

PART A: Executive Summary

1. INTRODUCTION

This executive summary contains an overview of the Lachlan Inquiry 1998, including a summary of the findings of the performance audit of the Lachlan Centre conducted in November 1997, as well as an assessment of progress made since the Community Services Commission's Lachlan investigation into the Use of Exclusionary Time-Out and other related matters at Lachlan Residential Centre, completed in 1995. It also includes conclusions and recommendations.

It was seen as important to revisit the Lachlan Centre two years after the 1995 investigation to determine how both the Ageing and Disability Department (ADD) and the Department of Community Services (DoCS) had performed with implementing the recommendations and to see if life for the residents of the Lachlan Centre had improved substantially.

The commission was acutely aware that the attention and media coverage received by the Lachlan Centre following the investigation was regarded as having a negative impact on the service's reputation and staff morale. Considerable efforts were made by the commission to make public, in our Can Do newsletter, in the media and in our correspondence to the Minister and the Director-General, reports we received of positive progress at the Centre following that investigation report. The Commissioner also visited the Centre on two occasions.

We were aware that "revisiting" the investigation in the course of this inquiry was likely to elicit a strong reaction and cause some anxiety. Nevertheless, we took the view that, as devolution of Lachlan (as recommended by the investigation) has not happened and does not appear to be imminent, it was in the interests of residents, the disability sector and the broader community that we assess the overall standard of care and progress made. As well, many of the recommendations arising from the 1995 investigation were aimed at improving the service system overall and not just Lachlan. As such, this inquiry presents a "snapshot" of how much the system has changed since 1995.

While staff and management of Lachlan have found the process difficult and have commented on the additional work it has created, they have worked cooperatively with the commission and committed considerable staff time

and effort to the process. We acknowledge their concerns and will use this feedback to review our own practice. We note however that DoCS' response to the preliminary report has not led to substantial changes to the inquiry's findings. The department's response also indicated that strategies are being implemented to rectify some of the problems uncovered.

2. BACKGROUND TO THE INQUIRY

2.1 The Lachlan investigation

In June 1995, the commission concluded an investigation in response to complaints about the standard of care provided to two residents at the Lachlan Centre. The findings and twenty-nine recommendations made as a result of this investigation were published in the Lachlan Report in October 1995. (A summary of the recommendations is contained in Appendix I).

The complaints concerned the circumstances of two individuals and included allegations about the use of "exclusionary time-out",¹ lack of consultation by the service with the Guardianship Tribunal, guardians and parents, and the general manner in which services were provided.

The findings of the investigation raised issues about:

- the lack of departmental policies on supporting people with challenging behaviour;
- models of service delivery which were inadequate for the needs of people with challenging behaviour;
- poor management systems incapable of identifying system breakdowns; and
- a variety of staffing issues.

Some of the report's recommendations were directed at improving the circumstances of those residents who were the subject of the complaints and other residents in similar circumstances. Others were for the immediate closure of the Lachlan Centre's Crisis Care Unit (CCU), where exclusionary time-out was being used, and for the planned devolution of the service as a whole. A number were directed at improving service provision and the standard of care for residents (within large residential services in NSW, not

¹ Exclusionary time-out (sometimes referred to as seclusion) is a form of solitary confinement of an individual. It is a widely discredited and usually unlawful practice which involves placing a person (often by the use of physical force) in a room where they are confined, by being locked in, or prevented from leaving by physically blocking the doorway or by the use of threats or intimidation.

just at the Lachlan Centre) through the development of appropriate policies and procedures, improved management systems, and monitoring and review mechanisms. The recommendations also addressed staffing issues including: training; relationships between different professionals in the residential setting; staff establishments; and staff to resident ratios.

Thus, while the focus of the investigation had been on the Lachlan Centre, the findings had broad applicability and the majority of recommendations were directed at those with responsibilities over and above the Lachlan Centre, namely DoCS and ADD.

Over the last two years the commission has been monitoring the implementation of the recommendations through progress reports from DoCS and ADD.² This has been supplemented with relevant information from our complaint, review, Community Visitor and monitoring functions.³ It was seen as timely to incorporate into this inquiry an assessment of overall progress since the 1995 investigation.

2.2 The performance audit of large residential centres

Following the release of the Lachlan Report, the Hon. Ron Dyer MLC, the then Minister for Community Services, Minister for Ageing and Minister for Disability Services, requested in October 1995 that an audit of other large residential centres in NSW be conducted to establish whether similar practices found in the Lachlan investigation were occurring elsewhere. The audit was undertaken jointly by the Community Services Commission and the Audit Office of NSW to determine if the human and legal rights, safety and dignity of people with an intellectual disability were protected in these settings.⁴

The report of the audit concluded that practices in both government and non-government centres fail to protect residents in this regard. It identified factors contributing to this situation as: the absence of minimum criteria for the protection of residents' human and legal rights, safety and dignity; inadequate policies to direct service delivery; the absence of staff training to

² The commission received three progress reports from DoCS dated December 1995, April 1996 and September 1996, and two progress reports from ADD dated 23 November 1995 and 14 July 1997. The commission was also represented on the ADD Behaviour Intervention and Support Working Group established in response to the Lachlan investigation, which met throughout 1996.

³ There are two appointed Community Visitors at the Lachlan Centre who each visit on average twice a month. One was on leave for six months between July 1997 and January 1998.

⁴ The results of this audit can be found in the report "Performance Audit Report: Large Residential Centres for People with a Disability in New South Wales" June 1997.

reinforce practices; low levels of supervision; and the absence of effective monitoring systems.

The Lachlan Centre was **not** one of the 10 large residential centres selected for the performance audit as it was felt that it was not timely to subject it to further scrutiny. However, DoCS agreed that it would be useful to do an audit of Lachlan at a later date, when improvements to service provision might be further progressed.

2.3 The Lachlan Centre performance audit

The Lachlan Centre audit was a means of further assessing the outcomes of the Lachlan investigation some two years on and reviewing the general standard of care for residents. It was commenced in October 1997. The Terms of Reference for the audit are contained in Appendix II.

The audit team consisted of three staff of the Community Services Commission, with a range of experience in service management and review, direct care, legal and social advocacy, policy development and education in the disability field.⁵ The team leader was involved in the development of the performance audit methodology with the Audit Office of NSW and was a member of the team which audited 10 large residential services in 1996 and 1997. The Lachlan Centre audit was undertaken in accordance with the methodology and procedures set out in the "Methodology for the Review of Residential Services for People with Disabilities".⁶ This manual has also more recently been used by DoCS to inform its peer review process.

Parallel to the audit we also commenced individual reviews of three residents at the Lachlan Centre. Two of these were the subject of the original complaints in the 1995 investigation and the third was a resident about whom we had received allegations concerning her well-being and the standard of her care.⁷ While they are the subject of separate reports, information from the reviews, where it concerns systems and service delivery issues, has informed the audit findings.

2.4 Opportunity for comment on findings

⁵ The team comprised of Senior Review Officer Edwina Pickering (BSW), Senior Projects Officer Matthew Keeley (LLB) and Disability Policy and Liaison Officer Jenny Klause (BA, Grad. Dip Adult Ed.) who was the team leader.

⁶ Developed by the Audit Office of NSW in conjunction with the Community Services Commission and in consultation with DoCS and ADD.

⁷ The commission chose to review this resident's circumstances rather than take the matter as a complaint, because it was seen as important to focus on her immediate needs, well-being and options for the future.

A preliminary inquiry report was distributed to those parties affected by, or with an immediate interest in, its findings in April 1998. This included the Minister for Community Services, Minister for Disability Services, Minister for Ageing and Minister for Women, The Hon. Faye Lo Po' MP, the Director of Nursing (DON) at the Lachlan Centre, senior management within DoCS and ADD, the NSW Council for Intellectual Disability, the Disability Council of NSW, the Office of the Public Guardian (OPG) and the two Community Visitors allocated to the Lachlan Centre. Comments were sought on its accuracy. We were also interested in suggestions to address identified weaknesses and build on positive developments already underway.

We received responses from all parties to whom the preliminary report was provided (including two from parents of consumers who received a copy from the Lachlan Centre), with the exception of the Minister. (Copies of the written responses are at Appendix III). Where necessary, additional information was sought to clarify or update particular issues.

The Commissioner and commission staff met with Lachlan Centre management and staff and other relevant DoCS managers to discuss the preliminary findings in May 1998.

We have considered all responses and comments made in finalising this report. Where appropriate, we have included additional information or amended our findings.

3. OVERVIEW OF PROGRESS WITH IMPLEMENTING THE 1995 LACHLAN INVESTIGATION RECOMMENDATIONS

3.1 Method used

Following the on-site component of the audit in November 1997, DoCS and ADD were requested to provide the commission with up to date information on progress and outcomes against the recommendations of the 1995 Lachlan investigation and to include supporting evidence. Additional information was provided following the release of the preliminary report.

In assessing progress, we categorised the information according to its source and the degree of evidence provided. The commission also developed a scoring system based on that developed by DoCS for services to assess

themselves against baseline criteria.⁸ This enabled a rating of progress with implementing the recommendations on a 4 point scale from “no action” to “fully implemented”. Details of the relevant recommendation, the organisation responsible, progress made, the source of this information, evidence provided and an overall score are at Appendix IV. An overview and analysis of this follows.

3.2 Progress with recommendations relating to ADD

ADD has provided information indicating that all recommendations for which it has responsibility have had some degree of implementation.

Most progress has been made by ADD on recommendations relating to the development of a centralised policy on the use of exclusionary time-out and support for people with challenging behaviour (recommendations 1-4 and 19). These have largely been met through the development and distribution of the “Positive Approaches to the Management of Challenging Behaviour” policy (June 1997). The policy contains requirements recommended by the Lachlan investigation and appears comprehensive and clear. A review date for the policy is set for the end of 1998.

ADD’s role in monitoring implementation of the policy to ensure compliance (recommendation 7) appears to be evolving. ADD has reported that services’ adherence to policy requirements will be promoted and monitored through:

- the distribution of the Standards in Action Manual which sets out minimum and enhanced practice requirements across the Disability Service Standards;
- the development of the “Good Practice Guide in Large Residential Services” manual (yet to be distributed) which will provide guidance to residential centres to “conform as closely as possible” and improve service delivery in the absence of transition funding, and which will be used by Service Support and Development Officers (SSDOs) for monitoring purposes;
- monitoring of non-government organisations by 45 SSDOs who will visit, on a scheduled basis, between 40-60 services each over a 12 month period. As well, ADD’s Service Review and Support Project focuses on services where there are identified issues of concern. Here, action plans are

⁸ “Baseline criteria for ensuring a basic level of care for residents’ safety and protection from abuse in large residential services” is a checklist which was developed as a result of the “Performance Audit Report of Large Residential Centres for People with a Disability in NSW” in 1997. The purpose of the criteria is to provide the minimum requirements for services to adopt which at least ensure residents’ basic human and legal rights, as well as safety and dignity are protected.

- developed and monitoring undertaken by SSDOs. These monitoring mechanisms are still being developed and do not apply to DoCS services;
- monitoring of DoCS services by Senior Clinical Practitioners, who are employed by DoCS in each area (with one additional position each for the two largest residential services) to provide clinical and program support, supervision and monitoring. ADD reports that the role of Senior Clinical Practitioners incorporates a focus on behaviour management and that these positions will report to ADD on practice issues, enabling ADD to fulfil its monitoring role for DoCS services, although such arrangements are not yet in place;
 - annual self assessments by services which incorporate feedback from family members and others and which DoCS services, as well as non-government organisations, must undertake. For non-government organisations, this leads to the development of the deed of funding agreement and performance agreement or transition plan, against which monitoring by SSDOs is undertaken. For DoCS services, ADD undertakes a desk audit of self assessments and provides feedback to DoCS central office.

According to ADD such mechanisms ensure a broad approach to quality improvement and a focus on all aspects of a consumer's life, not just the management of challenging behaviour.

ADD's emphasis on continuous improvement, the introduction of a self assessment process linked to funding and performance agreements, and a more formalised role for SSDOs are positive developments. So are the "Standards in Action" and the "Good Practice in Large Residential Services" manuals which should make it clearer to services what is expected of them.

However, there are still some concerns. ADD has acknowledged that the role of SSDOs to support as well as monitor services creates some tensions. This, coupled with the number of services that SSDOs must visit, raises questions about how comprehensive their monitoring role will be. It has also taken some time for ADD to finalise how SSDOs will work and what monitoring tools they will use so that results by which to judge effectiveness are not yet apparent.

It is concerning that monitoring of DoCS services will, reportedly, rely on information provided by Senior Clinical Practitioners. As DoCS employees, they will not be able to provide independent scrutiny. As well, such reporting/monitoring arrangements are not yet in place.

Within all of this, it is unclear how a focus on behaviour management and ensuring policy compliance (which was the essence of the relevant 1995 recommendation) will be attained.

Information provided by ADD in relation to monitoring highlights inconsistencies between requirements for non-government services and for DoCS. Unlike non-government services, DoCS services do not have individual performance agreements linked to ongoing funding and are not routinely monitored by SSDOs. It is concerning that some three years after the creation of ADD, its relationship to, and monitoring of DoCS services remain unclear. Even if these issues were resolved, it appears unlikely that ADD's resources could be stretched to incorporate a focus on DoCS services.

ADD has made minimal progress with those recommendations around developing an implementation strategy for the "Positive Approaches to the Management of Challenging Behaviour" policy that addresses staff training needs and the role and availability of specialist support services (recommendation 5). Information provided indicates that:

- eight orientation sessions were held to introduce the policy to service providers in August 1997 and a "scoping" of staff training needs is planned;
- ADD has provided DoCS with funding for competency training for its disability staff. However, DoCS has reported that due to resistance from the Nurses Association (NSW) this will not be provided to nursing staff of large residential centres, but only to program staff of these centres and staff of community based services. ADD also reports that services are responsible for providing ongoing training on the behaviour management policy;
- specialist support to assist staff manage challenging behaviours will be provided through the Senior Clinical Practitioners in DoCS services. ADD reports that discussions with DoCS about providing case management services to non-government services through the Senior Clinical Practitioners are occurring.

This information indicates that training initiatives by ADD have either been one-off or are yet to be fully implemented. There is also no evidence that the requirement for services to provide ongoing training in behaviour management is monitored or enforced. Further, the provision of specialist support to non-government organisations is still apparently subject to negotiations between ADD and DoCS. The range of responsibilities that Senior Clinical Practitioners are expected to fulfil in relation to DoCS services makes it difficult to see how they could take on additional responsibilities for

non-government organisations. The commission understands that DoCS shares this view.⁹

Least progress has been made by ADD with devolution of the Lachlan Centre (recommendation 12). Lachlan has an adopted transition plan but ADD reports that there is no funding for devolution. ADD reports that DoCS has identified the Lachlan Centre as a priority for closure, when additional funds become available.

In light of the government's stated commitment to the devolution of institutions, the serious and disturbing findings of the 1995 Lachlan investigation, the 1997 performance audit and numerous other reports and inquiries (including this one), the government's recent announcement that it will close institutions by 2010 is positive, if overdue, some way off and lacking in detail. It is important that such an announcement is followed by the necessary resource allocation, planning and development of new service models to ensure that the process results in positive, timely outcomes for the residents of these institutions and their families. As well, strategies to ensure adequate care in these institutions prior to and during the devolution process need to be developed.

3.3 Progress with recommendations relating to DoCS

DoCS has provided information indicating progress, although varied, with all recommendations for which it is responsible.

According to DoCS, its major focus in implementing the recommendations of the Lachlan Report has been the development, implementation and revision of the departmental manual, "Policies for Working with People with Disabilities" (1996). This contains the Behaviour Intervention and Support policy which incorporates the requirements contained in the Lachlan Report recommendations (recommendations 1-5 and 19), such as providing clear guidance on the use of particular practices, minimum standards and responsibilities and accountabilities.

As with ADD, less progress has been made on developing a comprehensive implementation strategy addressing training needs, the role and availability of specialist support services and the need for flexible service provision (recommendation 5).

DoCS reports that competency assessment and training for programming staff (with nursing staff reportedly excluded because of industrial issues)

⁹ Meeting with DoCS staff re: peer review process, 22 July, 1998.

commenced in 1997 and covers the development of behaviour management programs, programming for user outcomes and improving staff understanding of the *Guardianship Act 1987*, substitute decision making and consent issues. As of April 1998, only 8 of the 50 programmers had been assessed as competent, with the remainder requiring training. This consists of self paced learning modules against which staff will be assessed by workplace assessors once they have been completed. A review of this training model is scheduled for 1999.

DoCS has also reported that a two day training workshop for 160 managers on program services management was held in August 1997.

According to DoCS, the Senior Clinical Practitioners will play a major role in providing clinical advice and support for particular cases, ensuring consistent practice standards across areas and quality control of the Behaviour Intervention and Support policy.

In relation to the provision of flexible services for people whose needs are not adequately met by the current system, DoCS has stressed the importance of developing appropriate models for people with high support needs as such models do not currently exist.

