care facility had a disruptive impact on residents and staff.

## Case study

CS

Two years ago, a woman diagnosed with a dual disability and complex medical conditions was placed at Mooraleigh aged care residential facility, following multiple admissions to emergency departments, acute units, PARCs and CCUs and being assessed as being unable to live independently. She is significantly younger than most other residents.

Throughout this period, the resident experienced bullying by residents of both sexes and, despite attempts by staff to counteract this behaviour, she was still subjected to verbal taunting.

In January 2018, the resident reported that she had been sexually assaulted by a much older male resident. The woman did not report the incident until three days later, stating that the alleged perpetrator was bigger and stronger than her, and she feared for her safety.

The police subsequently interviewed her and counselling was arranged. No charges were laid but the male resident accused of the sexual assault was transferred to another facility.

The case highlights the limited accommodation options available to younger people with complex needs and the difficulties that arise when these people are placed in aged care.

## Treatment and care

Consumers at a number of Alfred Health facilities reported dissatisfaction with staff communication about discharge plans and pathways. During a visit to their ground floor acute unit, Community Visitors spoke to the parents of a consumer who expressed concern that their daughter had been discharged prematurely following previous admissions.

A key concern for Community Visitors to Alfred Health facilities is the limited availability of suitable housing options for consumers following discharge. It is estimated that 40-60 per cent are homeless. Some are being discharged to inappropriate accommodation or accommodation that does not adequately meet their support needs. Alfred Health is liaising with local housing and support agencies to identify and access further housing options for discharged consumers.

## Legal rights and information provision

Consumers at Baringa and Alfred Health Ground Floor Acute Inpatient Unit reported the theft of personal belongings, including, in one case, a laptop computer. Alfred Health has purchased new lockers for inpatients in an attempt to address this issue.

## Facility management

After many years of reporting on the poor state of Monash Acute Inpatient Unit (P Block), funding has been secured to carry out renovations to the HDU, kitchen and laundry areas. More is needed to improve the environment in this outdated unit.

The transfer of the adolescent unit (Stepping Stones) to the Monash Children's Hospital was carried out this year without issue, and providing consumers with a much brighter and friendlier space in which to recover. The new Oasis Unit has also opened at the Monash Children's Hospital providing support to children with complex mental health and neurodevelopmental needs and their families. Community Visitors note that further funding may be required to assist with outreach for this program and will monitor the situation.

Community Visitors had anticipated that Monash's TSU for people with a dual disability would have been fully operational by now. When Community Visitors visited in May 2018, two consumers were being transitioned to the unit.

Monash Health's Casey Hospital has received funding for five extra beds to assist with low-risk consumers needing a little more time prior to discharge, while Doveton CCU has had funding approved for a wheelchair accessible bathroom.

Maintenance works and refurbishment were required at a number of Alfred Health facilities. Community Visitors expressed concern that the outdoor courtyard at Baringa had no garden, little seating and no shade, however, the courtyard has now been refurbished. The courtyard at Alfred Health's ground floor unit was reported to be unkempt and run down. Funds have been secured to upgrade the unit.

The general appearance of Alfred Health's first floor acute inpatient unit was reported to be poor, requiring maintenance to repair curtains and a water fountain. Community Visitors were pleased to hear that a number of long-overdue refurbishments were taking place, including dining rooms and bathrooms in both of Alfred Health's acute units.

## Activities and programs

Four residents from the Peninsula Health CCU have been accepted by the Haven Foundation Frankston Project. The project will involve the construction of 20 self-contained, one-bedroom units along with staff facilities. The units will enable the foundation to provide long-term supported accommodation to people with severe and enduring mental illness.

### Case study

CS

The Doorway Program was funded in 2015 to support people with mental health issues to access the private rental market.

It is a Housing First model, aimed towards providing participants with sustainable outcomes in both housing and mental health. Peninsula Health's Adult PARC has highlighted the value of the program in successfully placing a number of residents in accommodation.

Work is being done to evaluate and capture all the outcomes of the program and it is likely that its success to date has enabled it to gain future funding, as there were concerns that the program would cease at the end of the financial year.

## Service provider responsiveness

Community Visitors at Monash Health continue to be frustrated in carrying out their prescribed function under the Mental Health Act. Several sexual incidents and alleged assaults at Monash Health facilities have been reported, however, it has been difficult for Community Visitors to fully enquire into these due to incident reports being unavailable.

The Ombudsman and, subsequently, the DHHS Secretary have made it clear that Community Visitors have the right to access to incident reports. However, without an explicit statement in the Act, some services including Monash Health continue to deny Community Visitors the access they need to perform their role effectively.

