

**Evaluation: Person Centred Active
Support in rural Victoria**

January 2008

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Contents

Executive summary	iv
Introduction	1
Background	1
Methodology	2
Impact on residents	4
Choice and decision making	4
New activities in the home	7
New activities in the community	12
Range and volume of activities	16
Behaviours of concern	19
Other changes for people with a disability	21
Incident reports and claims	23
Impact on staff	25
Staff job satisfaction	25
Some barriers and issues	29
Conclusion and recommendations	31
Appendix 1: Methodology	33
Appendix 2: Staff questionnaire	35
Appendix 3: List of resources	36

Executive summary

The *Victorian state disability plan 2002–2012* (the state plan) is a whole-of-Government policy document setting out Victoria's vision for people with a disability. It is based on guiding principles of dignity and self-determination (choice) for people with a disability to pursue individual lifestyles and participate in the life of their community. The new *Victorian Disability Act 2006* gives effect to the state plan and reinforces in law the rights of people with a disability to exercise control over their lives and to participate actively in decisions that affect them.

Person Centred Active Support is a program helping to make the principles of the state plan and the new legislation a reality for people living in government-managed community residential units (CRUs). The Department of Human Services (the department) aims to provide staff working in CRUs with the skills required to develop new ways of working with people with a disability, in activities of choice at home and the local community. The approach is based on a philosophy of staff working *with* people rather than doing things *for* them.

In June 2007, the Nucleus Consulting Group was asked to evaluate Person Centred Active Support across a randomly selected sample of 20 of the 44 pilot CRUs. The evaluation investigated if the program had improved the quality of life of people with a disability living in the pilot services and if it had impacted on the job satisfaction of staff.

Both quantitative and qualitative data was collected through a review of records held at houses, other departmental records, face-to-face interviews with people with a disability and staff participating in the pilot, and a confidential survey of staff.

Although there were some problems in obtaining reliable quantitative data (due to the structure of data collection systems prior to the commencement of the evaluation and the capacity of people with a disability to distinguish change over the time the program had been running), the evaluation indicates that Person Centred Active Support has improved both the quality of life of people with a disability and the job satisfaction of staff.

Improved quality of life for people with a disability was demonstrated in a number of ways:

- All 20 sample houses provided people with a disability with decision-making opportunities and findings suggest they were exercising greater choice with regards to everyday activities. Most houses (80 per cent) had detailed communication boards and books on prominent display, many listing options as the basis for selecting preferred activities and photographs demonstrating how people liked support to be provided. In this and other ways, staff had shown willingness and creativity in devising mechanisms to offer choice and encourage people with a disability to make their own decisions.
- All 20 sample houses showed people with a disability were engaged in new activities evidenced by:
 - staff participating in the evaluation (99) identifying 28 new activities in the home and 18 new activities in the community
 - people with a disability participating in the evaluation (34) identifying 23 activities in the home and 21 activities in the community (although many of those interviewed had difficulty saying whether these activities were undertaken prior to Person Centred Active Support).
- All people with a disability living in the 20 sample houses were spending more time engaged in activities than they were prior to the implementation of Person Centred Active Support, with 70 per cent spending at least an extra 10 hours per week engaged in activities.

¹State Government of Victoria 2002, *Victorian state disability plan 2002–2012*, Department of Human Services, Melbourne.

- 71 per cent of houses (12 of 17 houses within the sample of 20) believed behaviours of concern had reduced since the implementation of Person Centred Active Support. Five houses (30 per cent) indicated the amount of pro re nata (PRN) medication administered to manage behaviours of concern had decreased. This was perceived to have been as a result of people with a disability being happier, exercising choice or having improved relationships with staff through Person Centred Active Support. Greater staff focus on positive interactions was also mentioned.

Staff perceptions in this area were supported by a reduction in the number of WorkCover claims and disease, incident, near-miss and accident (DINMA) reports for occupational violence and stress related to behaviours of concern among people with a disability.

These findings demonstrate a number of positive effects of Person Centred Active Support and identify some further promising outcomes. Additional investigation would be required, particularly in areas where reliable quantitative data was difficult to obtain, in order to prove definitive links.

A confidential survey completed by 97 staff in the 20 sample CRUs showed that 85 per cent felt more satisfied with their work since the introduction of Person Centred Active Support. Staff perceived this change to have been a result of:

- people with a disability being happier
- the workplace being more enjoyable and less stressful
- better relationships between staff and people with a disability.

Of the 15 per cent of staff who indicated they were not more satisfied with their work, 8 per cent indicated no change in the level of satisfaction and only 7 per cent indicated that their job satisfaction had decreased since Person Centred Active Support was introduced (due mainly to increased workload and more paperwork).

Staff identified some concerns within Person Centred Active Support, including:

- capacity of the existing data collection system to accurately reflect the true level of engagement of people with a disability (and the level of paperwork required to achieve this)
- potentially limited resources (transport and staff) available to support community participation particularly for those with high and complex care needs.

Ongoing leadership from house supervisors, modelling appropriate behaviour and encouraging staff to reflect on their work were cited by several staff as critical in maintaining the impetus of Person Centred Active Support. The high level of support provided by the department's head office was also identified as having been a factor in success to date, in particular ongoing promotion of good initiatives and sharing these across regions to stimulate ideas and build a significant support base.

In order to sustain and build on the gains produced by Person Centred Active Support, the following recommendations are made:

1. Assist houses to access specialist advice and support on aids and equipment to improve the independence of people with a disability, especially those with high support needs.