Two recommendations from the Lachlan investigation related to the need for DoCS to monitor compliance with the behaviour management policy and develop review and quality control mechanisms (recommendations 3 and 6). DoCS reports that a number of initiatives focusing on compliance and service improvement have occurred or are underway:

- a self assessment undertaken in January 1996 by all DoCS institutions, which focused on behaviour management practices and identified weaknesses in four major areas.¹⁰ This led to the development and implementation of the Behaviour Intervention and Support policy, the establishment of the Senior Clinical Practitioner positions and the competency assessment and training for programming staff;
- self assessment by large residential services against the “Baseline Criteria for Resident Safety and Protection from Abuse” in October 1997, to determine the extent to which they met the baseline criteria, and develop strategies to address weaknesses;

¹⁰ These were policy development and implementation; practice systems, service structures and accountabilities; practice standards, quality assurance and monitoring; and staff knowledge and competence.

- a peer review process for all large residential centres, due to be completed by December 1998.¹¹ 28 staff from 14 large residential services have been trained as reviewers to assess the status of services against the baseline criteria. Teams of two reviewers conducted the first part of a two staged process in June 1998 which will result in the development of service action plans to address identified weaknesses;
- the application of the Supported Accommodation Risk Assessment (SARA) tool to large residential services, commencing in July 1998. This will enable the department to assess on a state, area and unit basis whether services are operating in accordance with policies and guidelines and will alert managers to potential risks. It consists of a questionnaire completed quarterly by the Area Manager in conjunction with the Senior Clinical Practitioner for each accommodation site, covering issues such as clients' well-being, systems to monitor client outcomes, and unit management and related issues.

While the establishment of these monitoring and service improvement initiatives is positive, measurable outcomes are not yet available as many of them are still being implemented. In some instances it remains unclear whether the strategies will be ongoing and how information from them is collated and used centrally. In particular, the commission understands that funding for the Senior Clinical Practitioner positions is for two years only. Also, the number of initiatives underway and their overlapping focus creates the potential for confusion, duplication and inefficiency. (For example, two self assessment processes and a peer review process within 18 months).

It will be important to evaluate these strategies, after a suitable period of time, to ensure effectiveness, coordination and outcomes for consumers. As none of them is independent of the department, the need to consult, involve and report to consumers, families and others with an interest in outcomes is vital.

DoCS has reported that it recognises the need for more effective practice systems, service structures and accountability mechanisms (recommendation 13). A number of strategies have been or are being implemented to achieve this aim, in particular the appointment of Senior Clinical Practitioners and the development of the Supported Accommodation Risk Assessment tool, as described above.

¹¹ The peer review process uses a methodology based on the one developed by the Audit Office of NSW for the Performance Audit of Large Residential Centres for People with a Disability in NSW. At present it is unclear if it will continue beyond 1998. The Community Services Commission assisted the department in adapting the audit methodology for peer review purposes and in the training of the reviewers.

DoCS reports that ongoing monitoring of staff to resident ratios (recommendation 16) is part of line management responsibilities and will be monitored by Senior Clinical Practitioners. It is unclear how this information will be used centrally by DoCS.

DoCS acknowledges that there are still problems with clarity in relationships between nursing staff, programming personnel and consultant services (recommendation 17) but says that these will be addressed by Senior Clinical Practitioners. DoCS reports that all large residential services have instituted protocols for referral to behaviour support services and a protocol exists clarifying how to work effectively with consultant psychiatrists (recommendation 20). No information is provided indicating the effectiveness of these protocols.

Some progress appears to have been made in relation to an audit of staff knowledge of the *Disability Services Act 1993* (DSA), guardianship and consent requirements, positive approaches to challenging behaviour, etc (recommendation 14), through the competency based assessment and training. However, as this is only available to residential care workers (RCWs) and residential care assistants (RCAs), and not nursing staff due to industrial issues, its application to institutions has been limited. Only one institution currently is able to employ RCAs and RCWs.

No progress has been made on closure of the CCU at Lachlan (recommendation 18) which continues to receive referrals and pressure to take people. DoCS reports this is due to the lack of funds to move current residents to community based services. While a number of those in the unit have had funding applications made to ADD and one resident has a funding package, plans to move them are not imminent.¹² The reasons for this are seen by DoCS to be the lack of resources to fund the staffing levels required to support these individuals in the community, and the low priority that their transition is accorded by the area of origin. DoCS also reports that the Lachlan Centre has not yet made submissions to ADD for all residents in the CCU.

Overall, as with ADD, DoCS has made the most significant gains in the area of policy development through the "Policies for Working with People with Disabilities" manual. Approaches to addressing training needs appear less comprehensive. Monitoring mechanisms are in the process of being established and while this is positive, it is too early to assess their effectiveness, contribution to service improvement and whether they are an efficient use of staff resources.

¹² There are tentative plans to assist this resident with a funding package to move to the community in late 1998.

The department's response indicates that the role of the Senior Clinical Practitioners will be crucial to ensuring consistent practice and monitoring of service provision. As there is only one position assigned to each area (covering all institutions and group homes) and the two larger residential services, their responsibilities are considerable. It may be too much, and possibly a conflict of roles, to expect them to focus on day to day service provision and providing advice and support to direct care staff, as well as undertake quality assurance/performance monitoring roles. Again, an assessment after a time to ensure that expectations are realistic and outcomes achieved, will be important. Given their core role in service improvement, it is also likely that there will be a continued need for these positions beyond the two year funding period.

As with ADD it is concerning that, while there is a lot of activity around monitoring strategies within DoCS, many are only just being implemented some 3 years after the Lachlan investigation. As such, their capacity to address the issues identified in the Lachlan investigation and contribute to improved lives for residents remains to be seen.

3.4 Progress with recommendations relating to the Lachlan Centre

A number of recommendations coming out of the Lachlan investigation required action on the part of the Lachlan Centre itself, although in all cases general oversight and support from DoCS senior management for their implementation can be assumed.

The performance audit demonstrated that the Lachlan Centre has made significant progress in relation to a number of the recommendations which has led to improvements. These include: addressing role confusion amongst staff; the development of Behaviour Intervention and Support (BIS) strategies so that no resident experiences exclusionary time-out; clarification of the role of the consultant psychologist; controls on seeking consents for restrictive behaviour management practices; the requirement that restrictive practices are only sought following an analysis of the individual's behaviour; staff training on the *Guardianship Act 1987*, the DSA, and DoCS policies; the development and/or implementation of transition plans, Individual Service Plans (ISPs) and clinical review meetings; and a review of the staffing establishment.

The performance audit has verified improvements to management systems through a management restructure, more clearly articulated decision making

processes, the introduction of formal supervision practices, revised job descriptions and some increase in training for direct care and program staff.

Improvements to residents' quality of life include introducing single room accommodation, refurbishing and renovating some areas to create a more pleasant environment, and greater community access for some residents. There is also an increased focus on positive programming, an increase in the choice and quantity of food at mealtimes, the introduction of regular resident meetings in some units, and attempts to provide privacy.

There are however some recommendations from the Lachlan investigation around which only minimal progress has been achieved. For many of these, attempts have been made by the Lachlan Centre but factors outside the service's control appear to have impeded progress. For example, Lachlan has conducted an internal review of resident A's needs, resulting in a behaviour assessment report (recommendation 21). However an independent review focusing on accommodation and support services appropriate to his needs and the development of such services has not happened. As such, while he is no longer subjected to exclusionary time-out, the environment and circumstances in which he lives have not changed substantially.

Similarly, while all residents of Unit Nine have current ISPs in place, their "integration into the community with all necessary supports" (recommendation 22) is not progressing.

Residents of the CCU are in a similar situation, with their transition to the community unlikely to occur in the immediate future despite the investigation recommending that the unit be closed (recommendation 23). While resident B was placed in a community setting in late 1995 (recommendation 24), the placement lasted less than a month before she returned to the CCU. The reasons for this are seen to be Resident B's difficult behaviour and reputation, the size of the household where she moved, and the lack of appropriately skilled staff and specialist resources to assist her to live in the community.¹³ Although options for her going back into the community are being considered, there is no date for when this will happen. It is tragic and a major indictment of the department that this placement was allowed to fail for what were essentially reasons of bad planning and lack of foresight.

The reasons for the lack of progress generally in relation to the above recommendations are seen by all relevant parties as relating to insufficient

¹³ Taken from the summary of the Preliminary Review Report of the Circumstances of a Person in Care (Resident B), June 1998, Community Services Commission.

funds and not enough suitable community placements. A contributing factor appears to be, in some cases, lack of action on the part of the area of origin. For both residents A and B, responsibility for case management and ISPs still rests with the area of origin and in both cases, action to relocate these residents has been minimal. This is clearly a matter for closer attention by DoCS.

Attempts have been reported by Lachlan to recruit individual advocates for residents of Unit Nine and the CCU (recommendation 25) but with little success.¹⁴ Again it does not appear that the supervising area office or those with relevant case management responsibilities have assisted Lachlan in considering alternative strategies, nor that locating advocates has been seen as a high priority.

There was evidence from the audit that the process of service improvement at the Lachlan Centre is ongoing. For example: weekly resident consultation meetings have been established to enable resident input into improved practice; the development of a system to capture critical incident information to inform management of key areas of concern is in progress; Lachlan Centre staff were included in a knowledge/skills audit of all staff undertaken by Northern Sydney area office in July 1997; staff training will be provided as part of the Northern Sydney area staff training program; and the adoption of area based systems such as the Northern Sydney area quality assurance checklist and documentation/file management systems has commenced.¹⁵

4. SUMMARY OF AUDIT FINDINGS

The audit has made specific findings (detailed in full in Part B, Section 4) in relation to each objective of the audit and these are summarised as follows:

- **The Lachlan Centre does not have an adequate policy or procedural framework to guide practice in key areas across the service.** A contributing factor is that the DoCS policy manual which provides the overarching framework does not adequately cover the areas of fire safety, critical incidents, medication and nutrition. While the service has

¹⁴ Resident B in the Lachlan Report now has an advocate, as a result of action initiated by Citizen Advocacy after the Lachlan investigation and an advocate is being recruited for Resident A as a result of action initiated by Citizen Advocacy after the audit.

¹⁵ The Northern Area Quality Assurance checklist monitors performance of service delivery and the impact on residents through direct testing of practice and consulting service users and family members. Results are collated at area level and fed back to the Lachlan Centre for incorporation into continuous improvement plans for residential units and performance reviews for staff.

produced a summary of the DoCS policy manual, this is lacking in detail, which increases the risk of breaches or poor practice. A range of local procedures and guidelines have been developed but these focus on administrative processes and tasks; are not linked to an overriding policy; are sometimes at variance with DoCS policy; approximately half are undated and unauthorised; and many are still in draft form. Not all practice areas are covered and not all procedures are documented. Procedures are kept together, but are not indexed and are not readily accessible. The department has advised that, since the completion of this audit, funds have been allocated to enable the development of a local procedures manual (see below).

- **As well as the lack of a comprehensive policy framework, there is an inadequate implementation and monitoring system, which means that the rights and safety of residents are compromised.** The audit found gaps in policy coverage and inconsistent practice across the service in a number of key areas. Mechanisms to ensure staff awareness of policy requirements and to monitor compliance are inadequate. This is compounded by a substantial reliance on casual staff who have limited access to training opportunities. Lack of clear procedures and reporting requirements in key areas, such as the management of critical incidents and complaints handling, means that management is not able to appropriately respond and develop service improvement strategies. Current policies and procedures are inadequate for quality assurance purposes. While DoCS reports that Senior Clinical Practitioners will monitor compliance with policy and procedure, particularly in the area of behaviour management, it is too early to judge the effectiveness of this. A database to report on critical incidents and to analyse trends and inform preventative strategies is being developed but is yet to be completed.
- **The Lachlan Centre has made significant improvements to its management of challenging behaviour and this, along with other practice improvements, contributes to a higher quality service in particular areas.** Clear policies and procedures for managing challenging behaviour exist, behaviour intervention and support plans are developed and compliance with these by staff is increasing. No resident has time-out as part of their behaviour intervention strategy. Further assessment, monitoring and oversight processes are needed to ensure that behaviour intervention strategies are used appropriately, unmet need is identified and addressed, and to increase the focus on positive, rather than reactive, strategies. Other service improvement efforts include clear procedures in relation to medical and dental treatment, regular medical and dental reviews, attempts to improve the physical environment and address privacy, and the introduction of a case management system.

- **However, in some key areas, the service is unable to meet residents' individual needs, provide them with the service they require in a timely manner and ensure their optimal care and development.** There are high numbers of resident to resident injuries and unexplained injuries, and staff are not clear on what incidents need to be reported. There were instances found in the unit communication book and medical charts where practices around consent to, and the recording and prescribing of, PRN medication were outside legal requirements. While there were procedures in place for recording health and physical status, there was evidence that health concerns did not always trigger a timely response. Systems for ensuring adequate nutrition for residents were lacking. There was evidence of inadequate and inconsistent recording of information on resident files and poor file management practices.

ISPs are not used to direct service delivery. ISPs for residents focus predominantly on daily routine and basic needs. The opportunity for skill development is limited, partly due to a lack of staff competency in this area. Whilst the plans are reviewed regularly, there is little demonstrated progress with goals. There has been an increase in community access for some residents but it does not focus on community integration and achieving long term goals. The majority of residents reviewed for the audit spent a large proportion of their days on-site engaged in "free time". Those residents with little or no family involvement generally do not have advocates. The 35 family members consulted as part of the audit reported varied experiences in being kept informed, their involvement in decisions and how their complaints or concerns were dealt with.

- **Since the commencement of the inquiry, a number of initiatives have been instigated by both the Lachlan Centre and DoCS central office to improve service management and delivery.** These include: the development of the Lachlan Centre Procedures Manual to rectify inadequacies; the establishment of an Assistant Manager, Programming position to supervise program staff; the introduction of a quality assurance checklist developed by the area office to monitor service performance; improvements to the Lachlan Centre's filing and documentation system in line with the area office system; some action arising from property condition and fire audits to improve safety and the physical environment at Lachlan and other large residential centres (although both these audits were undertaken at least 12 months ago); and the development of a DoCS Nutrition policy. Such initiatives demonstrate the importance of providing additional resources and area and central office leadership and support in achieving improvements.

- **While an improved management structure exists and the service is perceived as being more open and accessible, further systems and strategies are needed to enhance staff performance, accountability and service quality.** Internal monitoring systems are labour intensive and do not enable the timely and systematic detection of weaknesses or problem areas. While the role of nursing staff has shifted over time from focusing on personal care to individual development, this has not been accompanied by the necessary training, reportedly because of industrial issues. A reliance on supervision which does not always occur regularly, a lack of performance indicators and inadequate internal monitoring and quality assurance mechanisms limit the accountability of staff and the service as a whole. While DoCS reports that recently introduced strategies will impact upon accountability and performance, results in this regard are as yet unknown.
- **Accountability to and monitoring of the service by DoCS and ADD is poor. Public accountability is also limited.** No key result areas or performance indicators exist and standard reports in relation to key areas are not produced or required by area level or beyond, so that routine monitoring against identified benchmarks is minimal. How DoCS will relate to ADD and how independent monitoring of DoCS services like Lachlan will be undertaken is unclear. Support and guidance from these bodies to assist Lachlan achieve improved outcomes has been lacking until fairly recently. The lack of formal reporting to external stakeholders and the limited involvement of families, residents and advocates in reviews of and decisions about service provision also lessens the Lachlan Centre's public accountability.

5. CONCLUSION

The primary objectives of revisiting the Lachlan Centre were to determine if progress had been made in implementing the recommendations of the 1995 Lachlan investigation and to assess the current standard of care.

This inquiry verifies that progress has been made with most of the 1995 recommendations, but few have been fully implemented. Importantly, policies for the management of challenging behaviour and other good practice guides for residential services (both DoCS and non-government services) now exist. Monitoring strategies and quality assurance mechanisms are also in the process of being developed and implemented, and SSDOs have commenced monitoring non-government organisations in a more structured way.

DoCS has instituted a peer review process for its large residential services and specialist support and quality assurance is now provided in DoCS services through the Senior Clinical Practitioner positions. At the Lachlan Centre itself, a number of changes have taken place including a management restructure, improvements to the physical environment, clarification of staff roles, implementation of controls around use of restrictive practices, the provision of some training and the introduction of staff supervision.

However, the recommendations that would have had the most impact on residents' quality of life (such as closure of the CCU where time-out was being used, the provision of advocates and devolution of the service) have not been implemented. The two residents who were the subject of the 1995 investigation tragically have not been moved to more appropriate accommodation, DoCS services like Lachlan are still not subject to independent monitoring by ADD, and the development of flexible services to meet the needs of those with high support needs has not happened. Overall, the pace of change has been exceedingly slow.

As well, the plethora of service improvement and monitoring initiatives being implemented by DoCS and ADD are potentially confusing, in many instances have yet to produce concrete outcomes, and have not been evaluated or reviewed to determine effectiveness.

The performance audit has demonstrated that, while significant improvements are continuing, residents' quality of life at Lachlan is far from optimal. Their human and legal rights, safety and dignity cannot always be ensured and opportunities for skill development, participation in the community and achieving their potential remain limited.

This is despite the attention, focus and responses generated by the 1995 investigation, the findings of the 1997 performance audit of ten large residential centres, and the efforts and hard work on the part of the Lachlan Centre itself. The commission's revisiting of the Lachlan Centre has resulted in increased attention for the service and staff and the allocation of additional resources. While this must be seen as positive, it begs the question of why such support was not provided sooner.

It is acknowledged that since the release of the 1995 investigation report, considerable effort on the part of the Lachlan Centre has been directed at improving the quality of care for residents. It is appreciated that staff at Lachlan are doing a difficult job in the face of increased expectations from government, community and families. However, despite this good will, staff dedication and the service improvements that have occurred, there are still

weaknesses in practices and systems that mean that residents are not getting what they need to ensure their optimal development and quality of life.