Communication between Monash Health management and Community Visitors has improved significantly over the past year, with regular meetings and discussion contributing to positive changes. Despite this, there is a need for Monash Health to provide training and information regarding the role of Community Visitors to all parts of their service network.

Community Visitors have experienced some difficulties with the timeliness of responses at Peninsula Health. The service contends it generally meets the required timeframes.

In a positive move, Community Visitors at Peninsula Health now have access to the Mental Health Consumer Coordinator and Peer Support Program at the adult acute unit. They are able to liaise with these services if Community Visitors are unable to visit promptly in response to a call for assistance, or where further follow-up is required regarding consumer issues.

## West Division

WEST DIVISION INCLUDES WESTERN METROPOLITAN MELBOURNE, COMPRISING THE DHHS AREAS OF BRIMBANK MELTON AND WESTERN MELBOURNE, AND THE REGIONAL VICTORIAN AREAS OF BARWON CENTRAL HIGHLANDS AND WIMMERA SOUTH WEST.



## Barwon and Wimmera South West area

### Introduction

The Barwon South Western Region spans from Geelong to the South Australian border.

There are two major providers: Barwon Health in Geelong and South West Healthcare in Warrnambool, which, between them, manage two acute inpatient units, two emergency departments, two PARCs, one aged persons unit, one extended care unit (ECU) and one community rehabilitation facility (CRF). Two nursing home providers, Lyndoch Living and Western District Health Service, manage some psychogeriatric beds in Warrnambool and Hamilton. A new PARC opened in March 2018 adding ten mental health beds in Warrnambool.

## Serious incidents, assaults and safety

There were 13 incidents in January involving one resident in the Lyndoch aged care facility. These included allegations of resisting and hurting staff, placing a pillow over another resident's face, and pushing residents. Residents reported being very frightened of this resident. It was reported that there are regular multidisciplinary meetings to manage the resident and an extra staff member has been allocated to him for several hours a day. Community Visitors do not know whether this issue is resolved as the provider is denying their right to access the facility.

## Treatment and care

The Swanston Centre in Geelong reported an increase in aggressive incidents and difficulties in managing aggressive residents in the physical setting. A resident with a mental illness and autism has been housed in the low stimulus area for many months, because of a lack of suitable accommodation. This area was therefore unavailable for other residents. This problem is compounded by the lack of an HDU. Vulnerable residents are housed in the aged persons unit along with some aggressive residents. Nurses say that the area is unsafe because the only exit is via the nurses' station and there is often no nurse near the door. Residents have complained about staff not acting on requests concerning medical (non-psychological) problems.

Blakiston Lodge, an aged persons facility, also reported increased aggression. The nurse unit manager observed that recently admitted clients have been more ill than in the past, because good community care is keeping clients out of long-term care for longer. There were a few incidents of pressure sores and an infected wound.

Residents at Warrnambool acute units and ECUs generally praised staff.

## Facility management

The Swanson Centre has recruited more nurses and increased the number on shifts. Their aim to keep more nurses out on the floor has had some success.

## Legal rights and information provision

Community Visitors were given a blunt and unsympathetic report of a death at Blakiston Lodge. However, further enquiry found there was detailed and appropriate management of the situation.

## Grampians area

There are nine units in the Grampians region providing mental health care through Ballarat Health Services. There is one unit for general acute, one for acute aged care, a SECU, an aged residential unit, an emergency department and a mother and family unit. There are six funded psychogeriatric beds at Nhill and Stawell, and a CCU in Sebastopol.

In December 2017, the CCU at Ballarat East was closed and consumers were transferred to the Jack Lonsdale Unit in Sebastopol. At present there are only three residents in the unit which remains fully staffed. Management indicated that no further admissions would occur until Occupational Health and Safety (OHS) risks had been mitigated. Community Visitors were notified in June 2018 that the OHS works, which had been outstanding since December 2017, were finally completed. Community Visitors look forward to seeing this unit being used appropriately.

## Incident reports

Incident reports are given on a monthly basis from most units but they are difficult for Community Visitors to follow-up as residents have often been discharged prior to the reports being received.

The number of incidents at the adult acute unit are high, and a review of incident reports in January 2018 showed 37 incidents for the unit ranging from mistakes with medications by staff to physical assaults on staff. Security guards provide good back-up to the acute unit and Sovereign House.

## Treatment and care

Community Visitors are concerned that there is still no gender-specific lounge in the Sovereign House where there are often only one to three females. Submissions over many years for upgrades have been unsuccessful. There is inadequate space for alternative activities or programs. The lack of space, places additional pressure on SECU clients and the need for security assistance. There is no longer a sensory room available.

There is a lack of qualified occupational therapists to provide meaningful programs across most of the units and nursing staff are often filling these positions.