2. Provide opportunities for houses to share their successes, tips and ideas about different ways that Person Centred Active Support can be applied, including through an electronic newsletter and statewide forums.
3. Encourage houses to link with other programs designed to improve community access, for example, Access for All Abilities, Companion Card and rural access workers. These initiatives may provide strategies to address resource issues such as transport and volunteer availability. Other strategies to increase community access – especially for people with a disability with high support needs – should also be explored at a regional level (for example, sharing staff and vehicles across CRUs when planning outings and activities).
4. Review requirements to determine the scope for Person Centred Active Support data to be incorporated within existing records (for example, case notes). Electronic data collection could also be investigated, where data is entered once and activity reports generated from the database.
5. Provide ongoing training and support for staff to reinforce and ensure understanding of the principles of Person Centred Active Support and ability to implement it on a day-to-day basis.
6. Continue to provide a high level of Department of Human Services head office support to regions and ensure regional offices remain actively engaged in the initiative.

Introduction

Background

The *Victorian state disability plan 2002–2012* (the state plan) is the Victorian Government’s policy document that sets out its vision for people with a disability living in Victoria:

By 2012, Victoria will be a stronger and more inclusive community – a place where diversity is embraced and celebrated, and where everyone has the same opportunities to participate in the life of the community, and the same responsibilities towards society as all other citizens of Victoria.²

The state plan is based on guiding principles of dignity and self-determination (choice) for people with a disability to pursue individual lifestyles and participate in the life of their community. The new Victorian *Disability Act 2006* gives effect to the state plan and reinforces in law the rights of people with a disability to exercise control over their lives and to actively participate in decisions affecting them.

Person Centred Active Support helps to make the principles of the state plan and the new legislation a reality for people with a disability living in managed community residential units (CRUs) under the care of the Department of Human Services (the department). Person Centred Active Support assists people with a disability and staff to engage positively in everyday activities, directed by the person’s interests and choices.

Person Centred Active Support was developed by the University College of Wales, Welsh Centre for Learning Disabilities, and adapted for use in Australia by the University of Sydney, Centre for Developmental Disability Studies.

Based on the philosophy of staff working *with* people rather than doing things *for* them, Person Centred Active Support aims to provide staff working in CRUs with the skills required to develop new ways of working with people with a disability, in activities of choice at home and the local community.

The first round rollout of Person Centred Active Support was piloted in 44 CRUs across the department’s five rural regions (Barwon South West, Gippsland, Grampians, Hume and Loddon-Mallee) between October 2006 and June 2007. A second round rollout is currently occurring across these regions, due to be completed in June 2008. Rollout of the approach is also occurring across the department’s metropolitan regions and is being evaluated by RMIT University, School of Health Sciences and the University of Sydney, Centre for Developmental Disability Studies.

The model adopted by the department for rollout across the rural regions has involved taking two or three staff off-line in each region for up to 12 weeks to spearhead the approach. This has involved delivering training to pilot house staff and returning regularly (during the time they were off-line) to assist staff to embed the approach into everyday practice.

² State Government of Victoria 2002, *Victorian state disability plan 2002–2012*, Department of Human Services, Melbourne.

Methodology

In June 2007, the Nucleus Consulting Group was appointed to evaluate Person Centred Active Support across a randomly selected sample of 20 of the 44 pilot CRUs (four CRUs per rural region). The objectives of the evaluation were to investigate if the program had:

- improved the quality of life of people with a disability living in the pilot services
- made an impact on staff job satisfaction.³

To meet these objectives, the evaluation sought to collect and analyse quantitative and qualitative data to determine the impact of Person Centred Active Support on people with a disability and staff. More information about project methodology may be found at Appendix 1, including its approval through the department's Human Research Ethics Committee (HREC).

There was significant variation in the mix of people with disabilities living in the 20 sample houses: some had very independent people who worked and travelled in the community while others had people with complex care needs. The purpose of the evaluation was not to make comparisons between houses but rather examine how Person Centred Active Support had been implemented across the sample houses overall.

Staff, people with a disability and next-of-kin (in cases where the resident could not consent) were provided with information about the evaluation and asked to agree to participate. Participation in the evaluation for all parties was voluntary.

Consent to participate in the evaluation was obtained from 76 people with a disability (of these, 35 people signed their own consent forms with the remainder signed on behalf of the person with a disability) and 99 staff working in the sample houses.

The Nucleus Consulting Group visited each CRU and completed the following:

- People with a disability were interviewed and asked questions designed to determine quality of life changes since Person Centred Active Support had been implemented. Questions were asked about decision-making opportunities and the type of activities they undertook in the home and the community since Person Centred Active Support was implemented.⁴ A total of 34 people with a disability were consulted either individually or in small groups; where there were communication difficulties, staff assisted with the consultations.

There were some limitations to this data (referred to later in the report) including poor recognition of Person Centred Active Support among people with a disability (as staff rarely referred to the approach by name) and limited capacity of people with a disability to distinguish changes to their lives over an extended time period.

- Staff were interviewed and asked how people with a disability made decisions and whether there had been any changes in the way that decisions were made since the implementation of Person Centred Active Support. Staff were also asked to indicate the type and frequency of activities people with a disability were engaged in before and after Person Centred Active Support.

³ Department of Human Services, Disability Services Division, *Request for Quotation*, April 2007.