A number of factors appear to have contributed to this lack of progress, being:

- the institutional environment and its “cancellation” effect on service improvement initiatives;
- within the Lachlan environment, the lack of a sufficient policy framework, a predominantly medical model of care, lack of adequate training, supervision and accountability, and problems in recruiting appropriately skilled staff;
- minimal assistance from DoCS and ADD in addressing these problems and inadequate monitoring and accountability systems to enhance service performance and inform planning processes;
- the ongoing failure to resolve the relationship and reporting requirements between ADD and DoCS and to establish independent, consistent monitoring of Lachlan and other DoCS residential services;
- a lack of resources for, and government planning to enable closure of, the CCU in the short term, movement of residents into community placements and devolution of the service in the long term.

The findings of this inquiry demonstrate that, no matter how hard services like Lachlan try, they will continue to expend considerable effort for little gain in the current environment. Without support, resources, commitment and planning from bureaucracies and government, the fundamental reforms needed to make a real difference to individual lives will not happen.

While the recent announcement by the Minister for Community Services that all institutions will close by 2010 is a good start, it needs to be backed up by serious planning, resource allocation, the development of appropriate service models and consultation with parents, advocates and others in the disability sector. As well, strategies and safeguards are needed to ensure an adequate standard of care in the lead up to and during the devolution process.

6. RECOMMENDATIONS

Our recommendations are aimed at outcomes on three levels: achieving continued service improvements and enhanced quality of care at the Lachlan Centre in the short to medium term; building on and improving monitoring by, and accountability to, DoCS and ADD, of the Lachlan Centre and other similar large residential services; and facilitating the devolution of the Lachlan Centre through a planned, staged and financially viable process. As

much as possible, we have tried to build on service improvement initiatives already underway.

Enhancing the quality of care at the Lachlan Centre

1) Lachlan Centre management, with assistance from DoCS Service Development Directorate, should ensure that, in relation to the recently developed Lachlan local procedures manual:

- it gives clear and sufficiently detailed guidance across all key practice areas (including responding to critical incidents and complaints handling) and identifies relevant responsibilities and authorisations;
- it is consistent with the DoCS manual “Policies for Working with People with Disabilities”;
- staff, parents, advocates and consumers have been sufficiently consulted and involved in its development;
- there is an identified review mechanism which involves consultation with consumers, families advocates and staff and specified review dates;
- a plain English version is produced and available to everyone with an interest in the service.

2) To ensure effective implementation of these procedures Lachlan management, with assistance from the Northern Sydney area office, should ensure that:

- training in relation to the manual is incorporated into the area training plan and occurs in early 1999;
- all staff (including casuals) are familiar with local requirements and systems (such as supervision) exist to detect and rectify any gaps in staff understanding;
- the Lachlan Centre’s staff induction program is reviewed to incorporate a thorough overview of the new procedures manual.

3) As part of its review of the “Policies for Working with People with Disabilities” manual (scheduled for November 1998), DoCS should develop additional policy and practice guidelines spelling out responsibilities, requirements and procedures for the following areas:

- fire safety;
- reporting, investigating and managing critical incidents and injuries involving residents;
- the use and provision of medication; and
- the promotion of adequate nutrition, hygiene, exercise and health care.

The review should also incorporate a focus on the continuing adequacy of DoCS' Behaviour Intervention and Support policy.

4) DoCS should ensure that the introduction of these new and/or revised policies is accompanied by strategies to ensure staff are aware of and understand them, service managers understand and are able to fulfil their responsibilities, and monitoring mechanisms are developed or adapted to measure compliance.

5) As part of the area training plan, the Northern Sydney area office in conjunction with Lachlan Centre management should ensure that all staff at Lachlan receive training throughout 1999 to address the gaps in skills identified in this inquiry in areas such as: ISPs and case management; resident skill development; critical incident reporting; positive programming; and promoting resident and family member participation in decision making.

6) In relation to staffing issues, Lachlan management, with support from DoCS area and central office, should:

- continue, as a priority, negotiations with the relevant industrial associations to broaden the recruitment base for the Lachlan Centre and to address the need for nursing staff to access competency based training;
- complete the review of staff roles and responsibilities already underway to ensure they reflect the competencies required to implement the "Policies for Working with People with Disabilities" manual;
- develop strategies to ensure that casual staff have access to training and the necessary competencies to fulfil their job requirements.

7) Lachlan Centre management should ensure that revised and improved procedures for the maintenance and management of consumer records and files exist, are consistent with area office requirements and are understood and implemented by staff.

8) DoCS should continue to address the findings of the property and fire audits carried out at the Lachlan Centre as a matter of urgency, to ensure a safe and adequate standard of care. A committee comprising consumer, parent and advocate representatives as well as DoCS and Lachlan Centre management should be established to advise on priorities, oversight the improvements and ensure accountability.

9) Lachlan's Assistant Manager, Programming should develop, in consultation with the Senior Clinical Practitioner, a quality assurance mechanism to ensure appropriate development, implementation and monitoring of BIS Plans. This should have the capacity to ensure that consent

to, and the recording and prescribing of PRN medication, are within legal requirements.

10) The Assistant Manager, Programming should assess and/or review the behavioural support needs of all residents at the Lachlan Centre to determine the extent of unmet need, the appropriateness of current intervention, and to enable the development of priorities and a planned approach to meeting these.

11) The Senior Clinical Practitioner should review the Lachlan Centre's proposed critical incident database to determine its effectiveness, consistency with other departmental data collection strategies, and ability to provide information on key issues of concern and inform preventative strategies. A project plan, with identified responsibilities and a timeframe for the development of this monitoring tool, should be developed.

12) The Lachlan Centre should establish mechanisms to ensure all residents' nutritional needs are adequately monitored and addressed. As part of this, resident weights should be regularly recorded and checked against BMI, and residents whose weight is of concern referred to a nutritionist for assessment and follow up. The Lachlan Centre, with support from the area office, should ensure that the DoCS nutrition policy, once developed, is implemented and staff training provided.

13) The Lachlan Centre, with appropriate area office support, should ensure that all residents have an ISP and case manager and that:

- case managers are responsible for the appropriate development, implementation and review of ISPs, including allocation of responsibilities;
- all residents are provided with meaningful daytime activities (preferably off-site) which focus on skill development, community contact and integration, and which are linked to ISP goals;
- for residents with limited or no family, guardian or advocate contact, increasing such contact and/or securing advocacy involvement are specified as goals in the ISP, with clearly defined strategies and responsibilities;
- NUM3 positions periodically monitor the implementation of ISPs as a means of quality control, and use supervisory processes to address any identified concerns.

14) The Lachlan Centre should enhance resident and family involvement in decision making, both at the service management and individual resident level, through:

- the provision of information on policies and procedures;
- increased opportunities for family members to contribute to policy and procedure development (for example by providing the parent forum with the opportunity to discuss/comment on draft policies prior to implementation);
- ensuring they are regularly informed of ISP meetings and reviews and given opportunities and assistance (including ways other than having to attend the meeting) to have input to the development of ISPs; and
- improved and consistent communication in relation to informing relatives about incidents and accidents, with the relevant policy and procedures developed in consultation with parents and families.

15) The Senior Clinical Practitioner, in close consultation with the Lachlan executive and the Area Manager, should review existing internal reporting, monitoring and quality assurance mechanisms to enable the development of efficient and effective systems that build on statewide reporting/monitoring mechanisms, avoid duplication, and provide management with crucial and timely information on service delivery issues, key areas of concern and the need for service improvements.

16) DoCS should ensure that regular reporting against critical indicators occurs between the Lachlan Centre DON and Area Manager so that the Area Manager is informed of general service delivery issues, key issues of concern and the need for improvement; and can offer support and direction as required.

Improvements to monitoring and accountability mechanisms

17) DoCS should require and assist the Lachlan Centre to publish a yearly business plan, developed in consultation with key stakeholders. The plan should:

- aim to ensure that the Lachlan Centre conforms as closely as possible to the Objects, Principles and Applications of Principles of the DSA;
- focus on consumer outcomes;
- identify key result areas, performance indicators and timeframes;
- be consistent with the focus of the baseline criteria and incorporate other service improvement initiatives such as the peer review process and transition action plans;
- identify responsibilities and accountabilities at the local, area and head office level; and

- specify partnership arrangements for collaboratively working with consumer advocacy organisations.

The Lachlan Centre should be required to report at least annually on its performance against the business plan through the provision of quantitative and qualitative data demonstrating outcomes for consumers and service improvements in the key result areas, to area and central office, consumers, families, other advocates and ADD.

18) DoCS should review and refine its recently introduced peer review program, with a view to ensuring that:

- the Lachlan Centre (and other large residential services) undergo such a process on an annual basis;
- input from family members, advocates, guardians and Community Visitors is built into the process;
- it results in the development of a service improvement plan (incorporated into the business plan);
- progress with service improvement is monitored at area and central office; and
- it is consistent with ADD monitoring and reporting requirements.

Again, outcomes of the peer review process should be reported to families, guardians and other advocates.

19) Given the crucial role of the Senior Clinical Practitioner positions in achieving service improvements, DoCS should commence any necessary planning, negotiation and action to secure these positions preferably on a permanent basis and at least for another two years.

20) DoCS should review its recently established monitoring mechanisms such as the Supported Accommodation Risk Assessment, the Senior Clinical Practitioner positions and the peer review process by the end of 1999, to ensure that they are effective, integrated, streamlined and an efficient use of staff resources. This review should include feedback and comment from staff, consumers, parents, advocates and ADD.

21) ADD should review, by the middle of 1999 and in consultation with relevant stakeholders, the role of the Service Support and Development Officers to assess their effectiveness, particularly focusing on:

- their dual roles of service development/support and monitoring;
- the monitoring tool to be used by SSDOs; and

- their capacity to adequately cover the number of services assigned to each of them.

22) DoCS should take action to rectify immediately critical concerns identified from the fire and property audits of residential centres and to address other concerns in a planned and timely manner. The results of the audits and action arising should be communicated to consumers, families and advocates.

23) ADD should establish individual funding and performance agreements with DoCS services (as currently exist for non-government services) to ensure equity and consistency in relation to performance expectations, accountability requirements and continuation of funding.

24) As part of this, ADD should establish a monitoring mechanism for DoCS services that is consistent with that established for non-government services and that enables public reporting against identified performance indicators across residential services for people with a disability. This should take place by mid-1999 and should involve the allocation of adequate resources to enable ADD to expand its monitoring function in this way.

Long term plan for devolution

25) DoCS should, through its Service Development Directorate, monitor and ensure that all the relevant areas of origin fulfil their responsibilities to residents in large residential services who either have or are waiting on individual funding packages to relocate them in a planned and responsible manner to appropriate accommodation in the community by mid-1999. This should include the relevant residents at the Lachlan Centre who live in CCU; residents A and B (as identified and recommended in the 1995 Lachlan investigation); as well as the approximately 10 residents in Karingal, moved from Riverglade pending community placement availability, who have now been at the Lachlan Centre for five years.

26) As a matter of priority, DoCS should require the area of origin to ensure that outstanding individual funding submissions for those Lachlan Centre residents of CCU who do not currently have a package, are put to ADD.

27) DoCS should immediately implement a “no admissions policy” for the Lachlan Centre (as recommended by the Joint Performance Audit of Large Residential Services (1997) in relation to all institutions). When residents from CCU and Karingal have moved, these units should be permanently closed.

28) The government should act urgently to resolve the dispute regarding the appeal against the Lachlan Centre's transition plan. Once this has been resolved, the government should implement the Lachlan Centre's adopted transition plan as a matter of priority and no later than 2002, as part of a statewide devolution strategy.

29) As part of the implementation of this transition plan, DoCS should undertake a staged process to relocate the remaining residents of the Lachlan Centre to community accommodation with appropriate supports by the year 2002.

30) To support the implementation of appropriate community based models, ADD should ensure that individual assessments, consultation with advocates and family members, and the exploration of suitable options occur.

31) To enhance the success of such community placements, ADD should, as a priority, establish a working party with community, expert and departmental members, to oversee the identification and development of a range of flexible options for accommodation and support for people with high support needs in order to minimise the likelihood of placements for Lachlan and other residents failing.

32) The recent announcement by the Minister, regarding the devolution of all large institutions by 2010, should be followed by consultation about how this will happen, the development of a plan, including timeframes and costings that is made public, and the establishment of a committee comprised of community, expert and departmental representatives to oversee and report publicly on the process. ADD, as lead agency in the devolution process, should ensure that the lessons learnt from previous devolution exercises are built on. The devolution plan should be developed by mid-1999 and should include strategies for ensuring an adequate standard of care up until closure, retaining appropriately skilled staff, assessment of residents' individual needs, and consulting with families, guardians and advocates throughout the process.

33) To ensure the recommendations from this inquiry are acted on, the Directors-General of both DoCS and ADD should appoint senior officers to oversee allocation of responsibilities, implementation of recommendations and reporting on progress, internally and to the commission. These senior officers should be required to develop an action plan clearly detailing tasks, timeframes, persons responsible, and performance indicators. This plan should be forwarded to the commission within 2 months of the publication of this report.

PART B: Findings of the Performance Audit

1. CONDUCT AND SCOPE OF THE LACHLAN CENTRE AUDIT

The audit was conducted in accordance with the provisions of s.83 (1) (d) of the *Community Services (Complaints, Appeals and Monitoring) Act 1993*. This section of the Act is attached as Appendix V.

1.1 Terms of reference

The audit's Terms of Reference contain four objectives, relating to service policies and procedures, service delivery to residents, and monitoring and accountability at the Lachlan Centre (see Appendix II).

1.2 Methodology

The audit drew on the methodology developed for the Performance Audit of Large Residential Centres for People with a Disability (1997). This methodology was developed by the Audit Office of NSW in consultation with the commission, DoCS and ADD in 1996. The methodology enabled an examination of policies and practices to determine if they protected the human and legal rights, safety and dignity of residents. It also enabled an assessment of progress made in the key areas the subject of the Lachlan Inquiry.

1.3 Scope

Of the seven units at the Lachlan Centre, three units, accommodating in total approximately 27 of the 74 residents at the Lachlan Centre, were selected as the sample for the audit. The units chosen were the Kyewong and CCU (both the subject of the previous inquiry), as well as the Kooinda West unit.¹⁶

Kooinda West unit was selected by the audit to enable an examination of the standard of care in units other than those covered by the 1995 Inquiry. While there are two units which accommodate residents of similar support needs to those in Kyewong and CCU, it was decided to include Kooinda West in the audit because of the particular barriers it faces in relation to service improvement.¹⁷

¹⁶ This is a unit of 9 residents with high support needs although not all have the behavioural support needs of those in Kyewong and Crisis Care units.

¹⁷ These barriers include a long term vacancy in a NUM position. Kooinda East and Lambrook residents have significantly higher physical support needs than those in Kyewong, Kooinda West and CCU. Karingal was not chosen as it accommodates a number of ex-

The 'on-site' component of the audit was conducted at the Lachlan Centre from 10 to 14 November 1997. In conducting the audit, the commission collected information through the following activities: observations, scheduled interviews with Lachlan Centre staff and management, residents, family members, the Community Visitor and OPG staff, as well as reading service and resident documentation. The following is a detailed breakdown of this process:

- inspection of the Lachlan Centre accommodation and grounds;
- interviews with nursing staff, including Clinical Nurse Specialist (x 4);
- interviews with Nursing Unit Manager (NUM)2 (x 1) and NUM1 (x 1);
- interviews with the DON, Deputy DON and NUM3;
- interviews with program staff (x 3);
- interview with Adult Therapy Unit Coordinator;
- interviews with residents or secondary consumers (family members and advocate), randomly selected (x 6) from the sampled units;
- discussions with parents and family members (x 35) and advocates (x 4) in forums, OPG staff by phone (x 4), and the Community Visitor by interview (x 1);
- written submissions from parents (x 5);
- review of service documents;
- review of 12 client files (9 randomly selected, 3 selected for individual review, 2 of whom had been the subject of the 1995 Lachlan Inquiry and one who was the subject of a more recent complaint to the commission);
- information collected by the commission since July 1996 through complaints, monitoring by the Community Visitor, and the reviews of three residents under s.11 of the *Community Services (Complaints, Appeals and Monitoring) Act 1993*.

While information was provided from these sources about the residents and units selected for the purpose of the audit, anecdotal information was also received about units not included in the sample. This information was provided through staff, family members, advocates, the Community Visitor and staff of the OPG and, where appropriate, contributed to the audit findings.

1.4 Opportunity for comment on initial findings

Following the on-site component, the audit team conducted an exit interview with members of the Lachlan Centre executive and representatives from

Riverglade residents who were moved to Karingal in 1995. The additional resources and focus allocated to them in this unit to facilitate their placement into community based settings were not applied to other units.

nursing and program staff. The purpose of this interview was to advise the service of initial findings in relation to the adequacy of local policies, procedures and practices for the purpose of discussion, and to provide an opportunity for the service to offer further information to the audit. As a result of this exit interview, additional information was provided to the commission and was taken into account in the preparation of the preliminary and final reports.