Both Nhill and Stawell have had trouble filling vacancies for their six funded psychogeriatric beds, resulting in very few clients over the last decade. Stawell beds are always empty, Nhill numbers have significantly dropped this year and Ballarat Health says these beds have not been required. Community Visitors think that a range of complex factors contribute to the underutilisation of these psychogeriatric beds, including their location. This is particularly the case with the Stawell beds as they would be much more likely to be fully occupied if they were located in Horsham.

## Service provider responsiveness

Regular quarterly meetings with hospital management give Community Visitors the opportunity to discuss outstanding issues and raise queries or concerns. These meetings are informative and Community Visitors are fully supported.

## Western Metropolitan Melbourne area

Western Metropolitan Melbourne consists of North Western Mental Health Service (NWMH), Inner West Area Mental Health Service, Mid-West Area Mental Health Service, Orygen Youth Health, Mercy Health Services and the Royal Children's Hospital mental health services.

These services consist of eight adult acute inpatient units (including the first women-only adult acute unit in Victoria), two aged acute inpatient units, one aged residential unit, one adult rehabilitation unit, four CCUs, one eating disorders, one neuropsychiatric unit, one mother and baby unit, two adolescent acute units, four PARCs and three emergency departments.

## Serious Incidents, assaults and safety

One resident was physically assaulted by another resident. An ambulance was called and police notified. By the time Community Visitors visited, the resident who committed the assault had been discharged from the facility. There was good follow-up by staff to support the resident who had been assaulted.

There was an alleged sexual assault at a PARC involving two male clients. The police were involved and the client later retracted his allegation.

Installation of CCTV at the CCU has enhanced security, however, residents have reported discarded syringes on site which left them feeling unsafe. While these concerns have been raised at OHS meetings, and meetings among staff, there seems to be little they can do given the location of the facility.

One PARC incident log showed no incidents reported for six months. This was confirmed by the team leader.

In one incident, a male consumer was quickly and efficiently transferred to the emergency department after being identified as a suicide risk.

A consumer indicated to staff that they would attempt serious self-harm and, some days later, tried to do so by using their nasogastric tube. The consumer again attempted self-harm a month later and was subsequently transferred to an acute ward.

A CCU consumer insisted on sleeping in their car as they were afraid they may kill their roommate. After the treatment team discussed various alternative sleeping arrangements, the consumer made an informed choice to sleep in their car which was deemed to be a reasonably safe option.

At the mother and baby unit, a laundry door with signage reading 'Keep locked at all times' has often been left unlocked or open. Community Visitors reported four times in six months that the doors were unlocked, allowing consumer access to potentially toxic chemicals. Management says they are working to ensure this does not happen in future.

## Treatment and care

Most consumers are happy with their treatment. Prolonged waiting times to see treating psychiatrists and other specialists, and the lack of firm future appointments is a cause of concern. Common concerns from consumers were difficulty in understanding their treatment plan, or feeling that no one has explained it to them.

Community Visitors noticed a consumer in a dilapidated wheelchair in the car park next to a facility with very long and dirty toenails. This consumer chose not to wear shoes and was resistant to staff efforts to attend podiatry appointments. Feedback from the service provider indicated they were waiting on delivery of a hired wheelchair for the client and had been successful in the client being attended to by a podiatrist.

Staff told Community Visitors that a consumer from a CCU, who had been moved to another facility due to an aggressive incident, would be more suitably placed at a rehabilitation facility. However, due to budget constraints there were no beds available at this facility.

A psychologist has now commenced in the mother and baby unit, three days a week. On every visit, this unit was reported as being warm, quiet and comfortable with many positive reports from consumers regarding the treatment received and the professionalism of staff.

The Werribee women-only inpatient unit, which opened this year, is a great credit to the Mercy Health staff. Community Visitors often receive positive feedback

from service users of this first women-only unit in Victoria. Most importantly, the women feel safe.

## Legal rights and information provision

Medication errors make up a large percentage of the incident summaries that Community Visitors have received from various facilities.

An analysis of the monthly incident report summaries reveals that there are 30 per cent more medication errors than there are assaults. Some clients had been given other client's medication, an incorrect dosage, or their medication had not been administered. There were also incidents of medications incorrectly or wrongly prescribed on charts by doctors. In one instance, repeated errors were made by one staff member.

Several facilities are now submitting monthly summaries of all incidents. This works well as Community Visitors are able to view the incident reports and then ask to see full reports of more serious incidents. This saves time for both parties and enables Community Visitors to better perform their role.