⁴ Self-determination (choice) and social inclusion are accepted measures for determining the quality of life of people with a disability. Plimley, LA 2007, 'A review of quality of life issues and people with autism spectrum disorders', *British Journal of Learning Disabilities*, 35, 205–213.

- Activity and support plans and house communication books were reviewed to determine changes in the number and type of activities people with a disability were engaged in before and after Person Centred Active Support. Data was collected for 64 people with a disability.

Some limitations were also identified in relation to this data, including inconsistent record keeping across houses, data not available for some people (including 12 who had consented to be part of the evaluation) and difficulties identifying data that pre-dated Person Centred Active Support.

- Staff were interviewed as a group and provided with a brief confidential questionnaire (see Appendix 2) in order to address the second evaluation question – the impact of Person Centred Active Support on work satisfaction. To determine changes, staff were asked whether they were more satisfied (yes or no) with their work since the implementation of Person Centred Active Support. They were also asked to provide examples to substantiate claims made.

The number of WorkCover claims made by staff for occupational violence and stress related to resident behaviours of concern (before and after Person Centred Active Support) were also analysed. High levels of stress are known to have a negative impact on job satisfaction and are associated with staff absenteeism and decreased rates of staff retention.

This report provides an analysis of the data collected through the evaluation and a discussion of findings.

Impact on residents

Choice and decision making

People with a disability were asked how they decided what activities they wanted to do in the house and the community and whether this had recently changed.

Only nine people with a disability were able to provide a response to this question, as shown in Table 1. Of these, four indicated they asked staff when they wanted to undertake an activity but were unable to be clear about whether they were asking permission from staff to undertake the activity or were seeking assistance with an activity of their choice.

This finding is not unexpected as, like anyone else, people with a disability need to develop decision-making skills. This occurs through the ongoing provision of opportunities to acquire and cultivate the necessary skills, with steady and consistent support from staff. For many people with a disability living in the 20 sample houses, it is likely that previous residential placements and service experiences provided few opportunities to participate in, and make, decisions in the manner now being offered.

Those people who were able to respond to this question provided responses that showed they did have decision-making opportunities. People with a disability who indicated they made their own decisions provided responses such as:

- *‘Can do what we want to.’*
- *‘I tell one of the staff.’*
- *‘Do everything when I want to.’*
- *‘I ask staff to do things.’*

These comments were frequently accompanied by people smiling and nodding affirmatively.

People with a disability gave the following examples as to the type of choices they made in the home:

- *‘I decide what pictures we go to see by picking from the paper.’*
- *‘I make my own breakfast when I want to.’*
- *‘I pick what to cook from here (recipe book) and I cook tonight.’*

Table 1: Resident decision making (n=9)

Residents' decisions	Number
Ask support staff	4
Make own decisions	3
House meetings	1
Don't know	1
Total	9

Three people with a disability were able to articulate there had been no change to the way they made decisions as they had always made their own decisions, characterised by the comment:

- *'I have always done what I want to.'*

All 20 sample houses promoted choice and decision making for people with a disability. Eighteen of the 20 sample houses had photographs on display of people with a disability engaged in different activities, and 16 of the 20 sample houses had communication boards and books. While a number of the sample houses had these tools available prior to the implementation of Person Centred Active Support, since the approach, they were being used more often and in a more sophisticated fashion to assist people with a disability to recognise planned or regular activities, and to identify forthcoming special events. They were also used to identify preferred activities from a range of options.

Eighteen of the 20 sample houses indicated time was spent in house meetings discussing how Person Centred Active Support was progressing. In particular, this included generating new ideas and suggestions to more actively engage people and promote more choice. House meetings were also used to plan for specific activities and initiatives. Moreover, house meetings were used by supervisors to actively encourage staff to think about new and different ways to engage people with a disability. Several examples were provided of staff coming up with ideas outside of work that could be applied later in household activities. For example, while out shopping, a staff member saw kitchen utensils suitable for use by people with a disability, purchased them and tried them out in the house.

Good practice examples

- ☑ Recipes were cut from magazines and newspapers and pasted into books. Each week, people with a disability choose meals from the recipe book. Colour photographs of ingredients were also cut out and people with a disability and staff used these to develop shopping lists and purchase goods.
- ☑ Take away food containers from different restaurants and cuisines were collected and used by staff to offer choice to non-verbal residents regarding which take-away food they would prefer.
- ☑ Staff created 'chat books' of photographs of people with a disability with family members celebrating special events, involved in community activities and completing household tasks. The books were used to engage people in discussion and to check the preferences of people with a disability.
- ☑ Staff and people with a disability looked at local newspapers each week to see activities happening in the local community. Other household activities such as food shopping were then scheduled around particular events.
- ☑ One house commenced a footy tipping competition. A bear mascot for each team, wearing the team jumper, was purchased. Each week the bears were paired according to matches and arranged on the couch and people with a disability selected the bear of the team they wanted to win.
- ☑ A person with a disability saw an advertisement for Nutella spread and said 'I want that'. Staff took the person to the supermarket, identified the product and helped them to purchase and eat it when they got home. Staff reported the person has since begun to ask more often for things within the house.