2. CONTEXT OF THE AUDIT

The key principles, standards and expectations applied in this audit are found in a number of pieces of legislation and their associated instruments. These include the:

- *NSW Disability Services Act 1993 (DSA)*, which requires that services are provided in line with the Objects, Principles and Application of Principles of that Act. These include requirements that services further the integration of people with disabilities into the community, and enable people with disabilities to achieve positive outcomes and their maximum potential as members of the community.
- *Disability Services Standards*, which provide an interpretation of the Principles and Application of Principles and are used by services and ADD to determine whether services are being delivered in accordance with the Principles and Application of Principles.
- *Guardianship Act 1987*, which established principles in relation to the rights of people with a disability to exercise freedom of decision making and action, and to express and have their views taken into account in key decisions. The Act also provides a framework for acknowledging the importance of family relationships, the need to encourage self reliance in people with disabilities, the provision of substitute decision-making where necessary and the need for protection from neglect, abuse and exploitation.

3. SERVICE BACKGROUND

3.1 Service profile

The Lachlan Residential Centre is a large institution operated by DoCS in North Ryde. There are currently 74 adults living there.¹⁸ All residents are

¹⁸ Provided to audit via "Lachlan Centre Units", a breakdown of number of residents in each unit and their support needs.

described as having from “moderate to profound developmental disability” and all units have at least some residents with “problem behaviour”.¹⁹

3.2 Physical accommodation

The Lachlan Centre was originally established as a developmental disability accommodation service attached to and located in the grounds of Macquarie Hospital, and regarded as part of Macquarie Hospital when accommodation services for people with a disability were funded through the Department of Health. In 1989 the transfer of disability services from the Department of Health to DoCS occurred.

While this transfer meant a change of funding body and name (to the Lachlan Centre), the centre has remained in the grounds of the hospital with few changes to its physical structure and appearance. The buildings are still large and congregate in nature. There have been progressive attempts to individualise living conditions by introducing partitions to offer single rooms and, in some units, by painting rooms different colours, carpeting some rooms and encouraging personal possessions.

The Lachlan Centre is comprised of unit and cottage accommodation. There are five units: Kyewong, CCU and Karingal in the one two storey building, and Kooinda and Lambrook in two single storey buildings. All are divided into groups of five or six residents. There are two residential houses, known as cottages, on two residential blocks of land at the corner of the site, which accommodate five people each. All units have a separate dining room and a living room used for recreation and television. The outdoor recreation areas attached to each building consist of a covered courtyard, with a BBQ and a small fenced-in yard which, in some cases, contains a swing and/or a trampoline.

The grounds of the Macquarie Hospital include grassed fields, one cafe and a swimming pool. Some of the Lachlan Centre residents access these facilities either as part of a recreation/community access program or in their free time. The grounds of the Lachlan Centre are in a noticeably poorer state than those of Macquarie Hospital.

3.3 Staffing and management

¹⁹ Provided to audit via “Lachlan Centre Units”. It should be noted that, for one of the individuals selected for review, medical experts query whether she has an intellectual disability.

The centre is managed by the Director of Nursing (DON) who is responsible for all its services and who reports to the DoCS Northern Sydney Area Manager. Service provision, staffing issues and transition progress are overseen and monitored by the executive team, consisting of the DON, the Deputy DON, a NUM3 who is the Transition Coordinator and another NUM3 who coordinates staff training, EEO and OH&S. Three NUM2 positions manage and oversee the day to day operations of the units.

Service provision is based on a medical model of care. Direct care staff consist of Clinical Nurse Specialists, Registered Nurses, Enrolled Nurses, Program Officers and Assistants in Nursing. Other staff employed by the Lachlan Centre and who have direct contact with the residents include psychologists, domestic staff and a recreation officer. During the week of the audit, staff establishment was reported to be 109 (including Registered Nurses and other staff). Of this total number, 10% of staff were reported to be on leave, while 48% of positions were vacant.²⁰ There is a substantial reliance on casual staff for service delivery.

4. EVIDENCE AND SPECIFIC FINDINGS IN RELATION TO OBJECTIVES

4.1 Objective 1 - Service policies and procedures

To identify whether key policies and procedures to protect the human and legal rights, safety and dignity of consumers are in place, and accessible to direct care staff and consumers, their families and other advocates.

Under this objective the audit examined the key areas of: policy development; policy coverage and adequacy; accessibility of policies and procedures; and policy implementation.

4.1.1 Policy development

4.1.1.1 The executive reported that the Lachlan Centre uses the DoCS manual "Policies for Working with People with a Disability" to guide practice. The audit was provided with a document, "Lachlan Centre DCS Policies Summary", which is an introductory guide for staff to most to the policies contained in the DoCS policy manual and covers the following areas:

- advocacy;
- behaviour intervention and support;

²⁰ From "Staff Establishment" provided by Lachlan Centre, 13 November, 1997.

- case coordination;
- consent for specific behaviour intervention practices, exchange of consumer information and for medical and dental treatment;
- consumer files;
- decision making and choice;
- dignity of risk and duty of care;
- general health and safety for consumers;
- healthy lifestyles;
- individual planning;
- maintaining family relations;
- participation and integration;
- privacy, dignity and confidentiality;
- response to sexual assault, physical assault, emotional abuse and neglect;
- sexuality and human relations; and
- valued status.

While this summary document is brief, it refers staff to the detailed relevant policy in the DoCS policy manual.

4.1.1.2 In addition, the following guidelines, checklists, forms or procedures have been developed to guide practice:

- Lachlan Centre ISP Checklist (endorsed by DON, 24/7/97);
- recording Procedures and Guidelines:
 - information to be recorded in daily progress notes
 - writing a weekly routine
 - writing an ISP meeting report
 - ISP review guide template
 - ISP plan template
 - assessment form (includes goal progress, health assessment, medication review, dental review, views of family/advocate)
 - psychotropic medication consent request form
 - medical/dental consent request form
 - Lachlan Centre ISP monitoring (records occurrence of quarterly review);
- purpose of clinical meetings at the Lachlan Centre;
- psychologists' criteria for accepting and prioritising referrals;
- pharmacological support in behaviour intervention: psychoactive medication (endorsed by DON, 22/11/96);
- procedures for reporting the use of PRN medication;
- PRN Medication chart (guide);
- behaviour intervention and support checklist (draft endorsed by DON, 5/12/96);

- behaviour intervention and support assessment checklist (endorsed by DON, 25/11/96);
- reference guide for the use of restricted practices;
- managing a significant critical incident - restraint checklist (draft endorsed by DON, 25/11/96);
- unit based restraint register - crisis management (draft endorsed by DON, 25/11/96);
- managing a significant critical incident - seclusion (draft checklist endorsed by DON, 25/11/96);
- unit based seclusion register - crisis management;
- managing a significant critical incident - containment (draft checklist endorsed by DON, 25/11/96);
- unit based containment register - reactive strategy;
- Northern Sydney area, behaviour intervention and support monitoring mechanisms, Tier 1 draft June 1997 - procedures and templates;
- Northern Sydney area Tier 2 draft April 1997 - behaviour intervention monitoring structure;
- Crisis Care Unit - Entry and Exit procedures;
- behaviour intervention - What you can and cannot do;
- Karingal and Cottages Checklist for Management of critical accidents/assaults (endorsed by NUM of Karingal/Cottages, 1/7/97);
- Lachlan Centre Grievance Resolution Procedure (endorsed by DON, 17/3/97);
- Fire Emergency Orders;
- protocol for using medical services;
- missing persons (27/3/96, no authorisation);
- Infection Control Guidelines;
- recreation referral forms;
- Activity and Training Unit referral forms;
- psychologist referral forms;
- management of status epilepsy (August 1996); and
- Quality Assurance Checklist - draft copy.

Except for the behaviour management and intervention guidelines, these guidelines outline administrative processes and relevant delegations only. They do not refer staff back to the relevant policy in the DoCS manual, and are predominantly task focused.

4.1.1.3 Approximately half of the policy/procedural documents are undated and not endorsed by management. The audit acknowledges attempts made by the executive in 1997 to seek funding to interpret the DoCS policy manual through the development of local implementation procedures and checklists and an induction manual. While this submission was unsuccessful,

DoCS reports that, as a result of this audit, the Lachlan Centre has employed a consultant to document the procedural framework and produce comprehensive local procedures for the centre.²¹ The Lachlan Centre reports that the Lachlan Centre Procedures Manual project was completed in October 1998 and covers the following:

- the development of a local policies and procedures manual;
- the development of an ongoing plan (and costings) for staff education to ensure implementation;
- the development of a local induction manual for service orientation; and
- an assessment of management processes and the development of recommendations in order to increase efficiency and effectiveness.

DoCS also reports that development of the manual will address the following concerns raised by the audit:

- possible confusion arising from the “Lachlan Centre DCS Policies Summary” due to the brevity of this document;
- inadequate links between local procedures and DoCS procedures;
- the need for clarity of authorisations and responsibilities;
- the need for clear dating and management endorsement of procedures.²²

The commission has not verified these claims.

4.1.1.4 The audit viewed the Lachlan Centre’s self assessment response to the “Baseline Criteria for Ensuring a Basic Level of Care for Residents’ Safety and Protection from Abuse in Large Residential Services”, completed on 27 October 1997.²³ This stated that the Lachlan Centre has written procedures in the following areas:

- behaviour management;
- management of incidents including injuries and assaults (for one unit only - not service-wide as yet);
- medication controls and consents; and
- individual planning.

²¹ Letter from DoCS Deputy Director-General, Brendan O’Reilly to the Community Services Commissioner, Roger West in response to the preliminary report of the Lachlan Centre Audit, June 1998 page 5.

²² As above.

²³ This is a tool developed by DoCS to identify key practice areas for service improvement and resources required, as part of the recovery project in response to the major recommendations of the Performance Audit Report, “Large Residential Centres for People with a Disability in NSW”, 1997.

The audit substantiated the existence of these procedures.

The service reported that it did not have local procedures on:

- Nutrition, hygiene and health care;
- promoting access to families and friends;
- privacy and dignity;
- safety; and
- complaints and concerns.

The audit substantiated that these did not exist. DoCS reported that the Performance Audit Report "Large Residential Centres for People with a Disability in NSW" (1997) identified operational procedure gaps in the manual "Policies for Working with People with Disabilities" in the areas of safety, including incident reporting and fire safety, and nutrition. DoCS reports that it will develop these procedures for inclusion in the policy manual, which is to be reviewed by November 1998, and that Lachlan Centre will develop local procedures based on these.

4.1.1.5 Where local procedures exist, they are sometimes lacking in detail or at variance with the DoCS policy manual. For example, there is no guide for staff on who or what triggers a referral for a behaviour management intervention, or how this occurs, although psychologists say it is the case manager's role to determine when such an intervention is required, while the DoCS policy indicates it is the NUM's responsibility to ensure a referral is made. According to DoCS, Lachlan Centre has a documented procedure for referring consumers to psychology services. However it was not sighted during the audit, nor provided prior to or following the preliminary report.

4.1.1.6 The audit was informed by the executive that new policies and procedures are developed either through clinical services meetings, NUM meetings, and/or executive meetings. Documents are distributed in draft form to staff and then ratified by the Transition Planning Committee, which includes 2 consumers and 4 parent representatives and meets every two months. It was also reported that individual positions (psychologists) are asked to develop procedures, where necessary. The audit found an instance where one unit had developed its own procedure for the management of critical incidents which was different to the centre-wide procedure titled "Accidents and Incidents" (see 4.2.2.1). At the time of the audit it was unclear which of these procedures applied across the service and their status.

4.1.1.7 The executive reports that it contacted all parents and guardians in September 1995, inviting them to have input into policy development. As a

result of this, one parent joined the Policy and Procedures Committee and four joined the Transition Planning Committee. On the whole, parents spoken to as part of the audit did not know how policies were developed or what policies the Lachlan Centre had developed. A majority of parents were aware of the DoCS policy manual, that the Lachlan Centre had obtained a copy for the use of parents and that it can be accessed through the executive. In response to the preliminary audit report DoCS has indicated that consultation on Lachlan Centre procedures will occur in future through:

- informing all service users, families and guardians of the procedures set out in the procedures manual recently completed;
- once developed, making the manual available to service users and stakeholders in each unit at the centre;
- agreeing on procedure review priorities in consultation with the Transition Planning Committee;
- providing the review schedule to service users and stakeholders through a newsletter;
- inviting participation from family members/advocates and guardians in reviews through written submission or attendance at focus groups.

4.1.1.8 Currently, existing local policies are not subject to review and there are no review mechanisms in place. The executive stated that it informally monitors the need for such review. Half of the procedures identify a review date scheduled for 1998 and will be reviewed as part of the procedures manual project.

4.1.2 Policy coverage and adequacy

4.1.2.1 Policy Coverage is listed in 4.1.1 above.

4.1.2.2 Local policies and procedures have mainly been developed where there is a requirement under the Disability Services Standards, or to meet an identified need e.g. behaviour management and intervention policies and procedures have been driven by the Lachlan Centre's response to recommendations made in the Lachlan Report.

4.1.2.3 Service-wide policies and procedures do not adequately cover key practice areas. Gaps include:

- guardianship generally, with the exception of medical and dental consent;
- use and provision of medication except for the use of psychoactive medication as part of a behaviour management program;
- standards of nutrition, hygiene and health care;

- access to the community and recreational opportunities;
- safety;
- complaints and concerns.

4.1.2.4 Approximately half of the procedures do not identify key responsibilities or authorisations, or provide all necessary information, including legal obligations. For example, the current Lachlan Centre Accidents and Incidents procedure includes: the responsibility the Case Manager has in regard to contacting the resident's guardian, a list of incidents and accidents covered by the procedure, instruction to seek first aid, and guidance on form completion. No further accountability requirements, such as line responsibility, are mentioned.

4.1.2.5 There are no documented links between the "Lachlan Centre DCS Policies Summary" and the local forms and guidelines which inform staff practice. For example, the ISP template provides limited direction to staff about information to be entered. There is no accompanying documentation indicating monitoring and review processes or case management responsibilities in relation to ISPs. Procedures, checklists and guidelines are not accompanied by, and do not refer to, a corresponding policy to provide staff with a rationale for, and a more comprehensive understanding of, their actions.

4.1.2.6 Due to the lack of detail in the "Lachlan Centre DCS Policies Summary" it provides an inadequate guide to staff as to what constitutes good/bad practice. For example, the Lachlan Centre DCS Policy Summary on Healthy Lifestyles requires staff to recognise and respect that it is the "consumer's choice" whether or not to participate in a healthy lifestyle (where healthy lifestyle includes safe sex, healthy eating practices and participation in regular preventative medical reviews). This summary, while referring readers to the DoCS Policies for Working with People with Disabilities, does not detail any other duty of care requirements, e.g. referral for guardianship if a resident's choice is placing them at risk. DoCS reports that the new procedural framework developed by the consultant addresses this possible confusion.

4.1.3 Policies and procedures are accessible

4.1.3.1 The DoCS policy manual, the "Lachlan Centre DCS Policies Summary" and other local procedures are physically accessible to nursing staff, located in the nursing station of each unit. There is also a folder containing loose leaf practice guidelines and checklists. Staff were aware of where these documents were kept and how to access them. The practice

guides and checklists, however, are not indexed to indicate whether a complete set is in the folder, and to facilitate easy reference.

4.1.3.2 The audit is aware that the Lachlan Centre purchased a copy of the DoCS policy manual for the use of the Parent Forum (parent representative association). This is kept in the executive office and members of the Parent Forum were aware of how to access this. The executive reports that all parents were posted individual copies of a user friendly version of the DoCS manual, published by DoCS. The vast majority of parents and advocates who gave input into the family forums held during the audit said that they were not aware of the local practice guidelines nor the “Lachlan Centre DCS Policies Summary”, nor how they could access these. The two residents interviewed during the audit had no knowledge of policies or procedures or how they could find out about these.

4.1.3.3 The president of the Parent Forum sits on the Transition Planning Committee and advises members of the Parent Forum at meetings and through their newsletter of the new procedures developed. A member of the executive also attends the Parent Forum regularly to advise on and clarify points raised from these procedures.

4.1.3.4 The induction process requires new Registered and Enrolled Nurses to read the staff induction folder, which includes the general DoCS induction material and the local Lachlan Centre procedural guidelines and checklists. There is no capacity for new staff to work supernumerary to familiarise themselves with policy requirements. There are attempts for new staff to be buddied with staff who are familiar with the units and the clients. From interviews with staff this tends to work when longer term staff are on shift, but this is not always the case. On their first shift, staff are required to pick up a basic knowledge of duties and familiarise themselves with client profiles and progress notes as well as any behaviour management strategies required. Most staff interviewed for the audit reported that achieving this, as well as reading all the DoCS policies, the “Lachlan Centre DCS Policies Summary” and the local guidelines, realistically takes anywhere from between a week to a month, depending on the shift, the staffing ratios and time available.

In response to this finding in the preliminary report, DoCS reported that the Lachlan Centre induction manual will be amended to include reference to the Lachlan Centre Procedures Manual. As a priority new staff will be required to familiarise themselves with the manual during the induction process. DoCS also reported that the department has almost completed a revised induction manual for all DoCS staff.

4.1.3.5 Staff are also informed/reminded of practice requirements through dated Lachlan Centre memorandums kept in a manual in each unit and placed on a staff notice board. These act as reminders of the responsibilities of staff and rights of residents, e.g. allowing consumers to choose which TV programs and videos they watch, and that staff must not eat food provided for residents. They do not appear to be linked to procedures.