Following on from last year's annual report, accessing incident reports at the Royal Children's Hospital Banksia Ward remains challenging. This has resulted in ongoing communication with unit managers, senior management, and the Chief Psychiatrist. Community Visitors often have to wait for around twenty minutes or more and requests of full incident reports are not always actioned; often senior nursing staff have to explain the summarised incidents to the Community Visitor which is time consuming for all involved.

Senior management advised staff that copies of incident reports are not to be given to Community Visitors under any circumstances.

## Facility management

Management at Broadmeadows CCU action maintenance issues raised by Community Visitors promptly, and the facility is always tidy and welcoming.

Community Visitors have reported on lack of appropriate window furnishings in the bedrooms in the John Cade unit at the Royal Melbourne Hospital for many months. These are now being replaced with double-glazed windows fitted with an internal venetian blind. This will give privacy, remove the availability of any ligature points (curtain tracks) and reduce the maintenance involved with previous curtain furnishings.

In one CCU, the lack of maintenance of the outside of the units, including door bells and screen doors, has been an ongoing issue.

Homeless consumers are having to be kept in one emergency department longer than usual as staff cannot source appropriate discharge accommodation.

The sub-division of the unit into (the now) four separate units is working well. The recently established women-only adult acute unit does not suffer the problems associated with the male client overflow when there are no beds available on the male corridor.

The Werribee mother and baby unit urgently requires new carpet. Some mothers have expressed concerns to Community Visitors about the state of the carpets. One mother refused to let her baby crawl on the floors as "they are too old and dirty" for her child to be playing and crawling on. Staff report the carpet is around 15 years old but is cleaned regularly. All bedroom mattresses have been recently replaced.

The female-only corridor at the Ursula Frayne Centre often has males in its beds. Staff and managers have told Community Visitors there is constant pressure to fill the beds regardless of gender. Staff report undertaking extensive risk assessments before placing male persons within the female corridor.

## Activities and programs

Community Visitors report positive feedback from residents at the CCUs and PARCs in this region including feeling supported by staff, feeling safe, enjoying activities such as cooking and cleaning duties, gym, leisure and movie nights and feeling confident when leaving the facility.

In the Royal Melbourne Hospital Eating Disorders Unit there is a lack of activities. Resources are reportedly stretched, with art therapy students sought to assist in the unit.

Burnside PARC mid-west units are managed by different providers and there are reports from residents to Community Visitors about a lack of activities in Unit D compared to Unit B.

## NDIS

Finding suitable affordable accommodation for consumers leaving mental health services has been a challenge for many years.

Some services report longer waiting lists and discharge delays since the introduction of the NDIS, saying community mental health providers sometimes advocate for consumers to remain in mental health units until they can be approved for an NDIS package. The planning and approval process can take months. This results in a bed-flow issue from CCUs and PARCs that can then affect bed pressures in acute units.



# Community Visitors

## 2017-2018

Marta Acton  
Daniel Adamson  
Deanne Ades  
Ian Alexander  
David Allen  
Jo Allen  
David Anderson  
Arthur Apostolopoulos  
Beth Atkins  
Karina Au  
Kim Baker  
Joyce Ball  
Wendy Baneth  
Rati Banga  
Christine Barbuto  
Nicole Barden  
Jan Barker  
Judith Barlee  
Andrew Baugh  
Suzanne Beaton RC  
Cheryl Beatson  
John Beggs  
Efi Bellchambers  
Judith Bink  
Rose Blustein RC  
Marion Blythman RC  
Dominic Boland  
Sally Bolton  
Walinda Bonne  
Michael Boucher  
John Bowen  
Andrew Boyles  
Kathleen Bragge RC  
Rebekah Braxton  
Sheena Broughton RC  
Jennifer Broughton RC  
Geoff Brown  
Cheryl Brunton  
Lorraine Bryant  
Ian Buckles RC  
Ronald Butler RC  
Aaron Caddy  
Kevin Campbell  
Lyn Campbell  
Heather Campbell  
Eve Caplan  
Ken Castanelli  
Joan Castledine  
Julie Cesal  
Chris Chapman  
Patricia Cheary  
John Chesterman