Nineteen of the 20 sample houses indicated that Person Centred Active Support training had prompted them to provide choice and promote decision making in all activities. Staff provided a number of examples illustrating how decision making for people with a disability had changed since the implementation of Person Centred Active Support. These included:

Good practice examples

- ☑ Staff at one house used to provide all people with snacks and a drink at particular times of the day. Usually, only milk and biscuits were provided. More recently, people with a disability have been provided with a number of options, including not having anything at all at the 'usual' times.
- ☑ People with a disability in a number of houses were being supported to make choices about the clothes they wore on a day-by-day basis, and at different times during the day. Previously staff had made this decision for them.
- ☑ Individual preferences of people with a disability for particular tasks (such as vacuuming or mowing lawns) were being taken into account during the allocation of household tasks, rather than jobs being 'handed out'.
- ☑ Television guides were being discussed as a group within the house and staff were supporting people with a disability to make choices and gain consensus about what to watch.

Key finding: Choice and decision making

- ① All 20 sample houses were able to demonstrate choice and decision-making opportunities for people with a disability were being provided. Staff had shown willingness and creativity in devising new ways of providing choice and encouraging people with a disability to make their own decisions, since the implementation of Person Centred Active Support.

New activities in the home

In order to determine new activities undertaken in the home since the implementation of Person Centred Active Support, people with a disability (34) were interviewed and asked what types of activities were undertaken and if they had always done them.

A total of 23 activities were identified (see Table 2), with laundry, cooking and gardening most frequently cited. Comments made by people with a disability about activities undertaken in the home included:

- *'I make a cup of coffee, make my bed and put the powder in the washing machine.'*
- *'I feed my cat, look after my cat.'*
- *'I bring the letters in. The Cats are going to win. I put this up [Geelong Football Team poster]. Go Cats.'*
- *'I put the bins out and the letterbox – get the letters from the letterbox.'*

People with a disability were able to say most of these activities were carried out on a daily basis, but only three were able to articulate these were new activities, as indicated by the following comments:

- *'Doing more things now. Keeps me occupied.'*
- *'I now wash my clothes everyday.'*
- *'[Staff member] helped me fix my tyre when it was flat.'*

Table 2: Resident-identified activities in the home (n=34)

Rank	House activities	Frequency
1	Washing/folding/putting away clothes	10
2	Cooking	7
3	Gardening/mowing lawns	7
4	Wash/dry dishes/dishwasher	4
5	Make own breakfast/lunch/snacks	4
6	Play indoor puzzles/games/computer	4
7	Mopping/sweeping/vacuuming	3
8	Make own bed/change linen	3
9	Collect mail	3
10	Put bins out	3
11	Feed pets	3
12	Clean bathrooms	2
13	Choose clothes to wear	2
14	Watch TV	2
15	Read magazines/books	2
16	Clean own room/common areas	2
17	Set table	1
18	Listen to music	1
19	Ironing	1
20	Play basketball	1
21	Choose television programs	1
22	Sew	1
23	Paint	1

It should be noted that almost all people with a disability who were interviewed had difficulty distinguishing between ‘new’ and ‘old’ activities, given the timeframe over which Person Centred Active Support had been in place (for many houses, up to six months). This made it difficult to be clear which of the activities listed by people with a disability in Table 2 were new activities (however, responses from staff usually supported the responses from people with a disability – see later discussion).

People with a disability generally expressed satisfaction with being engaged in the activities in the home, as indicated by the following comments:

- *‘I do the mopping, floors, go shopping. I love it here, I love everyone here.’*
- *‘I clean the basin and the bathroom. I like doing that.’*
- *‘I make pizza. I like pizza.’*

At a group meeting of consenting staff, each house was asked to identify new activities undertaken since implementing Person Centred Active Support. Twenty-eight new activities were identified (see Table 3) across the 20 sample houses (although this may understate the true number as five houses were not specific and gave a blanket response of ‘all household activities’). Evening meal selection and preparation (75 per cent), laundry (60 per cent) and lunch/snack choice and preparation (60 per cent) were the activities most frequently identified by houses.

As noted above, the activities nominated by houses were consistent with those identified by people with a disability. However, staff perceptions of what constituted a ‘new’ activity were likely to be more reliable as they were better able to contrast activities over time (pre and post Person Centred Active Support).

Table 3: House-identified activities in the home (n=20)

Rank	House activities	Frequency
1	Choosing/cooking evening meal	15
2	Wash/hang out/fold/put away laundry	12
3	Choose/make own breakfast/lunch/snacks	12
4	Wash/dry dishes/dishwasher	9
5	Mopping/sweeping/vacuuming	8
6	Gardening/mowing lawns	7
7	Put bins out	7
8	Collect mail	6
9	Self-care	5
10	All household tasks	5
11	Choose clothes to wear	4
12	Clean own room/kitchen/lounge	4
13	Feed/care for pets	4
14	Ironing	3
15	Play ball games (football, basketball)	2
16	Make own bed/change linen	2

(cont.)

Table 3: House-identified activities in the home (n=20) (cont.)

Rank	House activities	Frequency
17	Pack/unpack bags	2
18	Craft activities	2
19	Singing/dancing	2
20	Relaxation, bubble baths/massage	2
21	Play indoor puzzles/games/computer	1
22	Watch TV/select programs	1
23	Read magazines/books	1
24	Set table	1
25	Wash car/bus	1
26	Repairing items	1
27	Footy tipping competition	1
28	Baking/bottling food	1

The 20 sample houses indicated all people with a disability were now engaged in new activities. For some people with a disability, this meant initiating wholly new activities; for others, where they may have had some previous, but minimal experience, this meant taking a more active role.