4.1.4 Implementation of policy

4.1.4.1 The audit acknowledges the Lachlan Centre's recognition of the need for training around policy requirements and the efforts made to meet this need. Up until November 1997, this comprised 11 hours training for each staff member on the DoCS Policies for Working with People with Disabilities, held in July and August 1997. This was attended by all permanent staff and casuals with case management responsibilities (61 in total) and was run internally.

4.1.4.2 The service relies on staff meetings as the primary mechanism for discussing new procedures with staff. Meetings are held each week. Staff who attend are the staff on shift at the time of the meetings. Minutes of the staff meetings do not provide sufficient information to adequately convey discussions about or implications of new procedures for staff who did not attend. One unit audited had not had a minuted staff meeting for over three and a half months. A positive attempt to address difficulties for staff unable to attend meetings has been made, whereby the nurse who is generally in charge at night is rostered to day duty one day per month so that she can have input to the NUMs' meeting or the Executive Meeting. At these meetings she discusses any significant problems or needs, clarifies any issues which are unclear and takes this information back to the night staff.

4.1.4.3 NUMs are required by their performance agreements to conduct supervision with staff on a regular basis, and to assess staff knowledge of policy and practice in the following areas: safety in the workplace, managing consumer complaints, teaching skills, managing crisis situations, teamwork, individual service plans, accessing the community, supporting independence and managing personal workload. Supervision was not recorded as occurring in Kooinda West (due to a NUM2 position vacancy) since September 1996. Without this regular supervision there is no way of assuring that practice is always consistent with stated policy.

DoCS reports that a permanent NUM has recently been appointed to Kooinda West and that regular supervision is part of the NUM's duties. Also, the Supported Accommodation Risk Assessment, to be conducted by Senior

Clinical Practitioners in July 1998, was to have included an assessment of the adequacy of supervisory systems.

4.1.4.4 The Northern Sydney area office conducted a policy evaluation session with Lachlan Centre staff in September 1997. This was intended to assess: the extent to which staff understood key concepts and strategies necessary to implement DoCS policies at the local level; staff understanding that the ISP process underpins all policy implementation; staff understanding of the links between DoCS policy and local practice; and knowledge of the steps service units need to take to meet policy requirements and to ensure consumer awareness. The results of this evaluation are not yet available, but it is intended that they will inform the Area Training Plan.

Major findings in relation to service policy and procedures:

1. The Lachlan Centre uses the DoCS Policies for People with a Disability manual as its policy guide. The service has developed a summary of this to facilitate staff reference, however its brevity may increase the risk of policy breaches or inadequate practice. Since the audit commenced, funding has been provided to develop a local procedures manual.
2. The Lachlan Centre has developed a range of local guidelines and checklists to guide staff practice. They are not linked to the DoCS policy manual, are task focused, are often undated, in some instances do not indicate key responsibilities, and are not indexed to provide an overview of all procedures to be followed or to allow for easy reference. There is also the potential for inconsistent practice in some areas, such as responding to critical incidents, as one unit has developed its own procedures which are not entirely consistent with the service wide procedure.
3. There are a number of key practice areas where there are no local procedures, such as complaints management; use and provision of medication and nutrition; hygiene and health care.
4. Where local procedures exist, insufficient efforts to provide information about them to consumers, family members (apart from those who attend the Parent Forum) and advocates limit their usefulness and do not promote accountability.
5. Staff induction to policies and procedures is inadequate as staff are not given sufficient time to read and absorb all necessary material. Not all staff attend staff meetings, which are the primary mechanisms for discussing new procedures.

Training has been held to improve staff knowledge of policy requirements but is not ongoing. The initial staff induction to procedures does not occur separately from shift duty responsibilities.

6. NUMs are required, through regular supervision, to ensure staff are aware of and able to implement policies. However, as supervision does not always occur regularly, this mechanism of monitoring compliance is inadequate.

4.2 Objective 2 - Service delivery to residents

To review the implementation of policies and procedures in key areas to ensure that they are effective in protecting and promoting consumers' human and legal rights, safety and dignity, and comply with government and service policy directions.

Under this objective, the audit examined service practices in ten key areas important in protecting residents' rights and safety.

4.2.1 Behaviour intervention

4.2.1.1 The Lachlan Centre has clear policy and procedures for responding to the needs of residents with challenging behaviour. Staff were generally able to indicate verbally their understanding of policy/ procedures and legal requirements in relation to behaviour intervention.

4.2.1.2 At the time of the audit the Lachlan Centre employed three psychologists whose role was to develop behaviour intervention and support plans and to support direct care staff in implementing these plans to reduce and replace inappropriate behaviour. The psychologists received peer support from other psychologists and social educators in the Northern Sydney area, but no formal clinical supervision. Given the caseload of the psychologists, their important role and the complexity of the cases they deal with, the lack of clinical supervision and opportunity for outside input was a concern.

DoCS reports that, as a result of a review of programming services in the Northern Sydney area, the position of Assistant Manager, Programming was created for the Lachlan Centre and filled in April this year. This position is now responsible for the provision of clinical and line management supervision to the psychologists at the Lachlan Centre. This includes

oversight of program development and implementation - including positive programming practice, and compliance with requirements. The position reports to the Senior Clinical Practitioner for the Northern Sydney area.

In 1995 the psychologists and program staff completed ten days' training conducted by the Training Resource Unit of DoCS. The purpose was to assist staff to better organise the behavioural assessment and intervention process within the Lachlan Centre. Lachlan Centre has commenced developing and providing the area office with Tier 1 applications.²⁴

4.2.1.3 The audit acknowledges that the Lachlan Centre has developed a comprehensive approach to the management of challenging behaviour, including the multi-disciplinary development and implementation of Behaviour Intervention Support (BIS) plans, weekly clinical review meetings, and monitoring mechanisms such as the use of the Behaviour Intervention Reactive Strategy data sheets to monitor compliance with the strategy (although these were rarely used to effect change in the plan or to improve compliance). No resident covered by the audit had exclusionary time-out as part of his/her BIS plan, nor was there any evidence of its use as a behaviour intervention strategy.

4.2.1.4 It is unclear whose responsibility it is to identify if or when someone requires a BIS plan. The audit was informed by the psychologists that it is the responsibility of case managers to identify when a referral for a behaviour management plan is required. The "Lachlan Centre Behaviour Intervention and Support Development, Implementation and Monitoring Checklist" requires the NUM to refer residents who may need behaviour intervention to the unit team/clinical meeting.

In response to this finding, DoCS indicated that there is a Lachlan Centre procedure which specifies the process for referral to psychology services, although no supporting evidence of this was supplied.

4.2.1.5 The psychologists' caseload policy states that they should have an active caseload of no more than 6 clients at any one time. However, most have a higher caseload which includes active monitoring. According to the

²⁴ Tier 1 applications are part of the monitoring and accountability functions attached to the DoCS Behaviour Intervention and Support policy, which are used by DoCS to monitor adequate implementation of the BIS policy. Services are required to develop a Tier 1 application for all residents who require restricted practices as part of their BIS plan, in order to demonstrate that minimum practice guidelines have been met and to identify staff who are responsible for: behaviour intervention strategies and practices; departmental approval of particular restrictive practices; and conducting local area monitoring of the behaviour intervention practices.

“Lachlan Centre - Psychologists’ Criteria for Accepting and Prioritising Referrals” document, priority behaviours to work on are:

- behaviour causing damage or injury;
- behaviour placing consumers at risk;
- behaviours interfering with learning opportunities/interactions;
- other, including urgent request/pressure from other sources.

One file reviewed indicated that when a referral was made for a resident who regularly smears faeces, it was referred back to the unit program officer and subsequently not dealt with, the reason given being insufficient time because of other priorities. Whilst priority is given to individuals whose behaviour poses a safety risk, this results in residents maintaining behaviour which is significantly limiting to their lifestyle and not addressed.

4.2.1.6 Families and advocates reported inconsistent involvement in the development of the BIS plans. About half the family members reported they had not been approached to have input into a plan, while the others indicated that they had been consulted. There was also no evidence of involvement of consumers (where they could participate) in the development of plans. There was, however, evidence of consents obtained and recorded for all plans viewed.

4.2.1.7 The BIS plans reviewed usually identify the behaviour regarded as the problem, but not always its function. The plans tell staff what to do and how to interact with the resident. However, information about desirable behaviour to replace the undesirable behaviour is kept in the behaviour assessment report in the resident’s file, not with the plan itself, which limits the ability of staff to reinforce desirable behaviour. The audit could find no data recording on an ongoing basis when appropriate or desirable behaviour was displayed; only records in relation to inappropriate behaviour.

4.2.1.8 Responsibility for implementation of BIS plans lies with the direct care staff. Senior staff at Lachlan and the OPG state that the prescriptive nature of BIS plans is to provide clear guidelines for staff interaction with residents, and staff are expected to complete data sheets to document their implementation. However, there does not appear to be a systematic way for management or those with supervisory responsibilities to monitor and evaluate the impact on the resident and to change or modify the strategy as necessary.

Staff implementation of plans is recorded and monitored by the psychologists, but there is very little information required to be recorded by staff on the impact of the interventions on the individual’s behaviour. The

audit was aware of one instance where a broad statement to guide positive interaction became the rationale for a protracted conflict lasting 4 hours between staff and a resident, resulting in a complaint to the service by the resident's family. The negative impact for all involved was compounded by the poor understanding of the positive intent of the BIS guidelines, the inappropriate and continued use of a particular strategy, and inadequate evaluation during and after the event.

4.2.1.9 The psychologists' BIS plan completion charts show an increase in compliance with implementation of behaviour management strategies in most units audited. They indicate that compliance had risen from 30% in 1995 to 85% in 1997. However, monthly psychologists' reports to the executive state that non-compliance with the BIS plan is still one of the most frequent trends identified as a result of regular monitoring.

Major findings in relation to behaviour intervention and support:

7. The audit acknowledges that the Lachlan Centre has developed a more comprehensive approach to the management of challenging behaviour. Guidelines are provided to enable staff to understand, and provide intervention and support to, residents with challenging behaviour.
8. The guidelines are unclear about who is responsible for making a referral for a BIS assessment.
9. Families and advocates reported inconsistent involvement in the development of the BIS plans.
10. There are insufficient requirements for BIS plans to focus on replacing undesirable behaviour with more desirable behaviour, as plans are more concentrated on controlling behaviour.
11. There is insufficient monitoring and oversight to ensure staff compliance with reactive strategies, which compromises the strategies' effectiveness and can lead to unintended consequences.
12. The high caseloads of the three psychologists means that individuals who require behavioural intervention are not seen as a priority, which impacts on their quality of life.
13. The lack of clinical supervision for psychologists has recently been addressed by the creation of the position of Assistant Manager, Programming, whose role is to provide supervision to psychologists, including oversight of program development and implementation.

4.2.2 Management of critical incidents

4.2.2.1 The Lachlan Centre has an undated procedure titled "Accidents and Incidents". It details the responsibility for notifying parents and guardians in the event of an accident, and defines reporting requirements as involving the completion of a Lachlan Centre "Accident and Injury Form" for accidents involving clients and the "Notice of Injury Form" for accidents involving staff. This local procedure does not comply with the DoCS policy as it does not require that near-miss accidents be recorded. Karingal and the Cottages have a separate procedure called "Checklist for Management of Critical Incidents/Accidents/Assaults". While the purpose of the document is not explained, it details what to do in response to a critical incident, accident or assault and the required form to complete, this being the OH&S form. At the time of the audit it was unclear which of these procedures applied across the service, as they were both supplied as current procedures. However, DoCS now reports that the Karingal and Cottages procedure was adopted as a centre-wide procedure on 27 November 1997.

4.2.2.2 The audit was informed by the executive that there are four forms for recording incidents: the DoCS OH&S "Injury/Illness/Accident Report Form"; the Lachlan Centre "DON Incident Report" (to be completed for all incidents); the Lachlan Centre OH&S data sheet (staff injuries only); and the DoCS "Briefing Note" (client on client assaults). The audit saw evidence that not all forms were completed as required. Completed incident forms are sent daily with the unit reports to the executive. The executive then directs action in response to significant incidents, and gives the forms to the NUM3 for data entry. DoCS reports that a "Completing OH&S Forms" procedure has been developed since the audit, which includes legislative requirements for reporting and recording incidents, accidents and assaults. This has not been sighted by the audit team.

4.2.2.3 The Lachlan Centre commenced collecting and entering data on incidents in November 1996, for the purpose of identifying trends, informing service improvements and the development of preventative strategies. As yet, data entry is incomplete and the database is unable to be used for trend analysis. It is concerning that this process is taking so long to set up, and that it is not clear when it will be completed and able to be used as a systemic monitoring tool. The executive reported they were unable to predict when it would be functioning, due to the backlog of data entry. In the interim, the executive's review of incident forms and action arising from this were the

only monitoring and service improvement systems in relation to critical incidents in place.

DoCS reports in their response to the preliminary report, that Senior Clinical Practitioners at area level will monitor injuries and accidents via OH&S reports and will determine area-wide trends and make recommendations on appropriate action. DoCS also reports that the Quality Assurance Checklist and the Supported Accommodation Risk Assessment initiatives are intended to collect data regarding incidents. The checklist targets reporting of incidents and will provide information to the Lachlan Centre and area office. The Supported Accommodation Risk Assessment, when underway, will collect data on the number of incidents and accidents, and provide information trends to Lachlan Centre, the area office and central office.

4.2.2.4 Staff interviews as part of the audit indicated that staff have different views on when critical incident forms should be completed, e.g. one staff member said they would only record an incident if there was an injury, while another stated that they would report an incident which may in future result in unsafe behaviour (e.g. playing with an electrical socket). Another staff member said that if the incident occurred while staff were carrying out a behaviour intervention reactive strategy, it would not be reported. A member of the executive acknowledged the wide variation in what is reported but could not provide any explanation for this. DoCS reports that the recently developed Lachlan Centre Procedures Manual clearly identifies procedures for reporting and documentation of all incidents and includes the requirements of the *Occupational Health and Safety Act, 1983*.

4.2.2.5 A small number of staff interviewed said that they under-reported incidents due to the time it takes to complete forms, the fact that they would be continually filling in forms, and/or some misunderstanding about what to report. There was wide variation between units regarding the number of incident forms completed. In the two units sampled (both with the same number of residents and with similar behavioural needs), one unit had produced 45 reports while the other had completed approximately 5 over the same 3 month period. One NUM expressed the view that the difference was due to under-reporting in one unit.

4.2.2.6 Parents reported inconsistencies in being informed by staff about injuries or accidents involving their relative, e.g. one parent said they had not been informed that their son had been found on the roof of the unit where he lives until some days after the event, whilst other parents said they felt fully informed and were tired of the constant phone calls.

4.2.2.7 The audit reviewed 48 incident forms for one unit from July 1996 to October 1996. Of these 48, 6 recorded that the parents had been notified, 3 recorded that they had not been notified, 15 recorded notification was not applicable and 24 had no entry regarding parent notification. About one third of the incidents were of unknown cause and unwitnessed. Almost one quarter of the incidents were a result of violent behaviour from other residents. Incident forms required staff to complete a section identifying preventative strategies to reduce the recurrence of incidents, however these were not always completed. Where they were completed, the most frequent proposals included the need for increased staff supervision of residents, that staff should follow the BIS, or that the incident was unpredictable/spontaneous.

4.2.2.8 The audit acknowledges attempts by management to resolve high numbers of critical incidents due to the violent behaviour of one resident, by dividing one unit of ten people into two smaller units (of four and six), although this had been identified by staff as a potential preventative strategy some 18 months earlier and was only implemented in October 1997. At the time of the site visit it was too early to see definite results, as data had only been kept for 6 weeks, but there appeared to be a reduction in incidents, based on the records kept by the psychologist on the use of containment and physical restraint for the particular resident.

4.2.2.9 The audit reviewed other documents (e.g. client files, unit reports, clinical meeting minutes) and identified a number of incidents which could be considered "critical", but which were not documented on the appropriate form and reported as such. The audit could find no evidence of any follow up in relation to these incidents.

4.2.2.10 The audit sighted a number of internal fact finding investigations regarding allegations of abuse or mistreatment of residents by staff. While these were conducted according to DoCS procedure, the outcomes were only determinations as to whether or not to pursue disciplinary measures. The Area Manager reported that such investigations are not used to identify systemic weaknesses or problems, but rather to substantiate allegations for disciplinary purposes. In all investigations reviewed there were questions raised regarding potential weaknesses in service provision, outside of whether the allegation was substantiated or not; e.g. during one investigation, it appears it was common knowledge that doors and windows were sticking in certain weather conditions, which resulted in a resident being "stuck" in their room. The Area Manager reported that he expects staff to appropriately address any service issues arising through fact finding investigations and that he does not issue a written request to do so, but may follow up verbally.

Major findings in relation to management of critical incidents:

14. At the time of the preliminary report, the Lachlan Centre had been in the process of collating data for the past year on critical incidents in order to establish a system which allows for the identification of risks, the development of preventative strategies, and informing service improvements. The data entry is still incomplete, which presents a barrier to commencing systemic monitoring. New initiatives which have recently been implemented or are only just commencing, such as the Supported Accommodation Risk Assessment, the Quality Assurance Checklist and the Senior Clinical Practitioners, will collect incident information, monitor trends, and inform service improvements; although it is too early to say how effective these will be.
15. There is inconsistent understanding amongst staff of what a critical incident is, as well as a high variation in compliance with reporting, which impacts on the information captured and the prevention strategies which follow.
16. Parents reported inconsistencies in being informed of incidents, and the sample of completed incident forms reviewed by the audit also raises questions about notification to family members.