Shri Chitale  
Pamela Clarke  
Tania Cleary  
Adison Cognian  
Jo Cohen  
Peta Collett  
Terry Collison  
Kim Conder  
Sandra Cooper RC  
Carmelo Corrente  
Jeanette Coulter  
Adele Coutts  
Erin Cowley  
Vicki Cowling OAM  
Bryan Crebbin  
Fiona Cromarty RC  
Patricia Cross RC  
Graeme Crutchfield  
John Cull  
Jeff Cummins  
Robyn Cunningham RC  
Peter Dalgleish  
Doreen Dalrymple RC  
William Daly  
Rose Daniels  
Linda Dare  
Wendy Davies  
Pat Davison  
Meryl Dawson  
Stephanie De Pasquale  
Susan Dedes Bonneau RC  
Tracey Denby  
Bev Devidas RC  
L'Shae Dib  
Graham Dickinson RC  
Christine Dimer  
Kerrie Dobrzynski  
Diane Doherty RC  
Diana Donohue RC  
Robert Drayton  
Blake Drever  
Jan Dunbar RC  
Ian Dunn  
Jennifer Dunn  
John Dunn RC  
Mick Dwyer  
Megan Edwards  
Christine Elliott  
Pam Evans  
Eveline Fallshaw  
Mary Farbrother  
Gillian Fawcett

Jennifer Fenwick  
David Ferguson RC  
Roger Findlay  
Trudy Firth  
Callum Fitzgerald  
Max Fletcher RC  
Maureen Fontana RC  
Debbie Fowler  
Paulette Fraser  
Kym Fraser  
Ian Freeman  
Judith Freidin  
Anne Freudenberger Kay  
Dale Furey  
Sandra George  
Dylan George  
Louisa Gibson  
Pamela Giles  
John Gleeson  
Daysie Goldenberg  
Karyn Golumbeck  
Cheryl Gould  
Audrey Grace  
Jillian Graf  
Ruth Graham  
Eddie Graham  
Brian Granrott  
Avril Green  
Kay Gregory  
Alison Gribble  
Alan Grigson  
Gerard Grogan  
Henry Grossbard  
Susanne Grosser  
Alan Gruner RC  
Suzanne Gubby  
Wendy Guy  
Frances Haberle  
Michael Hadley RC  
Ghassan Haidar  
Linda Haller RC  
Sam Haouchar  
Susan Harraway RC  
Lynette Harris  
Rowena Hart  
Lynette Hayes  
Barbara Hayes  
Carol Haynes RC  
Coral Heazlewood  
Lyn Hedger  
Veronica Henriquez  
Jennifer Henry

Clifford Heri  
Judy Heron RC  
Anne Hickerton  
Robyn Hickey  
Bill Hickey RC  
Glenys Hill  
Colin Hinckson  
Jennifer Hocking  
Wendy Holland  
Margot Holscher  
Mary Howlett  
Nan Hu  
Natasha Hunt  
Carolyn Hutchens RC  
Giordana Ienco  
Paul Iles  
Kim Inglis  
Chris Ingram RC  
Dallas Isaacs  
Felicity Jack  
Beverley Jacob  
Thomas Jambrich  
Rebekah Jardine  
Robert Jeferee  
Ray Johnson  
Val Johnson  
Lyn Johnson  
Prue Jolley  
Heather Jones RC  
Barry Jones  
Lynda Judkins  
Don Juniper  
Ivan Jurisic  
Peter Kadar  
Anthea Katsaros  
Karamjeet Kaur  
Carrie-Anne Keath  
Jenny Kerr  
Liam Kershaw-Ryan  
Sarah Khor  
Brian Kiley  
Debbie King  
Lisa Kirton  
Sandra Knorpp  
Sean Koerner  
Alan Kohn  
Sashank Krishnamoorthy  
Shiv Kumar  
Amanda Kunkler  
Justyna Kurzak  
Tineke Lagerwey  
Loi Lam

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 Debbie Lenon-McCartney  
 Mark Lewis  
 Beverley Libbis  
 Margaret Lippold  
 Vashti Lloyd  
 Debra Lobb  
 Louise Long  
 Roger Lount  
 Jennifer Lush  
 Desma MacDonald  
 Brian MacIntosh RC  
 Virginia Mack  
 Paul Mackaness  
 Colleen Macqueen  
 Umberine Madan  
 Carole Maher  
 Kaye Manners  
 Jessica Marie  
 Rohan Marlow  
 Annette Marrington  
 Jenny Marshall  
 Sandra Martin RC  
 Jenny Martin  
 Cindy Masterson RC  
 Thomas Mathew  
 Beth Matthews  
 Julian Maugey  
 Finn McAsey  
 Ian McBeath  
 Maura McCabe  
 Debra McCann  
 James McCarthy  
 Kaye McClure-Leckie  
 Carole McElvaney  
 Pat McGennissen  
 Irene McGrath  
 Deborah McLachlan RC  
 Heather McLeish  
 Brenda McMinn RC  
 Romy McNally  
 Louise McPhee RC  
 Hilary McVey  
 Jan Meikeljohn