Examples of new activities developed specifically to engage people with a disability included:

Good practice examples

- ☑ One house established a vegetable garden that won a local gardening award. In addition to gardening chores, people with a disability also learned to bottle and preserve vegetables from the garden to be consumed throughout the year.
- ☑ A house with people with a disability with very high support needs created separate garden spaces for each person that took into account their individual sensory needs. For example, highly scented flowers, very colourful flowers and foliage, highly textured foliage and overhanging foliage for a person in a chair bed.
- ☑ Staff taught one person with a disability how to fix the puncture in his bicycle tyre. Staff stated in the past they would have taken the bike to the shop to be repaired rather than teaching the person how to do it.
- ☑ A house purchased a barbeque and people with a disability were encouraged to use it and sit outside for meals.
- ☑ Staff encouraged people with a disability to bake muffins and other snacks rather than purchase cakes.

Staff also provided many examples of how people with a disability were more actively engaged in activities they already had some experience with. Staff often broke down such activities into smaller component tasks that could be completed either independently, with prompting or with hand-over-hand guidance. Prior to Person Centred Active Support, staff indicated they carried out many household tasks alone or with only peripheral involvement from people with a disability. However, since Person Centred Active Support, staff reported that people with a disability were much more actively engaged in a wide variety of tasks.

Examples of activities that facilitated more active involvement from people with a disability included:

Good practice examples

- ☑ People with a disability who had only minimal previous involvement in doing their washing were encouraged to complete as many component tasks as possible: taking clothes to the laundry, loading the machine, pouring in detergent, hanging out and bringing in the clothes and folding, ironing and putting them away. Some houses had also lowered washing lines or installed a second line to suit people with a disability.
- ☑ People with a disability who had previously only put their lunch into a bag were encouraged to choose fillings for their sandwiches and snacks and fruit to pack from a range of options. Some people progressed to making their own lunch without staff support or prompting.

In houses where people with a disability were quite independent, staff indicated Person Centred Active Support had less of an impact as people had always been actively involved in a range of household tasks. A small number of staff also commented that people with a disability with fewer support needs tended to be asked more often to participate in activities as they were easier to engage, quicker to acquire new skills and required less staff direction.

In houses where people with a disability had moderate to higher support needs, staff indicated that Person Centred Active Support had challenged them to think of different ways to engage and include all people in everyday activities. Houses with people with higher support needs also reported requiring a larger investment of time to break down activities into component tasks and actively support people to complete them. Examples included:

Good practice examples

- ☑ Several houses with residents with high support needs or limited capacity to make choices reported that prior to Person Centred Active Support they would do tasks without including the person with a disability. Now staff ensure the person is in the room when clothes are being selected and talk to them about items being chosen. They also place clothes on the person's lap while they are wheeled to the bathroom or when putting away laundry; and take the person out to the letterbox to collect mail and place it in their hand or on their knee to bring it in.
- ☑ Staff prompted people with very high support needs to pass their cup rather than staff clearing away the dishes. Over time, one resident initiated handing their cup to staff and now passes other people's cups as well.
- ☑ Staff in a house with people with very high support needs now use hand-over-hand techniques for carrying out the majority of tasks, for example raising and lowering beds. Staff indicated that people showed surprise and shock when this was first done, but now their eyes 'light up' when they assist with raising and lowering the bed.

New equipment

All 20 sample houses had made, or purchased from money provided, adaptive equipment to further support increased participation (see Appendix 3 for full list). Several houses purchased specialised equipment for people with a disability to use, especially those with high support needs, to increase independence in daily living activities. For example, non-slip bowls, modified drink cups and eating utensils.

Several staff commented they would like to purchase specialised equipment, but did not know from where or which equipment would best suit. Houses were generally unaware of specialist services that provided such advice for example, occupational therapists at community health services, and had limited opportunity to visit dedicated services such as the Yooralla Independent Living Centre (Melbourne).

Examples that illustrate the value of acquiring adaptive equipment included:

Good practice examples

- ☑ Staff purchased a small urn and placed it on a stand, enabling the coffee cup to sit underneath. This eliminated the need for people with a disability to pour boiling water from a kettle and reduced the risk of burns.
- ☑ Staff purchased recipe books that had been written for people with a disability. Over time people with a disability have learnt to follow the recipes with less and less guidance and now they express preferences as to which meals to cook from the range of recipes provided.
- ☑ Staff encouraged people with a disability to make their own coffee but found they had difficulty controlling how much coffee went into their cups. Staff purchased coffee and sugar sachets so that people with a disability could make their coffee without overfilling coffee and sugar.

Key finding: New activities in the home

- ① All 20 sample houses demonstrated people with a disability were engaged in new activities in the house since the implementation of Person Centred Active Support.

New activities in the community

In order to identify new activities undertaken in the community, people with a disability (34) were asked what activities they did in the community and whether they had always done them. Twenty-one different activities (see Table 4 below) were identified.

As with data in the previous section, from the responses provided by people with a disability, it was difficult to be clear which of the activities were new activities.

The activities most frequently identified by people with a disability included shopping (personal and shopping for the house), going for drives and outings, going to the movies and visiting relatives.