4.2.3 Medication and consent for treatment

4.2.3.1 The Lachlan Centre has a medical and dental guide for staff which is part of the loose leaf folder, and medical/dental forms for seeking consent, both undated. There are procedures in place for recording and administration of PRN medication. Appropriate medication controls are in place through medication sheets and the use of locked medication rooms/trolleys. Current medication and treatment sheets are the records used to instruct staff on dosages to be administered and these are signed off once medication has been administered. They are kept with the medication trolley in the medication room. Completed records are kept with the client's file.

4.2.3.2 The audit found evidence of regular reviews of medication, and the OPG reported that it receives regular and detailed information to enable decisions about consents to be made. Staff interviewed for the purpose of the audit were clear about practice around seeking consent. However, in some cases, practices around consent to, and the recording and prescribing of PRN medication were found to be outside legal requirements. For one individual, the audit found there were inconsistencies between the three PRN administration times recorded in the progress notes for a particular day and the records on the relevant critical incident forms. There is also evidence that PRN is given without valid consent, for example the audit sighted records where one resident was given 9 PRN doses over eight days in the absence of a valid consent or a BIS plan. DoCS reports that, since the audit, the Lachlan Centre has issued a local procedure for administering and recording PRN medication, although a copy was not provided to the audit team.

4.2.3.3 Some residents are prescribed PRN medication for behavioural management. Where PRN is the final strategy in a behaviour management plan, there is evidence of staff not following the prescribed reactive strategies prior to the administration of the medication. The psychologists reported that this could be due to inaccurate completion of the required documentation. DoCS reports that monitoring of PRN medication administration where it is part of a BIS plan is now included in the review processes carried out by the Assistant Manager, Programming.

4.2.3.4 There was evidence of poor documentation regarding PRN medication. The audit found that for one individual, the administration of two PRN doses on two different days was recorded in the individual's progress notes but not on the medication form.

4.2.3.5 The audit also found evidence of misfiling of medication charts. Medication charts were not always filed on the relevant individual's file, e.g. one resident's file contained medication charts relating to another resident. The audit was informed by the executive, and this was later confirmed by DoCS, that the Lachlan Centre is currently involved in the development and adaptation of the Northern Sydney area based standardised filing system.

4.2.3.6 While practice guidelines for staff around medication and consent are well established, compliance with these was not always demonstrated, particularly around recording that all steps in a BIS plan were followed prior to the administration of PRN.

Major findings in relation to use and provision of medication and consent for treatment:

17. Clear procedures existed in relation to medical and dental treatment and seeking consent. Appropriate systems for the storage, recording (aside from PRN medication), dispensing and replacement of medications were in place. There was evidence of regular reviews of medication and the OPG reported receiving sufficient information to inform consent decisions.
18. Audit found instances where practices around consent to, and the recording, prescribing and administration of PRN medication were outside legal requirements.
19. There was evidence of PRN being administered as part of a BIS plan, but where all reactive strategies to be implemented prior to the administration of PRN were not followed, resulting in a breach of the BIS. There was also evidence of poor documentation in relation to the administration of PRN medication and misfiling of medication charts. Monitoring of the administration of PRN medication as part of a BIS plan will now be undertaken by the Assistant Manager, Programming.

4.2.4 Health care, nutrition and hygiene

Health care

4.2.4.1 All consumers access General Practitioners either on or off site. Residents also access an external generic neurologist. The Westmead dental clinic is used by most residents. A psychiatrist visits the site on a fortnightly basis. A local pharmacist provides a daily pharmaceutical courier service. Some consumers access their own doctor, although some parents indicated they were unaware that this was a choice available.

4.2.4.2 There was evidence of regular medical and dental reviews for most residents. Regular annual medical reviews are required by, and occur as part of, the implementation of ISPs. There was evidence that one resident did not have a current ISP, as the most recent one on file was dated October 1995, which could mean he does not have regular medical reviews.

4.2.4.3 There is a system for regular recording of weight, seizures and menstruation. There is no correlation of weight charts with BMI, expected weight for age, or other objective criteria. Entries are not always made each month and changes or issues of concern do not always trigger appropriate action or follow up. For example, families reported instances where staff did not take appropriate or timely action for a seizure or for an irregular Pap

smear test. DoCS reports that the irregular Pap smear result occurred in 1994 when on site doctors were used and results were sent to the Lachlan Centre. According to DoCS, with the introduction of medical services through local GPs, and with results of tests sent directly to the referring doctor, the likelihood of failure to respond has been reduced. Lachlan Centre management acknowledges that there is a need for greater individual focus in routine care such as weighing, and follow up to address identified problems. This will be addressed through the new Lachlan Centre Procedures Manual.

4.2.4.4 The responsibility to identify the need for medical attention and to determine if there is any deterioration in health seems to rest with the RN on shift, then the nurse in charge, then night supervisor or NUM. Staff say, however, that to pick up problems, the staff member must be familiar with the residents. The "Information to be Recorded in Daily Progress Notes" procedure requires that physical status be recorded in progress notes at each shift. However, the audit's review of progress notes indicated that this reporting of physical status does not always occur, thus leaving potential health deterioration unreported.

4.2.4.5 The audit found a reasonable level of awareness amongst staff of infection control procedures, and an Infection Control Manual in all units.

4.2.4.6 Therapy services accessed by the Lachlan Centre include a physiotherapist, speech therapist, podiatrist, dietitian, music therapist and massage therapist. Referrals to these services occur as a result of ISP reviews, medical referral or case manager referral.

Hygiene/physical environment

4.2.4.7 The audit observed a clean internal environment, notwithstanding aged bathrooms in very poor physical condition. The audit was informed by an advocate that she had raised concerns with the service about a urine soaked bed base which was unhygienic and foul smelling. This was removed and suitable bedding replaced. Some of the outdoor equipment and verandah surfaces were dirty. There is minimal provision of shaded areas in the enclosed yards.

4.2.4.8 The executive reported that submissions have been made, to date unsuccessfully, to upgrade the Lachlan Centre site, including requests for refurbishment, renovation of bathrooms and increased shade for enclosed yards.

DoCS reports that property condition audits, as part of the department's Capital Works Program, were completed in December 1996. As a result, a

budget of \$250,000 has been allocated for refurbishment works at Lachlan within the 1998/99 financial year. This will involve refurbishment of bathrooms, kitchens and residents' accommodation, including provision for individual bedrooms. It is concerning that such improvements are only now being planned, 2 years after the audit.

4.2.4.9 Staff reported to the audit that consumers are made aware of cleanliness and hygiene through ISP programs, daily routines and prompts by staff.

4.2.4.10 Linen is contracted out to an external laundry service, while residents' individual clothing is done in washing machines on each individual unit.

Nutrition

4.2.4.11 The Lachlan Centre uses the cook chill system to purchase meals from Gladesville Macquarie Hospital. Breakfast is continental style. Lunch consists largely of sandwiches or hot meals. Residents have BBQs or buy fish and chips, pizzas and McDonalds for lunch once a week, as organised by the NUM. Residents also have morning and afternoon tea, as well as a light supper consisting of a variety of food such as pizza, toast, crumpets, fruit, cake, 'rice-cream' or custard as well as tea, coffee, juice and milkshakes, depending on diet and individual choice. There is a coke machine on the side verandah of one unit which can only be accessed by those residents who can use the machine.

4.2.4.12 The Lachlan Centre has a representative on the Gladesville Macquarie Food Services Committee. This committee meets quarterly to plan menus. Issues have been raised by this representative (over a year ago) with the committee regarding the size of meals. Previously, the food was prepared for the needs of people who were ill and had come into hospital for a short stay, rather than mobile adults in good health such as those living at the Lachlan Centre. As a result, meal size and the proportion of protein were increased. Menus for each person are selected and ordered each month. There is a dietitian on the Food Services Committee. Some residents have dietary supplements.

4.2.4.13 There is the opportunity for residents to have some choice in meals but this is limited to the type of food the food service can offer. Resident meetings (commenced in late October 1997) occur every week in Kyewong and CCU and are an avenue for these residents to raise their concerns and preferences. They have succeeded in making changes to some of the meals to better suit their preferences. According to the executive, it is both

the case managers' and NUMs' responsibility to set the menus for each individual. This is determined by what staff have ascertained residents would like, based on observation of their preferences and family information. Attempts are made where possible to comply with the particular religious beliefs of residents. One parent of Indian descent regularly provides dinner for their son, reporting that this is largely to suit his tastes.

4.2.4.14 Each unit has a dining room where residents eat meals, with a maximum of 6 people per dining room. There was evidence of flexibility in dining routines, with some residents in one unit occasionally eating in front of the television.

4.2.4.15 According to the policy on Healthy Lifestyles in the "Lachlan Centre DCS Policies Summary", residents have a right to choose not to participate in a healthy lifestyle, and they only have a right to education and information about healthy lifestyles "where their lifestyle is a matter for consideration in their ISP". There was evidence that this policy is upheld in practice and staff claim they are required to respect choice. One staff member interviewed for the audit said that if they identified a resident not eating and losing weight they would seek a medical explanation and if none was found, they would conclude that it was the resident's choice not to eat. DoCS states that the DCS Policies Summary stipulates that it is to be used to gain a broad overview of procedures only, and that comprehensive knowledge can only be gained by reading the "DCS Policies for Working with People with Disabilities" manual. However, there is still the risk that staff will only refer to the summary document and as a result not follow correct DoCS policy. DoCS also reports that it is in the process of developing policy and procedure on nutrition.

4.2.4.16 A number of residents were identified by staff in one unit as being underweight, however resident weights are not measured against a target such as BMI, so there is no ready means of determining if weight is an issue of concern. From the file reviews of two residents randomly chosen for the audit and who were identified as being underweight, there was no evidence that either had had a dietitian review, or an individual nutritional assessment. Staff to resident ratios in this unit at each meal time were reported to be 2 to 9 residents, with approximately half the residents requiring assistance with feeding.

4.2.4.17 There is no systematic means for the Lachlan Centre to ensure that appropriate and adequate nutrition is maintained, and that any underweight residents and/or those at risk of malnutrition receive appropriate intervention and monitoring. DoCS reports that the identification

of risks and recommendations for follow up are largely left to the General Practitioner once individuals have been referred.

Major findings in relation to nutrition, physical environment, hygiene and health care:

20. Residents undergo regular medical and dental reviews as required by their ISPs.
21. Direct care staff are responsible for identifying the need for medical attention and recording physical status in progress notes at the end of each shift, but this does not always happen. Follow up action in response to identified health concerns does not always take place.
22. Staff interpretation of the Healthy Lifestyles policy (from the “Lachlan Centre DCS Policies Summary”) leaves open the risk of residents’ nutritional health being overlooked. There is no systematic means of ensuring that appropriate and adequate nutrition is maintained.
23. The Lachlan Centre does not require that residents’ weights are measured against a target such as BMI. The result is that there is no measure against which to judge whether an individual’s weight is appropriate, requires monitoring, or is a concern. Systems for ensuring adequate nutrition for residents are lacking.

4.2.5 Access to the community

4.2.5.1 There is no local Lachlan Centre policy on community access.

4.2.5.2 The Lachlan Centre employs a full-time Recreation Officer to facilitate community access. Community access needs are identified through:

- a recreation referral form distributed to residents which they are assisted to complete (or a case manager completes if necessary) to indicate their preferred community based activities;
- individual consultation; and/or

- ISP goals.

4.2.5.3 Some residents have detailed information of their community access activities recorded on a Community Access Calendar each week. This notes the type of activity, location, staff ratio, size of the group and the length of time involved. Visits to the local shops, the on-site cafe, church and to parents/relatives, as well as medical appointments, are included as community access activities. Individual data is compiled and used to provide management with an overall picture of whether inequity in community access occurs and where to channel resources for community access. The data is also used by the Recreation Officer for planning purposes.

4.2.5.4 The Cottages, Lambrook, Kyewong and CCU are unlocked during the day. Here residents can come and go as they wish. Kooinda and some parts of Karingal are locked for reasons of resident safety.

4.2.5.5 Staff and families reported an increase in the amount of community access enjoyed by residents in the past year. There are still, however, significant differences between individual units in the provision of opportunities to access the community. Residents of two of the audited units had regular access and activities, while residents of another had extremely limited opportunities. Staff reported that this is due to the high support needs of the residents in one of these units and the limited staff available to support them on community access. The Parent Forum newsletter recently reported that “extra volunteers (on community access) are always a help to the staff as staff shortages are a constant and ongoing difficulty”.²⁵ Each unit has its own vehicle to facilitate community access. Staff said that this has increased community access for most residents.

One resident had 12 hours a week community access paid for by a DoCS area office. This was reportedly due to historical arrangements and the input of the Community Team case manager.

4.2.5.6 As part of transition a checklist was developed to assist staff ensure positive practices (including community access and communication systems) featured as ISP goals. However the audit saw little evidence that consumers’ community access activities were linked to their ISP goals.

4.2.5.7 Once a week the Recreation Officer takes one regular group of residents to the movies and another to the Homebush Aquatic Centre. Programs are devised in consultation with the NUM from each unit. The

²⁵ From “The Lachlander” Newsletter of the Parents and Friends of the Lachlan Centre Vol. 1 No 1. June 1997.

executive reported that due to limited resources for recreation, not every resident's recreation needs can be accommodated and meeting these needs then becomes the responsibility of the unit staff.

4.2.5.8 The Adult Therapy Unit coordinator reported that only 9 of the 74 residents have access to a day placement off-site despite attempts by the Lachlan Centre to secure more. Most residents attend an in-house program at the Activity and Training Unit. A group of ten residents is involved for 1/2 a day each week in a paper run in the local streets. Limited involvement in programs outside of Lachlan means that the majority of residents spend a great proportion of their time on-site.

The Lachlan Centre executive agrees that residents are disadvantaged by their lack of access to day programs off-site but states that this is affected by the limited availability of places in supported employment options and the fact that Lachlan residents are ineligible for Post School Options funding because of their age.

4.2.5.9 File reviews indicated that for some residents a large amount of their day is occupied with "free time".

4.2.5.10 File reviews indicated that the purpose of community access activities appears to be to provide residents with quality recreation time in the community, with only minimal focus on social integration, skills development, enabling residents to achieve their potential as members of the community, and linking community access to ISPs or transition plans.

4.2.5.11 Parents and advocates were unanimous in their disapproval of the cessation of the annual holiday for residents. The executive reports that the annual holiday was discontinued to enable a redistribution of staff resources to increase community access across the site to all residents and to increase staff to resident ratios. Unless a resident can pay the whole cost themselves, annual holidays are not provided.

Major findings in relation to community access:

24. The quantity of community access has increased significantly over the last two years, however the extent and quality of community access varies greatly between units. Some units have considerable amounts, while others have very little. Even where residents have significant amounts of access, it is not seen as a means of facilitating their social integration or development, and links with ISPs are rare.
25. Off-site day placement activities are accessed by only a small number of residents, with most residents spending the majority of their time at the

Lachlan Centre. A number of residents appear to have a large amount of "free time".

4.2.6 Access to families and friends

4.2.6.1 The Lachlan Centre has no local policy or procedures on promoting family access and maintaining family relationships. Parents and the executive reported that, on the whole, parents are informed of specialist medical appointments, family members are invited to ISP meetings, and information is sent about special occasions such as Christmas parties.

The Parent Forum has commenced publishing a newsletter, "The Lachlander", containing news regarding staff, Lachlan Centre activities, policy and procedures information and transition progress. The service pays for the cost of the distribution of "The Lachlander" to 83 parents, advocates and guardians, the OPG and Community Visitors. Staff identified attempts made to facilitate family contact, such as organising travel to and from their family for some residents.

4.2.6.2 Many families and advocates reported that they felt they could visit their relative at the service at any time, and were not hindered in any way from doing so. A few, however, reported a perception of restricted access, which they believed was due to their reputation for raising concerns. Families had variable experiences of knowing who to contact for information regarding their relative.

4.2.6.3 There was a concern raised by a number of parents regarding the extent of reporting between the executive and the Parent Forum. Some parents who are members of the Forum reported they would prefer more contact. The executive informed the audit that a representative attends (on a roster basis) the Parent Forum's bi-monthly meetings. Other than this, there are no formal mechanisms for general information dissemination from the service to family members who do not attend meetings about service issues and developments.

4.2.6.4 Few residents (compared to the large number who have been identified by the Lachlan Centre as needing an advocate) have advocates. Where residents do have advocates, these relationships were initiated by either the Lachlan Centre or Citizen Advocacy, Ryde/Hunters Hill. The executive reports numerous unsuccessful attempts to secure advocates due to the limited number available. Lachlan Centre has indicated an intention to investigate ways of training and supporting family members and guardians who may not feel confident to represent their family member or person for

whom they are guardian, in consultation with the Parent Forum. While this strategy is a positive one, it will be of limited assistance to those residents without guardians and involved family members. DoCS reports that there is a statewide shortage of advocates, and people in large residential services have low rates of access to the advocacy services that do exist.