Laurie Messenger  
 Neil Michael  
 Alex Miller  
 Sonia Miller-Randle  
 Frank Miragliotta  
 David Morrison  
 Marj Munro RC  
 Aneeka Munshey  
 Gerald Mutubuki  
 Sewwandi Navarathna  
 Danielle Neal  
 Rodna Nedanoska  
 Andrew Needham  
 Paul Newman  
 Craig Ng RC  
 Connie Ngu  
 Edwina Nutt  
 Sue O'Brien  
 Judy O'Brien  
 Kim O'Donoghue  
 Andrea O'Keefe  
 Joanne Page  
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 Christian Papadopoulos  
 Gloria Parker  
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 Wendy Patchett  
 James Paterson RC  
 Judith Pauwels  
 Cheryl Paxton  
 Simon Payne  
 Betty Pearce  
 Loes Pearson, JP  
 Peter Penry-Williams  
 Georgia Persson  
 Clare Peschel  
 Stephen Peterson  
 Wendy Pfeifer  
 Lyn Phelan  
 Elisheva Picker  
 Sally Polack  
 Maryann Pope  
 Nancy Price  
 Dame Price  
 Elyce Pugh  
 Margaret Purves  
 Anna Raicevic  
 Helen Rawicki  
 June Rea RC  
 Keren Reeve  
 Pam Remington-Lane  
 Edith Retemeyer

Sue Rewell RC  
 Maureen Rhodes RC  
 Fay Richards RC  
 Dawn Richardson  
 Kiera Riley  
 Julie Ritchie  
 Janis Ritchie  
 Dany Roberts  
 Sebastian Roberts  
 David Roche  
 Vivienne Roche  
 Mick Rosier  
 Ainsley Rozario  
 Linda Rubinstein  
 Bill Scott  
 Kyrstie Sebastian  
 Diane Seren  
 Debra Sevastianov RC  
 Nimit Shah  
 Gayathri Shastri  
 Rosemary Shaw OAM  
 Yvonne Sherlock  
 Puvana Sivakumar  
 Jenni Smith  
 Rebekah Smith  
 Mary Smith  
 Tanya Smith  
 Joanne Smout  
 June Soutar  
 Glenn Staunton  
 Nola Stavely  
 Ray Steadman RC  
 Margaret Stevenson RC  
 Graham Stickland RC  
 Susan Strohfeldt  
 Bernadette Sullivan  
 Sheryl Summons  
 Bill Swannie  
 Robert Swiger  
 Anne Tait RC  
 Suzanne Tatchell  
 Tanjila Tayeb  
 Deborah Taylor  
 Rachel Taylor  
 Kathryn Thomas  
 Mark Thompson  
 Graham Thornton  
 Rosslyn Thurrowgood RC  
 Cherie Titman  
 Rosemary Tomkins  
 Patricia Tot  
 Betty Traying

John Trevillyan  
 Helen Tribe  
 Julie Trompf  
 Merrill Tunstall  
 Gary Turner  
 Jordan Turner  
 Diane Tymms  
 Gail Upton  
 Malcolm Urquhart  
 Helen Vallance  
 Luke Van Den Dikkenberg  
 Antonia Veneracion  
 Alexa Viani  
 Robin Vote RC  
 Lyn Wallace-Clancy RC  
 Sebastian Waluk  
 Elizabeth Warren  
 Betty Waters  
 Anita Watt  
 Melinda Watt  
 Wendy Wereta  
 Carolyn Whillance  
 Susan Whitehead  
 Liz Whyte  
 Suzanne Wilcox  
 Dianne Wilde  
 Carole Williams  
 John Williams  
 Lauren Williams  
 Johanna Willoughby  
 Linda Wilson  
 Scott Wilson  
 Elaine Wilson  
 Graham Stickland RC  
 Columbia Winterton  
 Tricia Woodcock  
 Rhonda Woodrow  
 Ted Woollan  
 Trudy Wyse  
 Ying Yew  
 Noel Younger  
 Susan Zammit  
 Ignatius Zanetidis  
 Allison Zylberberg

# Facilities eligible to be visited by Community Visitors 2017–2018

## Mental Health Providers

Albury Wodonga Health  
Alfred Health  
Austin Health  
Ballarat Health Services  
Barwon Health  
Bendigo Health  
breakthru  
cohealth  
Eastern Health  
Ermha Ltd.  
Forensicare  
Goulburn Valley Health  
Latrobe Regional Hospital  
Life Without Barriers  
Lyndoch Living  
Melbourne Health  
Mercy Health  
Mind Australia Limited  
Monash Health  
Neami National  
NorthWestern Mental Health  
Peninsula Health  
Ramsay Health Care  
Royal Children's Hospital  
South West Health Care  
St Vincent's Hospital Melbourne  
Stawell Regional Health  
Wellways Australia Limited  
West Wimmera Health Service