Table 4: Community activities identified by people with a disability (n=34)

Rank	Community activities	Frequency
1	Shopping	6
2	Drives/outings	4
3	Choose and attend movies	4
4	Visit relatives	4
5	Dancing	3
6	Attend community groups/activities	3
7	Swimming	2
8	Meals out	2
9	Walking	2
10	Attend church	2
11	Activities with other CRUs	1
12	Bike riding	1
13	Watching football	1
14	Fishing	1
15	Catching the bus	1
16	Volunteering	1
17	Bowling	1
18	Choose and hire/buy DVDs	1
19	Hairdresser/beautician	1
20	Holidays	1
21	Playing sport	1

Note: some people provided multiple responses

Five people with a disability were able to articulate an increase in the frequency of these activities:

- *'I now go to church each week.'*
- *'I do more dancing.'*
- *'I like doing pottery. I do more now.'*
- *'I love fishing, we go fishing now and we have a beer.'*

- *‘New people are working here. We are now going to the movies.’*

At a group meeting of consenting staff, each house was also asked to identify new activities undertaken in the community since the implementation of Person Centred Active Support. Eighteen new activities were identified (see Table 5 below).

Shopping (75 per cent), attending new community groups and events (40 per cent), dancing (30 per cent) and going out for coffee or a meal (30 per cent) were the most frequently cited:

Table 5: Community activities identified by houses (n=20)

Rank	Community activities	Frequency
1	Shopping	15
2	Attend community groups/events	8
3	Dancing	6
4	Coffee/meals	6
5	Drives/outings	4
6	Choose and attend movies	4
7	Hairdresser/beautician/massage	4
8	Walking	4
9	Watch sports matches	4
10	Visit/telephone/write to relatives	3
11	Holidays	3
12	Play sport	3
13	Attend church	2
14	Fishing	2
15	Gym/yoga	2
16	Doctor	2
17	Friends for meal/coffee	2
18	Learn musical instruments	1

Note: some houses provided multiple responses

As noted in the previous section, from the responses provided by people with a disability it was difficult to be clear which of the activities were ‘new’ activities. However, staff responses, as shown in the table above, supported the responses of people with a disability. Staff were also able to be more certain about new activities.

Again, as with findings in relation to activities undertaken in the house, the level of engagement in nominated community activities was the factor that had changed most. (‘New’ activities were defined to include activities that people with a disability may have had some exposure to in the past, but were now more fully engaged in and participating at a more active level.)

To illustrate this, 15 of the 20 sample houses identified shopping as a new activity although in some cases people with a disability had previously accompanied staff on shopping trips. To demonstrate how the level of engagement and participation was increased, making an ‘old’ experience ‘new’ for some people with a disability, the following examples were provided:

Good practice examples

- People with a disability were asked to carry the shopping list and assist in identifying items on the shelves. Staff placed the items into the hands of the person to help them put the items in the trolley.
- People with a disability selected their own clothes and brands of items for their personal shopping. This included testing and sampling products such as perfume and nail polish.
- One house cancelled the home-delivered newspaper so people with a disability could walk to the shop and purchase it.
- People with a disability carried money in their own purses and were supported to pay for items themselves, instead of staff paying on their behalf.

Other examples of new community activities introduced since implementing Person Centred Active Support included:

Good practice examples

- Staff at one CRU used to cut the hair of people with a disability to save money. All people with a disability now attend the local hairdresser and have their haircut professionally, and interact with the hairdresser and others in the salon.
- People with complex care needs now attend the local doctor whereas previously the doctor made house calls.
- Staff individually take people with a disability shopping to buy birthday presents for family members or others in the house.
- Staff purchased a shopping trolley so people with a disability could walk to the local shops to purchase goods rather than being driven.

'Outings' was also identified as a new activity with staff reporting increased frequency and more creative destinations. Many of the examples provided showed staff considered local options that could be easily managed without a high degree of planning, such as having a barbeque in a local park. Other examples provided by staff indicated a high level of planning was undertaken to increase the range of community activities, for example going on a camping holiday.

Examples of new activities undertaken in the community included:

- attending art galleries and openings in local towns
- attending garden expositions
- attending local and regional markets
- attending concerts, shows and the football in Melbourne
- going on Puffing Billy
- going for walks through local forests
- attending local sporting events
- eating at different venues rather than going to the same restaurant or club that had always been frequented

- learning yoga, line dancing and a musical instrument
- joining a choir
- joining a theatre group
- having a massage
- going bike riding
- having nails done at the local shops.

The way staff supported people to identify interests in community activities varied according to the decision-making capacity of people with a disability. For people who were able to articulate their interests, staff indicated they supported people to pursue these within the community. For people with more limited capacity, staff reported they initiated a range of different experiences to identify those that most engaged people. Examples included:

Good practice examples

- ☑ Staff selected a range of different pieces of music and played each for a small group of people with a disability. They observed who responded most positively to which pieces, and noted individual preferences. Later, staff used each person's favourite for a variety of purposes including to engage them in dancing or relaxation.
- ☑ Staff in a house with people with very high support needs started walking to day programs rather than using vehicles. This resulted in neighbours stopping to chat with people and getting to know them. Staff also commented that people with a disability were looking healthier from being out in the fresh air and sunshine each day.

Key finding: New activities in the community

- ① Almost all people with a disability in the 20 sample houses were undertaking (or more engaged in) new activities within the community since implementing Person Centred Active Support.