4.2.6.5 To facilitate consumer contact with families, the Lachlan Centre has arranged for STD numbers to be keyed in so that calls to family members out of hours do not require going through the switch. Parents indicated that, where their family member had their own room, they felt comfortable and had a private space to visit. Not all residents have their own room. The only phones in Kooinda West and CCU for use by residents is one in the staff room or the NUM's office. This is perceived by some parents and advocates as a constraint to private and free contact. Kyewong, however, has a phone which is located in the outer lounge area to facilitate privacy.

4.2.6.6 The Lachlan Centre did attempt to establish a social companion program for residents whose family have minimal or no contact with them, to be resourced by the residents' amenities fund. However, this was abandoned due to industrial constraints and lack of applicants. There are severe limitations to initiating relationships between residents and people in the community.

Major findings in relation to access to families, advocates and friends:

26. Some provision is made to facilitate access to families, friends and advocates and, on the whole, only a few families reported any barriers to accessing their relative/friend at the Lachlan Centre.

27. There is little opportunity to develop friendships outside the Lachlan Centre. Attempts to match those residents who have no family or others involved in their lives with advocates have been unsuccessful. The lack of advocacy programs, and the low rate of access to those programs that exist for people from large residential centres, appear to contribute to this situation.

4.2.7 Privacy, dignity and confidentiality

4.2.7.1 The service has made efforts to promote privacy in line with DoCS policy, e.g. by remodelling larger rooms to provide a single room for most residents. Some units have undergone renovation and some have been refurbished.

4.2.7.2 Some aspects of the physical environment are not conducive to privacy, particularly the bathrooms. Some toilets have no doors, bathrooms are located off the main corridor, and men and women share the same bathroom. Some bathrooms have toilets within the bath area, with no screens, and some toilets do not have toilet seats. The service acknowledges the limitations of the bathrooms in achieving any privacy and has placed submissions with DoCS for remodelling.

4.2.7.3 Most residents have access to their own room at all times. For those who do not have access, this is to restrict other residents from entering their room and interfering with their possessions, or as part of a behaviour management strategy.

4.2.7.4 The general appearance of units varies greatly. Some units look like a hospital ward, while in others, significant attempts have been made to make them more home-like, with a new coat of paint and smaller dining rooms. Families interviewed for the audit were greatly concerned with the run-down condition of buildings, disrepair of the surrounding grounds and lack of maintenance of the gardens. Lachlan Centre reports that "at the time of the audit the gardener's position was vacant and the grass was being mown by staff at area office while the gardener's recruitment was finalised".²⁶

DoCS reports that "the buildings at Lachlan are the property of the Health Department and major structural change to improve quality of life for residents is dependent on the provision of funding, and agreement from the Health Department".²⁷ DoCS advised that a consultant would undertake an assessment of the Lachlan Centre in July 1998 to determine maintenance work required. The department has since reported that a property audit was completed in December 1996, an implementation plan developed, and consultants recently appointed in relation to architectural refurbishment works; with a budget of \$250,000 for the 1998/99 financial year. While this is a positive development, it has taken nearly two years.

4.2.7.5 The audit noted that staff had made positive attempts to provide/encourage age appropriate personal possessions and decorations in bedrooms. One resident's swing is kept in a locked yard, not in the area where he lives (although the executive reported that he can access this on request), which restricts his ability to use it freely.

²⁶ Letter from DoCS Deputy Director-General, Brendan O'Reilly to the Community Services Commissioner, Roger West in response to the preliminary report of the Lachlan Centre Audit, June 1998 page 11.

²⁷ As above, page 10.

4.2.7.6 Residents reported that they are able to take family members or friends into their room for privacy.

4.2.7.7 All residents were seen to have their own toiletries.

4.2.7.8 Current resident information is kept in the staff office in each unit. All staff can access this. Staff were familiar with the requirement for consent to access client information.

4.2.7.9 The audit found of the 12 resident files reviewed, 3 contained information about other residents, e.g: BIS plans and medical charts.

4.2.7.10 The form titled "Emergency Evacuation Client Profile" located on individual files and used to identify the resident and their needs, had out of date medication listed in some instances and descriptions of the individual which sometimes were negative and labelling, e.g. stealing, absconder. DoCS reported that the Lachlan Centre has completed stage 1 of introducing the Northern Sydney area client filing system which will provide a more systematic filing structure and allow easier identification of misplaced documents. As well, the guidelines for writing daily reports will be redesigned during the development of the Lachlan Centre Procedure Manual and will include statements on focusing on positive aspects rather than negative, and recognising valued status.

Major findings in relation to privacy, dignity and confidentiality:

28. The service is constrained by physical limitations and lack of resources in its attempts to provide a home-like environment and privacy for residents. However, good efforts have been made in providing single bedrooms for most residents, painting and refurbishing some units, and encouraging personal possessions and decorations. Funds have been allocated for further refurbishment during 1998/99.
29. Family members were greatly concerned with, and the audit noted, the run-down condition of buildings, disrepair of the surrounding grounds and lack of maintenance of the gardens.
30. Attempts are made to ensure confidentiality, however in some cases, poor file management has resulted in individual files containing information about other residents. There are also, in some instances, negative and labelling references to individuals in their files.

4.2.8 Skills development

4.2.8.1 Some living skills maintenance and development for residents is undertaken by nursing staff. However, without programming skills, nursing staff are not adequately equipped to promote effective skill development. Staff reported that much of their time is taken up by assisting residents with daily functional needs and that the availability of uninterrupted time to teach skill development is rare. The Community Visitor identified a resident who had a showering program which had been implemented over six months, with the resident consistently only achieving 7 of the 15 steps in the task analysis. In this instance, it appeared that staff were unable to identify that the training program required modification.

4.2.8.2 All residents are offered, on a weekly sessional basis, an opportunity to access the Activity and Training Unit (ATU) to participate in one or more of the following: relaxation, cooking, computer skills, art and craft, grooming and communication. Access is determined by ISP goals, availability of program space and, for some individuals, whether or not staff are available to take them to the ATU. These activities are primarily for recreational purposes although the cooking program, grooming and communication sessions are structured to promote some skill development. The unit has a drama therapist attending 1/2 day per week. The ATU coordinator is requested to provide progress reports for input into ISP reviews.

4.2.8.3 Kooinda West unit has limited access to the services of a Program Officer whose role is to develop task analyses for staff to follow to achieve skill development. At the time of the audit she was working on shift in a direct care role and her program work was limited.²⁸

4.2.8.4 As already noted, only a small number of residents have access to a day program and some residents spend a large amount of their day in "free time".

Major finding in relation to skill development:

31. While efforts are made, the Lachlan Centre is unable to promote the optimal skill development of residents due to the limited programs aimed at this, the lack of staff with programming skills and the predominant focus on meeting individual functional needs.

²⁸ Task analysis is a breakdown of steps to follow to facilitate teaching that task.

4.2.9 ISPs, case recording and documentation

4.2.9.1 Local Lachlan Centre procedures for the development and implementation of ISPs exist. The Lachlan Centre uses its DCS Policies Summary to set out general requirements, and supplements this with its own guides and checklists. The DoCS policy manual states it is the responsibility of case managers to coordinate the ISP and conduct the quarterly review. In some units the reviews are conducted at clinical meetings. As part of regular (six weekly) case manager supervision, NUMs monitor the currency of ISPs, but in the absence of a NUM this does not occur.

4.2.9.2 The executive also monitors the currency and implementation of ISPs across the service, by reviewing monthly reports from the NUMs, to ensure plans are updated and regular reviews are occurring.

4.2.9.3 All but one of the resident files audited contained a current ISP. Six of the twelve ISPs reviewed had had a current review of the ISP.

4.2.9.4 Most families and the OPG said they were regularly invited to annual ISP meetings.

4.2.9.5 One ISP sighted by the audit was excellent, showing clear long and short term goals, strategies to meet these, and a focus on progressive skill development. This plan was coordinated by an external DoCS case manger.

4.2.9.6 The majority of ISPs reviewed by the audit focused predominantly on daily routine and basic needs. They tended to be written around short term goals, with these often poorly defined and not broken down into strategies or objectives. In some instances, it appeared that ISPs were used as an opportunity to review and confirm service provision arrangements for residents, rather than as a mechanism for identifying and working towards developmental goals. For example, a short term goal identified for one resident was for “staff to consistently follow L’s written daily routine and procedures” and another resident’s was “for M to comply with unit procedures”. Staff interviewed during the audit stated that the function of an ISP was as a decision making tool rather than a tool to drive service provision. DoCS reports that “Lachlan Centre staff are working with Northern Sydney area to produce an area ISP manual which will contain detailed guidelines and responsibilities. The quality of ISP goals and the

timeliness of review, are part of the quality assurance program which has been implemented.”²⁹

4.2.9.7 Some ISPs observed by the audit had no documented goals, instead just listing the area in which skills were to be gained, e.g. “domestic skills acquisition”. This leaves room for considerable staff discretion as to what this means and how it is to be achieved. Where there were task analyses developed, they were often undated or unsigned.

4.2.9.8 It is common to see in ISP reviews that goals are repeated, remain unchanged over time, or are achieved earlier than anticipated with further development not identified. For example, for one resident, the development of a communication plan was the goal and it was achieved by the following review, but there was no additional goal identified focusing on further development of communication skills for the resident. For another resident, a goal in January 1991 was to “get a speech assessment”. This goal was the same for February 1992 and every other year until the last documented review in November 1997. There is no evidence on file that such an assessment was ever undertaken.

4.2.9.9 It is unclear who is responsible for ensuring implementation of ISP strategies. There is no documentation of decisions made at ISP reviews, only the progress made with goals and usually a statement of the goals unachieved.

4.2.9.10 The service provides case management by linking residents with a staff member who takes responsibility for implementing strategies and monitoring the ISP progress, and who is “to work with, and for, the individual consumer to enhance their access to services, to actively empower them and to coordinate services across organisational boundaries.”³⁰ Due to staff changes or absences some residents do not have a regular case worker. At the time of the audit a staff member was case manager for six residents, although staff usually only have one resident they have case management responsibilities for.

DoCS reports that the provision of case management in large residential centres differs from that provided by Community Support Teams. It is currently considering the development of a case management model and

²⁹ Letter from DoCS Deputy Director-General, Brendan O’Reilly to the Community Services Commissioner, Roger West in response to the preliminary report of the Lachlan Centre Audit, June 1998 page 11.

³⁰ From Case Coordination and Case Management [6.4-1] in “Policies for Working with People with Disabilities” October 1996.

guidelines for large residential services, as part of the review of the DoCS policy manual.

4.2.9.11 Psychologists stated that they provide some training to direct care staff about case management. The case coordination and case management policy requires line managers to supervise case management to ensure quality outcomes for consumers. As one of the units audited was without a line manager, supervision had not occurred for some time. Without regular supervision it is unclear how the service can be assured that the role and responsibilities of case managers are being appropriately fulfilled.

4.2.9.12 Lachlan Centre guidelines inform staff about the type of information in relation to individual residents that is required to be recorded. For example, the guidelines folder contains a checklist titled "Information to be Recorded in Daily Progress Notes", which lists information to be recorded for each resident over the course of each shift, covering issues such as participation in community outings, significant visitors, physical status, medication, etc. There was evidence of non-compliance with these recording requirements.

The audit observed that information recorded under progress notes in the client files often consists only of comments such as "quiet day" or "no problems", yet these were reported by staff as being the most important documentation about individuals. Staff are responsible for recording physical status of each resident at the end of each shift. The audit found inconsistencies between resident file entries and notations in other documents such as the unit books or behaviour charts. This inconsistency in reporting could allow for unrecognised health deterioration, and significantly limits the capacity for effective monitoring and the initiation of intervention by the service. (See also point 4.2.4.4.)

4.2.9.13 In one unit the audit found numerous documents in clients' files that were unsigned and/or undated, and instances where documents (including ISP reviews, progress notes, and medical notes) were not securely attached to the file or assembled in chronological order. DoCS has reported that these issues will be included in the quality assurance checklist.

Major findings in relation to ISPs and documentation:

32. There is evidence of procedures and processes in place for the development and implementation of ISPs, although there are some inconsistencies in how these are undertaken. Families and the OPG are generally invited to ISP annual meetings.

33. Accountability for the outcomes of the ISP process is lacking. Some ISPs do not have identified goals. For those that do, these are often general and do not identify the specific skill to be acquired, focus on meeting basic needs and remain unchanged over a considerable period of time.
34. While efforts have been made to establish a case management system, a number of factors limit its effectiveness, particularly the use of casual staff. The result is that the Lachlan Centre is unable to ensure that case management systems in relation to ISPs meet the requirements of the DoCS position statement in the Case Management policy, as consistent follow through by case workers with an individual resident is limited.
35. Documentation in residents' files and other recording systems is sometimes undated, unsigned, inconsistent and does not meet Lachlan Centre recording requirements.

4.2.10 Safety

4.2.10.1 The Lachlan Centre has copies of its Emergency Response Procedure Manual (instructing staff on procedures in the event of fire/smoke, medical emergencies, other emergencies, bomb threat, evacuation and armed hold-up) located next to all telephones. These are not targeted to residents.

The service advised the audit that the Lachlan Centre had a site visit by a fire brigade officer in April 1996 to assess fire hazards. Lachlan has an agreement with Macquarie Hospital which relates to the maintenance of fire hoses, hydrants, and fire blankets. Macquarie Hospital also includes Lachlan Centre staff in its fire lectures. The service has not conducted any fire evacuation drills. Residents have not been prepared for the event of a fire.

DoCS reports that the Lachlan Centre will implement fire evacuation drills during 1998 and that a fire audit of all large residential centres was conducted in April 1997, with implementation of recommendations from the audit dependent on funding. DoCS has since reported that an implementation plan has been developed which includes upgrading the fire alarm system to ensure a full early warning and back to base alarm system. The project is expected to be tendered by mid-November 1998. It is concerning that it has taken some 18 months to act on the findings of the audit.

4.2.10.2 The audit acknowledges that the Lachlan Centre has made attempts to identify and respond to the physical security needs of the service.

The premises are secured at night by locking the front doors, and people visiting after hours are required to ring the doorbell. Additionally, as part of the 'shared services agreement' with Macquarie Hospital, the Lachlan Centre has a 24 hour security officer who patrols the grounds and responds to any security concerns.

4.2.10.3 One unit audited had held a number of discussion sessions with residents to teach them protective behaviours when they were at risk of being hurt by another resident, through strategies such as "run when you are at risk of being hurt". While the initiative was a positive attempt, the number of resident to resident assaults suggests that further strategies are needed.

4.2.10.4 The service has in place direct dial emergency systems as well as distress alarm buttons and pendants for staff in crisis to gain extra assistance.

4.2.10.5 There are no documented procedures relating to local safety risks, such as repeated injuries or mistreatment of residents by other residents. A recent internal fact finding investigation reported a problem of windows and doors becoming stuck in wet weather (which was perceived by one resident as being locked in her room). The audit found no documented evidence that this finding was treated as a safety risk and appropriately addressed. The roads on the site do not have footpaths and at the time of the audit the grass was long, requiring residents to walk on the roads.

4.2.10.6 Critical incident reports are not currently systematically used to inform preventative strategies and service development, although the Lachlan Centre has commenced to enter them into a database for this purpose. The executive identifies significant issues of concern in the daily monitoring of the forms, and initiates action if and when it is determined necessary. This process would make it difficult to identify systemic issues.

DoCS reported that data on critical incidents and injuries will be collected through the Quality Assurance Checklist (commenced June 1998), and analysed by the Northern Sydney area Senior Clinical Practitioner. The Supported Accommodation Risk Assessment tool will collect information on correct reporting of, and response to, incidents. Analysis of this data from large residential centres will then be performed at central office and will inform the development of preventative strategies.³¹

³¹ Letter from DoCS Deputy Director-General, Brendan O'Reilly to the Community Services Commissioner, Roger West in response to the preliminary report of the Lachlan Centre Audit, June 1998 page 12.

4.2.10.7 The audit noted file entries and incident reports indicating a range of unexplained injuries to residents, including "bruising" and "cuts". Staff reported that it is not always possible to establish the cause of an injury, and that residents often incur injuries out of sight of staff. The audit sampled three months of critical incident reports from one unit and, of these forty-five reports, fourteen reported the cause of the injury as unknown.

Major findings in relation to safety:

36. While some steps have been taken to improve safety measures, more is required in relation to preparing residents for emergencies, minimising resident injuries and developing preventative strategies in a timely manner. There are currently no fire drills for staff or residents, however DoCS reports that a fire audit was undertaken of all large residential centres in April 1997, but some eighteen months later, action is still to occur.
37. There is currently no systematic way to capture critical incident information to ensure the reduction and/or prevention of incidents, although a number of recent initiatives are intended to fulfil this function.

4.2.11 Complaints and concerns

4.2.11.1 The executive stated that, in the absence of a local complaints policy, the DoCS complaints policy is used.

4.2.11.2 Staff interviewed for the audit demonstrated an inconsistent understanding of what a complaint is and how it should be recorded and responded to. The executive reported that in early 1996 all managers attended an "Effective Complaints Management" training day. DoCS reported that a revised complaints manual with explicit directions and guidelines for all staff in relation to the management of complaints was issued in December 1997, after the site audit, and this includes the requirement that all complaints are to be centrally registered on the computerised customer complaints system.

4.2.11.3 Complaints are generally handled at the unit level unless the matter cannot be resolved. It will then be referred up through the NUMs to the executive.