Western District Health Service  
within Australia

## Supported Residential Services

Aaron Lodge  
Absalom  
Acacia Gardens  
Acacia Place  
Achmore Lodge  
Acland Grange  
Adare Supported Residential Care  
Airlie (Closed May 2018)  
Alexandra Gardens  
Allbright Manor  
Alma House  
Angus Martin House  
Arnica Lodge  
Balmoral  
Bamfield Lodge  
Belair Gardens  
Bella Chara  
Belmont Manor  
Berwick House  
Bignold Park  
Blue Willows Residential Aged Care  
Brooklea Lodge  
Brooklyn House  
Browen Lee Home – Ballarat  
Browen Lee Lodge – Brown Hill  
Brunswick Lodge

Burwood Lodge  
Camberwell Manor  
Caulfield House  
Caulfield Manor  
Chatsworth Terrace  
Chesterfield  
Chippendale Lodge  
Coorondo Home  
Corandirk House  
Covenant House  
Cranhaven Lodge  
Crofton House  
Crosbie Lodge  
Crystal Manor  
Darebin Lodge  
Doncaster Manor  
Dorset Lodge  
Dunelm  
Eagle Manor  
Edwards Lodge  
Elgar Home  
Eliza Lodge  
Eliza Park  
Eltham Villa  
Fermont Lodge  
Ferntree Gardens  
Ferntree Manor  
Finchley Court  
Footscray House  
Galilee  
Glenhuntly Terrace

Glenville Lodge  
Glenwood Assisted Living  
Golden Gate Lodge  
Gracedale Lodge  
Gracevale Grange  
Gracevale Lodge  
Grand Villa Mentone  
Grandel  
Greenhaven  
Greenslopes  
Hamble Court  
Hambleton House  
Hampton House  
Harrier Manor  
Hawthorn Grange  
Hawthorns Victoria Gardens  
Hazelwood Boronia  
Heathmont Lodge  
Hillview Lodge  
Hollydale Lodge  
Homebush Hall  
Iris Grange  
Iris Manor  
Jasmine Lodge  
Kallara Residential Care  
Karinya  
Kilara House  
Kooralbyn Retirement Lodge  
Kyneton Lodge  
L'abri  
Landora Care

Lilydale Lodge  
Manalin House  
Maroondah House  
Mayfair Lodge  
Meadowbrook  
Melton Willows  
Merriwa Grove  
Mont Albert Manor  
Mornington House  
Mt. Alexander  
Mulvra Aged Care  
Mulvra Place  
Northern Terrace  
Oakern Lodge  
Parkland Close  
Pineview Residential Care  
Princes Park Lodge  
Queens Lodge  
Raynes Park Court  
Reservoir Lodge  
Rosewood Downs  
Rosewood Gardens  
Royal Avenue  
Sandy Lodge  
Seaview House Residential Care  
Southcare Lodge  
St James Terrace  
Stewart Lodge  
Strabane Gardens  
Sunnyhurst Gardens

Surfcoast Supported Accommodation  
Sydenham Grace  
Themar Heights  
Trentleigh Lodge  
Vermont Gardens  
Viewmont Terrace  
Warranvale Gardens  
Wattle-Brae  
Waverley Hill  
Westley Garden  
Whitehaven  
Woodford Gables (Closed May 2018)

### Disability Services Providers

Ability Assist  
Able Australia  
Accommodation and Care Solutions  
AGAPI Care Inc.  
Alkira Centre – Box Hill Inc.  
Amicus  
Annecto Inc.  
Araluen  
Asteria Services Inc.  
Australian Community Support Organisation (ACSO) Ltd.  
Australian Home Care Services  
Autism Plus  
Autism Spectrum Australia (Aspect)  
Bayley House  
CareChoice  
Carinya Society

Colac Otway Disability Accommodation Inc.	STAY Residential Services Association Inc.
Community Living & Respite Services Inc.	Sunraysia Residential Services Inc.
ConnectGV	The ONCALL Group
Cooinda Terang Inc.	The Tipping Foundation
Department of Health and Human Services	Trio Support Services
DPV Health Ltd.	Uniting (Victoria & Tasmania) Limited
Encompass Community Services	Victorian Deaf Society (Vicdeaf)
Epworth HealthCare	Villa Maria Catholic Homes (VMCH)
Ermha Ltd.	Wallara Australia Ltd.
focus Individualised Support Services	We Are Vivid
Gateways Support Services	Woodbine Inc.
Gellibrand Support Services	Yooralla
genU	
Golden City Support Services Inc.	
Healthscope Limited	
IDV Inc.	
Independence Australia	
Jesuit Social Services Limited	
Jewish Care (Victoria) Inc.	
Just Better Care	
Kirinari Community Services	
Kyeema Support Services Inc.	
Life Without Barriers	
MacKillop Family Services	
Mallee Family Care Inc.	
Mansfield Autism Statewide Services	
McCallum Disability Services Inc.	
Melba Support Services Inc.	
Melbourne City Mission	
Merriwa Industries	
Mind Australia Limited	
Mirridong Services Inc.	
MOIRA Inc.	
Monkami Centre Inc.	
Multiple Sclerosis Limited	
Nadrasca	
Nepean Centre Inc.	
Northern Support Services	
Noweyung Ltd.	
OC Connections	
OzChild	
Providing All Living Supports (PALS) Inc.	
Scope (Vic) Ltd.	
Southern Way Direct Care Service Inc.	
St John of God Accord	
Statewide Autistic Services Inc. (SASI)	