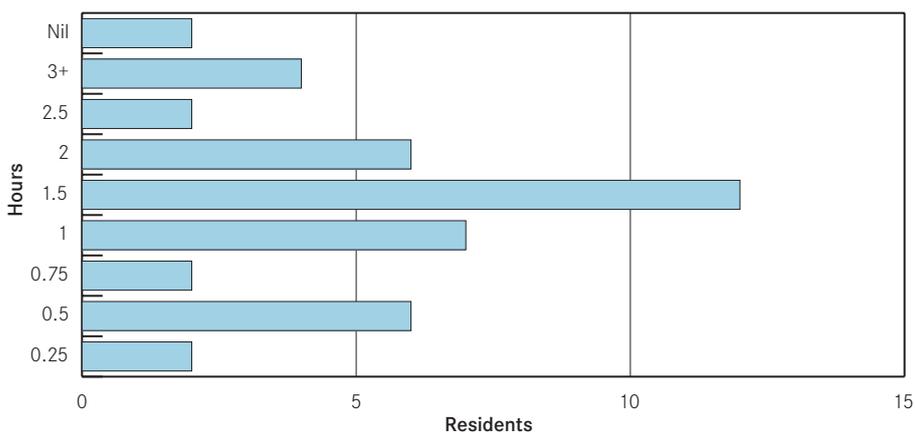
Range and volume of activities

In addition to the number of new activities undertaken by people with a disability (as described in previous sections), the breadth and range of activities as well as the amount of time spent participating in them, are also important indicators of the effectiveness of Person Centred Active Support.

Staff were asked to estimate the additional amount of time spent by people with a disability in activities since Person Centred Active Support was implemented.

Estimates were provided for 43 people, with 41 (96 per cent) identifying they were spending more time engaged in activities since the introduction of Person Centred Active Support (see Table 6):

Table 6: Additional hours per day in activities (n=41)



A breakdown of the data shows:

- four people (10 per cent) spent more than an additional three hours per day engaged in activities, totalling 21 hours per week
- eight people (20 per cent) spent an additional 2 to 2.5 hours per day engaged in activities, totalling 17.5 hours per week
- 19 people (46 per cent) spent between 1 and 1.5 additional hours per day engaged in activities, totalling 10.5 hours per week
- 10 people (24 per cent) spent up to an additional one hour per day in activities, totalling seven hours per week.

Only two people (4 per cent) were estimated to have had no increase in the number of hours spent in activities, although it was clear they were participating in a range of different activities. These people were identified as already being very active, independent and engaged with staff prior to Person Centred Active Support (and this had continued since the approach had been introduced).

The range of activities shown in activity and support plans over a one-week period was also reviewed for each resident. Of 57 people with a disability for whom data was available, the largest proportion, 18 (nearly 32 per cent), were engaged in between 11 and 15 *different* activities (see Table 7):

Table 7: Range of resident activities over one week

Number of different activities	Residents	Percentage
Up to 5	2	3.5
6 to 10	17	29.8
11 to 15	18	31.6
16 to 20	11	19.3
21 to 25	8	14.0
26 to 30	1	1.8
Total	57	100

Table 8, also based on a review of activity and support plans (and in this case supplemented by other documents such as communication books and case notes), shows that 70 per cent of people for whom reliable data was available were engaged in an average of over 100 activities per month.

Table 8: Average monthly activities for people with a disability (n=64)

Average monthly activities	People with a disability
1 to 50	15
51 to 100	4
101 to 150	9
151 to 200	20
201 to 250	6
251 to 300	4
301 to 350	4
451 to 500	1
500+	1
Total	64

Note: data in the table above is for the months of July and August 2007. It is not a count of the number of *different* activities undertaken, but a record of the total number of activities undertaken during this period.

The most frequently recorded activities were those associated with household tasks, for example meal preparation, laundry and self-care (showering and dressing). As noted earlier (and borne out by analysis of data contained within activity and support plans and other documents), often the emphasis of Person Centred Active Support was on engaging people with a disability and involving them to a greater degree in many of the activities happening around them on a regular basis.

It should also be noted that quantitative data on the total number of activities undertaken by people with a disability is qualified to the extent that:

- The number of activities undertaken by people with a disability before the implementation of Person Centred Active Support was difficult to determine with any reliability because the records kept within houses were not sufficiently detailed to allow comparison. For example, the word 'shower' was frequently written in activity and support plans when it was clearly not a new activity. However, discussions with staff revealed they had broken down the activity into a number of component tasks and were encouraging people to complete each within their level of ability and with decreasing staff involvement.

- There were variations across the 20 sample houses due to differences in recording practices. Three houses indicated they did not complete activity and support plans because they either did not understand completing the forms was necessary or they considered the house already had implemented Person Centred Active Support and there were no changes to record. Some other houses recorded incomplete data attributed in two CRUs to changes in house supervisors with immediate priorities lying elsewhere.
- The specific nature of some activities was difficult to determine. For example, 'relaxation' did not provide sufficient detail to identify the type of activity undertaken. Activities undertaken in the community were often less specific and were frequently listed as 'outing' or 'walk' and did not provide sufficient detail to determine where or how the activity was undertaken.
- Many staff felt the recording system was unable to accurately capture the level or quality of activity carried out (discussion of this issue is provided in a later section).

Key finding: Range and volume of activities

- ① There were limitations with the documentation before and after Person Centred Active Support was implemented. However, a review of available documentation and findings from staff consultations indicates people with a disability were engaged more often in a wider range of activities since the implementation of Person Centred Active Support.

Behaviours of concern

Staff were asked whether resident behaviours of concern had changed since Person Centred Active Support had been introduced.

Three of the 20 sample houses indicated the question was not relevant as there were no people with a disability with behaviours of concern living in the house. Of the remaining 17 houses, 12 (71 per cent) thought behaviours of concern had lessened, while four indicated there were no changes (see Table 9). Only one house indicated one person who had behaviours of concern had deteriorated, but attributed this to changes in health status rather than any influence of Person Centred Active Support.