4.2.11.4 If an allegation of a staff member assaulting a resident is made, it is followed up with an internal fact finding investigation, generally conducted by a Lachlan Centre staff member and/or a staff member from area office, or is referred to the police as required by the *Public Sector Management Act 1988*.

4.2.11.5 Other serious complaints have been taken up by complainants with external bodies, such as the commission.

4.2.11.6 Family members and advocates reported wide variation in their experience of how complaints are managed. Through discussions at the forums held during the site visit and from phone contact, some parents who had experienced problems with the service said they were not satisfied with the service's response and stated that they had been made to feel unwelcome or uncomfortable by staff and management after they had questioned aspects of their family member's care. Others reported that particular direct care staff were very efficient and effective in handling their complaints and concerns.

4.2.11.7 There is no formal mechanism to inform residents or families of their right to make a complaint and the process to use, aside from the departmental brochure developed for all DoCS services which was sent to all parents and family members of residents over eighteen months ago.

4.2.11.8 Although the Lachlan Centre has a complaints register, information from complaints is not used to identify service weaknesses, improve service practices, or influence policies. The data about complaints is not used as a performance indicator or as part of a quality assurance mechanism.

Major finding in relation to complaints and concerns:

38. Staff do not have a consistent understanding of what constitutes a complaint. There is no local policy on complaints handling, and family members and advocates reported variation in how their complaints were managed. Information from complaints is not used to identify service weaknesses or areas for service improvement.

4.3 Objective 3 - Monitoring and accountability mechanisms within the service

To assess the adequacy of the management and direct staff responsibility and accountability mechanisms for policies and procedures, including responsibility for their initial development, their dissemination, implementation, monitoring and regular review.

Under this objective, the audit examined the roles and accountabilities of staff and management, the mechanisms for monitoring and reporting performance, quality assurance mechanisms, and strategies for independent review.

4.3.1 Roles and accountabilities of staff and management

4.3.1.1 The Lachlan Centre has contracted a consultant to establish a mechanism for local procedure development and review (see 4.1.1.3). Policy dissemination takes place at transition planning meetings, executive meetings, NUM meetings, team meetings and in some instances at Parent Forums. Monitoring of compliance with departmental policy occurs as part of the area based quality assurance process.

4.3.1.2 Since the release of the 1995 Lachlan Inquiry Report, the OPG has noted that the transfer of NUM2 and NUM3 positions from direct care responsibilities to management and monitoring roles has resulted in improvements to the centre's management systems. Staff interviewed during the audit could identify who they were accountable to and where to obtain authorisations from.

4.3.1.3 Some Lachlan Centre guidelines for practice (including guides and checklists for behaviour intervention and support) specify the required authorisation requirements.

4.3.1.4 Some position descriptions are comprehensive and identify responsibilities, skills and knowledge required, while others are lacking in detail and provide a brief list of the tasks associated with the job only. Position descriptions do not explicitly require staff to work in accordance with relevant policies and procedures and are not linked to any framework within which staff must operate, such as rights of residents, the Principles of the DSA, or case management roles and responsibilities. Performance indicators are not defined. The audit acknowledges that the executive is reviewing position descriptions and that this process is not yet completed.

4.3.1.5 The Lachlan Centre uses formal internal fact finding investigations to identify whether or not to initiate disciplinary inquiries in relation to allegations involving staff assault of residents.

Formal supervision arrangements are in place for the executive, NUMs, RNs and CNSs, but from records sighted during the audit, and staff interviews, formal supervision for RN positions in Kooinda West does not always occur regularly, largely due to the vacant NUM position. The DON has regular supervision with the Area Manager.

DoCS reported, in response to the preliminary report, on new supervision initiatives which will be established at the Lachlan Centre. These include the following:

- replacing its supervision system with the departmental performance appraisal system, which will result in more systematic supervision of, and increased accountability for staff;
- nursing staff will be supervised through nursing line management, with overall accountability to the DON;
- the psychology staff are supervised by the Assistant Manager, Programming, with overall accountability to the Senior Clinical Practitioner; and
- the DON is supervised by, and has a performance agreement with, the Northern Sydney Area Manager.

4.3.1.6 The Lachlan Centre recognises the inadequacies in the medical model of care in meeting residents' needs. However, it is currently limited in its ability to develop and build on staff competencies in this regard. Lachlan had arranged with DoCS' Corporate Staff Development Unit to introduce competency based training to staff employed by the service. However, the Health and Allied Research Employees Association, which until recently represented nursing staff in institutions, instructed that no such training was to take place for staff employed in Nursing in Disabilities. The Nurses' Association (NSW) which now represents these staff has maintained this position. All permanent staff and casuals who have case management responsibilities did attend a course on the DoCS Policies for Working with People with Disabilities in July 1997. Other training offered to staff in the last 12 months has been run by either Macquarie Hospital or internally and has covered "stress debriefing", staff selection, OH&S committee training, computer skills, management skills and CPR. Management believes that additional training is required to ensure that staff are able to meet the requirements of the DSA.

DoCS reported in response to the preliminary report that the Northern Sydney area office is currently undertaking a comprehensive assessment of training needs for staff, including staff at Lachlan. This information will inform the development of an area and Lachlan Centre training needs plan.

However, DoCS has stressed that there are limited resources available at the Lachlan Centre or area level for training.

4.3.1.7 The high number of staff vacancies and problems with recruiting suitably experienced people affects the ability of the Lachlan Centre to provide a quality service.

DoCS reported in response to the preliminary report that Lachlan Centre management, in conjunction with central office, is currently working on options to broaden the recruitment base for the Lachlan Centre, including additional classifications for direct care staff. However negotiations with the relevant industrial associations were progressing slowly and considerable difficulty was expected in resolving these matters. We have since been informed that there has been a change of union coverage for nursing staff and the negotiations have yet to resolve this issue.³²

4.3.2 Monitoring and reporting performance

4.3.2.1 The service does not have identified key result areas or performance indicators. The centre reports to ADD on its transition plan progress on an annual basis, and has recently completed a self assessment for DoCS central office against the baseline criteria and participated in the first stage of the peer review process which is due to be completed in December 1998. It has also commenced providing the area office with Tier 1 applications. Routine monitoring by DoCS senior management occurs via the Senior Clinical Practitioners who commenced in April 1998 and use the Supported Accommodation Risk Assessment which assesses and reports on services practice and management systems. Monitoring by ADD will take place through the service performance agreement with DoCS, when this is established.

DoCS reported that a business plan for the Lachlan Centre will be completed for the 1998/99 year. Key result areas will be identified from the action plan that was developed following the centre's self assessment against the transition plan, and from the centre's performance against the baseline criteria. DoCS also reports that the Lachlan Centre has been included in the soon to be implemented Northern Sydney area Quality Assurance Program, which will monitor service standards, management systems to support practice, and service user views. The Supported Accommodation Risk Assessment to be conducted by Senior Clinical Practitioners will feed into and inform central office monitoring. While such initiatives are positive and

³² Phone call on 11 November, 1998 with NUM3 Lachlan Centre.

should contribute to better management and improved performance, it is too early to see any results in this regard.

4.3.2.2 The executive reported that it reviews the following documents on a daily basis: accident and incident reports, the daily unit reports, DON reports, and complaints which are registered, in order to monitor service delivery and be alerted to any issues which need immediate attention. Other documents regularly reviewed include those relating to staff recruitment, staff development, OH&S and HR issues, food services, quality assurance forms, community access details, minutes of Parent Forum meetings, budget and finance, shared services issues (arrangements between Macquarie Hospital and Lachlan Centre), maintenance, Tier 1 applications and ISP status. However, the service's current capacity to use this information to identify systemic weaknesses and areas for service improvement is limited, due to the lack of trend and patterns analysis provided by this information. DoCS reports that Lachlan is included in the Northern Sydney area quality assurance process, results of which will be collated at area level and made available to the Lachlan Centre. These will be incorporated into continuous improvement plans for residential units and performance reviews for staff.

4.3.2.3 There is an emphasis on nursing staff supervision by NUMs to monitor staff knowledge, practice and progress with responsibilities. Psychologists are now supervised by the Assistant Manager, Programming and Senior Clinical Practitioners in relation to clinical matters.

Monitoring of service provision by the executive appears to occur primarily through regular NUM, program and executive meetings, as well as reports on a range of practice areas presented at these meetings and during supervision. The audit saw evidence that Lachlan Centre also uses a range of internal, routine and random performance audits covering progress of ISPs and reviews, behaviour intervention and support strategies and community access. These audits are conducted by members of the executive. The purpose of these is to monitor compliance with departmental policy.

Monitoring strategies appear to focus largely on quantitative outcomes and compliance with process. For example, the quality of ISP goals or the degree of social integration involved in community access is not reviewed. The DON also uses regular spot checks on staff by walking up to a staff member chosen at random and asking a list of questions which check the following:

- understanding of policies and procedures, their role, duties and unit practices;
- evidence of completed induction, current supervision and appraisal; and
- progress with their case management responsibilities.

4.3.2.4 The Lachlan Centre is in the process of collating information about critical incidents in order for information to be systematically analysed so that appropriate intervention is triggered. This is not yet implemented due to the limited progress with data entry and is therefore not able to inform appropriate intervention or prevention strategies (see 4.2.2.3).

4.3.2.5 Staff's inconsistent understanding of what constitutes a complaint and which matters are required to be recorded means that not all relevant information is captured, which limits the service's ability to identify deficiencies in its practices or policies.

4.3.2.6 The DON meets with the chairperson of the Parent Forum regularly to discuss any issues of concern or interest to the forum. It is unclear what impact these discussions have on service delivery. There are only 3 parents and 2 consumers who are involved at a decision making level within the service via the transition planning meetings. There is no mechanism by which family members, consumers and advocates can contribute to a review of service performance.

4.3.2.7 There is no formal reporting to stakeholders by the service. Parents have initiated the Parent Forum newsletter to keep themselves up to date with news of the service. The newsletter had at the time of the audit published only one edition (in June 1997, although more have been published since this date), and it was distributed to all parents by the Lachlan Centre. Information for inclusion in the newsletter is sought by the president of the Parent Forum from NUMs of each unit. There are no Lachlan Centre initiated newsletters or information sheets provided to parents and advocates. The Lachlan Centre does not produce an annual report.

4.3.2.8 The Northern Sydney area office conducted a policy training evaluation amongst staff in September 1997 to assess the extent to which staff understood key concepts and strategies to implement policies at the local level to ensure consumer awareness of policy. As at March 1998, no results had been reported.

4.3.2.9 The Lachlan Centre reports that it responds to a range of external agencies or interest groups, including the OPG, Community Visitors, Guardianship Tribunal and the commission. These bodies expressed the view that they have a good working relationship with Lachlan Centre and staff, and that Lachlan over recent years has become more open, accessible and interested in external input.

4.3.2.10 The Lachlan Centre has made submissions to upgrade the Lachlan Centre site, including requests for refurbishment and renovation of

bathrooms and increased shade for enclosed yards, which have to date been unsuccessful. The “Performance Audit Report of Large Residential Centres for People with a Disability in NSW” recommended that the government make available sufficient funds to implement recommendations in the DoCS property condition audit that relate to resident safety and the basic condition of accommodation in large residential facilities.³³

4.3.3 Quality assurance

4.3.3.1 According to DoCS, the Northern Area Quality Assurance Program, the Peer Review process and the Supported Accommodation Risk Assessment tool will assist with monitoring service standards, management systems and service user views at the Lachlan Centre, and will be used by the Lachlan Centre and central office to identify service improvements. SARA, the Peer Review process and the Northern Sydney Area Quality Assurance Program appear to be valuable initiatives, however, as these mechanisms are only just being implemented and as only limited information on them was provided to the audit team, it is not possible to comment on their effectiveness.

4.3.3.2 Current policies and procedures are inadequate for quality assurance purposes. While there are many documented procedures available for staff (e.g. ISP process and behaviour management guides), other practices operate outside any guidelines (e.g. case managers’ responsibilities, which are not spelt out in job descriptions), and consistent implementation across the site cannot be ensured.

4.3.3.3 The service has sought input from professionals external to the Lachlan Centre in an attempt to improve service delivery. The DON, as part of the area senior management team, participated in the formulation of an annual training plan for the area. However, DoCS reports that it must be recognised that there are limited resources available to the Lachlan Centre or area level for training.³⁴ Some nursing skills training is provided on an ongoing basis through the Department of Health. Psychologists and program staff have recently completed a 10 day course run by the Training Resource Unit for the Northern Sydney area of DoCS on streamlining behavioural assessment and intervention. The Lachlan Centre takes nursing degree students from the Australian Catholic University, University of Technology

³³ The “Performance Audit Report of Large Residential Centres for People with a Disability in NSW 1997”, page xviii.

³⁴ Letter from DoCS Deputy Director-General, Brendan O’Reilly to the Community Services Commissioner, Roger West in response to the preliminary report of the Lachlan Centre Audit, June 1998, page 13.

Sydney and the University of New England. The executive acknowledges the value that new students, often with broad competencies, bring to the centre.

4.3.3.4 Unit staff allocation has been reviewed at the Lachlan Centre by the executive, and staff have been reallocated based on identified consumer needs. Staff identify this initiative as beneficial to residents, although some units acknowledge that they are still to maximise what can be achieved for residents with the extra staff. Staff rotation has been implemented between units in order to develop staff skills across the Lachlan Centre.

4.3.3.5 The service has established an Occupational Health and Safety Committee with representatives from most units, however this committee is currently inactive as there is a vacancy in the position of chairperson.

4.3.4 Independent review

4.3.4.1 In the last 2 years, the Lachlan Centre has focused on implementing the recommendations of the Lachlan Report and improvements to service delivery are clear. The audit was told of significant improvements for residents since the release of the Lachlan Report from a range of sources, including the OPG and Community Visitor, through strategies such as community access, reduction in the number of locked areas, improved behaviour management, seeking consent and developing ISPs. The OPG identified areas still requiring improvement but where progress was occurring, such as increasing the positive aspects of the BIS plans rather than focusing on reactive strategies. There were consistent concerns expressed in interviews with a number of senior guardians about the poor staffing levels and inadequate resources.

The Community Visitor also raised concerns with reward systems used as part of BIS plans and reported observing the escalation of behaviours as a result of implementing particular reactive strategies with individual residents (such as repeatedly telling the person to stop a behaviour). He also identified that skill development for residents is poor due to the lack of awareness or understanding by staff of how to develop and implement strategies that are appropriate to the individual's needs. His overall perceptions were that, whilst Lachlan Centre has developed a range of quite sophisticated tools to enhance the quality of service provision, their efficiency and effectiveness is limited by a lack of understanding about and training in how to use them, as well as insufficient time and resources to do so effectively.

4.3.4.2 DoCS has never initiated an independent review of service quality or overall practices. There also appears to have been only minimal

assistance provided by DoCS to the executive in establishing, reviewing and improving management and performance monitoring systems.

4.3.4.3 Independent professional input has been obtained for some residents from a speech pathologist, behaviour intervention specialists, and from medical practitioners, as well as others identified previously (see point 4.3.3.2). Outcomes of the Lachlan Demonstration Project have achieved significant flow-on effects to other units at the Lachlan Centre, such as the model for the development of transition plans for individuals.³⁵

Major findings in relation to accountability of management and staff:

39. Significant improvements to management at the Lachlan Centre have been reported from a number of independent sources. The centre is perceived as more accessible and open to outside input, however there are still risks to residents' safety, insufficient opportunities for skill development and limitations to an acceptable quality of life.
40. Performance monitoring systems exist but these lack the efficiency and effectiveness necessary to enable systematic and timely detection of weaknesses and the development of improvement strategies.
41. There are current limitations of some position descriptions and supervisory arrangements, changing skill and competency requirements, a focus on meeting residents' basic needs rather than skill development, a lack of appropriate training for nursing staff, and a high staff vacancy rate, all of which impact on the standard of care for residents and the capacity of staff to provide a quality service.
42. The management and internal monitoring systems used by the Lachlan Centre are not yet able to systematically report on the standard of care, systemic weaknesses and areas for improvement.
43. A number of monitoring mechanisms are in the process of being implemented (in the case of DoCS) or developed (in the case of ADD).

³⁵ As a result of the closure of Riverglade, a large residential facility for people with a disability, a number of residents were transferred to the Lachlan Centre until community based placements could be developed. The Lachlan Demonstration Project was established in April 1995 to develop strategies for the placement of ex-Riverglade residents into appropriate community based settings. This involved identifying individual needs then developing transition plans for all ex-Riverglade residents, which flowed on to all Lachlan Centre residents. The other aim of the project was to bring about changes within the Lachlan Centre to ensure an individual needs focus and an acceptable level of service provision whilst these residents were residing there.

However, at this stage, no key result areas or performance measures for Lachlan exist, yearly planning is not formally undertaken, and standard reports in relation to key areas are not required. Routine external monitoring by ADD does not occur and it is unclear how or if monitoring of DoCS services will be undertaken by ADD. While it would appear that improved planning, monitoring and performance measurement processes are being developed by DoCS for internal reporting purposes, it is too early to determine the effectiveness of these.

44. The lack of an annual report or other formal reporting to stakeholders and the limited involvement of families, residents and advocates in decision making about and reviews of service provision lessen public accountability.
45. The Lachlan Centre has made submissions to upgrade the Lachlan Centre site, including requests for refurbishment and renovation of bathrooms and increased shade for enclosed yards, which have to date been unsuccessful.