# Acronyms

<b>AAU</b> Adult Acute Unit	<b>MHRB</b> Mental Health Review Board
<b>ABI</b> Acquired Brain Injury	<b>NAMHS</b> Northern Area Mental Health Service
<b>ACSO</b> Australian Community Support Organisation	<b>NDIA</b> National Disability Insurance Agency
<b>BD</b> Brain Disorder	<b>NDIS</b> National Disability Insurance Scheme
<b>BSP</b> Behaviour Support Plan	<b>NPU</b> Northern Psychiatric Unit
<b>CAG</b> Consumer Advisory Group	<b>NUM</b> Nurse Unit Manager
<b>CALD</b> Culturally and Linguistically Diverse	<b>NWMHS</b> North Western Mental Health Service
<b>CAT</b> Crisis Assessment and Treatment	<b>OCP</b> Office of the Chief Psychiatrist
<b>CCU</b> Community Care Unit	<b>OPA</b> Office of the Public Advocate
<b>CDDHV</b> Centre for Development Disability Health Victoria	<b>OPP</b> Office of Professional Practice
<b>CHAPS</b> Comprehensive Health Assessment Plans	<b>PACER</b> Police Ambulance Crisis and Emergency Response
<b>CPAP</b> Continuous Positive Airways Pressure	<b>PAPU</b> Psychiatric and Assessment Planning Unit
<b>CRF</b> Community Rehabilitation Facility	<b>PARC</b> Prevention and Recovery Care
<b>CRP</b> Community Recovery Program	<b>PCP</b> Person-Centred Plan
<b>CSO</b> Community Service Organisation	<b>PDRSS</b> Psychiatric Disability Rehabilitation Support Services
<b>DAS</b> Disability Accommodation Service	<b>PEG</b> Percutaneous Endoscopic Gastrostomy
<b>DCS</b> Disability Client Services	<b>PRN</b> Pro Re Nata (medication provided as needed)
<b>DFATS</b> Disability and Forensic Assessment and Treatment Service	<b>PRS</b> Plenty Residential Services
<b>DDSO</b> Disability Development and Support Officer	<b>RMH</b> Royal Melbourne Hospital
<b>DHHS</b> Department of Health and Human Services	<b>SAVI</b> Supporting Accommodation for Vulnerable Victorians Initiative
<b>DSC</b> Disability Services Commissioner	<b>SECU</b> Secure Extended Care Unit
<b>DSR</b> Disability Support Register	<b>SOCIT</b> Sexual Offences and Child Abuse Investigation Team
<b>DWES</b> Disability Worker Exclusion Scheme	<b>SRS</b> Supported Residential Services
<b>ECT</b> Electroconvulsive Therapy	<b>STO</b> Supervised Treatment Order
<b>ECU</b> Extended Care Unit	<b>TEH</b> Thomas Embling Hospital
<b>ED</b> Emergency Department	<b>TSU</b> Transition Support Unit
<b>GP</b> General Practitioner	<b>VCAT</b> Victorian Civil and Administrative Tribunal
<b>HCA</b> Housing Choices Australia	<b>VDDS</b> Victorian Dual Disability Service
<b>HDU</b> High Dependency Unit	<b>VEOHRC</b> Victorian Equal Opportunity and Human Rights Commission
<b>IGUANA</b> Interagency Guideline for Addressing Violence, Neglect and Abuse	<b>VIHMS</b> Victorian Incident Health Management System
<b>IHBOS</b> Intensive Home-based Outreach	<b>VSA</b> Victims Support Agency
<b>ISP</b> Individual Support Package	<b>VSDP</b> Victorian State Disability Plan
<b>LGA</b> Local Government Area	<b>YPARC</b> Youth Prevention and Recovery Care
<b>MACNI</b> Multiple and Complex Needs Initiative	



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