Table 9: Changes in behaviours of concern

Change	Houses
Improvement	12
Deterioration	1
No change	4
Not relevant	3
Total	20

Staff attributed a perceived reduction in behaviours of concern to people with a disability being more actively engaged around the house, receiving encouragement for positive behaviours and having increased positive staff interaction. This is characterised by the following quotes:

- *'We spend more time just chatting to the clients, interacting with them. Their table manners have improved because now we sit with them and eat.'*
- *'Boredom has decreased. There are more activities and reduced antisocial behaviours.'*
- *'We talk more about their positive behaviour now rather than focusing on their negative behaviours.'*

Examples provided by staff related to a reduction in behaviours of concern included:

Impact: Behaviours of concern

- One person with a disability had engaged in aggressive behaviour towards a co-resident. The aggressive behaviour reduced when the person was engaged in activities. Staff also identified the person enjoyed blowing bubbles, which was used as a means to distract, occupy and calm him.
- One person with a disability frequently threw objects at staff and other residents. This behaviour significantly decreased after Person Centred Active Support was implemented.
- One person with a disability and complex care needs spent time lying on the floor and refused to sit in a chair. Staff commenced dance parties in the house as well as engaged the person in household activities. Staff stated the person now has improved behaviours, wants to sit in chairs, be involved in the dancing and has improved social skills.
- One person with a disability is reported to be 'more settled and purposeful' and easily directed towards alternative activities. The person has a calmer response and demonstrates less anxiety.
- One person with a disability was described as 'not destroying the room now because he is very active', resulting in a reduction in the number of DINMA reports.

Some people with a disability have behaviour management plans designed to reduce behaviours of concern. Some behaviour management plans permit staff to administer PRN medication – medication used as *required* rather than at a specific time interval, to help calm people when behaviours escalate and other methods of managing the behaviour have been unsuccessful. Five of the 17 houses noted the amount of PRN medication administered for behaviours of concern had been reduced for some people with a disability, which they attributed to the introduction of Person Centred Active Support. Comments included:

- *‘We are more likely to redirect people to different activities now than give PRN.’*
- *‘PRN would be approximately 30 per cent less because the clients are more active and less bored and we redirect them rather than give PRN.’*

While individual data about resident behaviours of concern was not collected as part of the evaluation, staff gave the following examples of reductions in PRN:

Impact: Behaviours of concern

- From November 2006 to February 2007 one resident received PRN medication 11 times for behaviours of concern. In the six months after Person Centred Active Support was implemented, the person received PRN medication only twice for behaviours of concern.
- One person with a disability who was administered PRN medication monthly for behaviours of concern had not had any PRN medication since Person Centred Active Support commenced.
- Staff in two CRUs discontinued PRN medication to restrain two people with a disability as they considered it no longer necessary given the significant behaviour changes since Person Centred Active Support.

Other changes for people with a disability

A number of other positive changes for people with a disability were also found.

Each house was asked if they had observed any other changes for people with a disability since Person Centred Active Support was implemented. Table 10 shows that of the 20 sample houses, 17 (85 per cent) indicated people with a disability were happier, had more choice and initiated activities, and 12 (60 per cent) indicated people with a disability had increased interaction with staff.

Table 10: House perceptions of resident changes (n=20)

Resident changes	Houses
Happier/more confident	17
Exercising choice/initiating activities	17
Increased interaction with staff	12
Decrease in negative behaviours	4
Learned new skills	2
Positive feedback from families	2
Improved physical health	1
No change	1

Note: multiple responses were received from each house

During the consultations, staff described the following changes:

- *'The clients are happier. One client now initiates making his own drink and even asked, "Do you want me to help?"'*
- *'The clients are more motivated because they are being included. They are proud of their achievements.'*
- *'Three of our clients are more vocal and articulate about what they want.'*
- *'They have ownership with activities – this means a lot.'*
- *'They are much happier, laughing more.'*
- *'They are now seeking out tasks to do, initiating tasks, wanting to participate. They are much happier.'*
- *'They are taking more pride in their appearance and are talking more to staff and are asking us what we are doing.'*

Good practice example

- ☑ One person with a disability showed a marked reduction in drooling as they spent less time sitting being disengaged and more time actively participating in activities around the house.

Staff attributed positive changes in residents to several factors, most notably:

- decreased boredom – people with a disability were spending less time disengaged in front of the television, or engaging in self-stimulatory behaviours, and more one-to-one time with staff in everyday household activities

- increased capacity and confidence to make choices produced positive behavioural change – examples included people with a disability asking for different foods, and non-verbal people taking the hand of staff and leading them to activities of their choice, such as going to the letterbox, into the kitchen to wash dishes or out to the car to go for a drive
- increased positive reinforcement, rather than focusing on negative behaviour.

Staff also provided a number of anecdotal reports of some residents enjoying increased visits from family members. In a small number of houses, staff had encouraged and facilitated family visits. In others, staff indicated family visits had increased due to the calmer behaviour of people with a disability and reduced behaviours of concern.

Additionally, staff stated several families had reported positive changes in their family member since Person Centred Active Support had been implemented.

Parents of one person with a disability contacted the consultants to comment on the changes in their adult child, reporting the person was calmer, related better to other family members and was better groomed. These changes followed Person Centred Active Support being introduced to the house.

Impact: Other changes for people with a disability

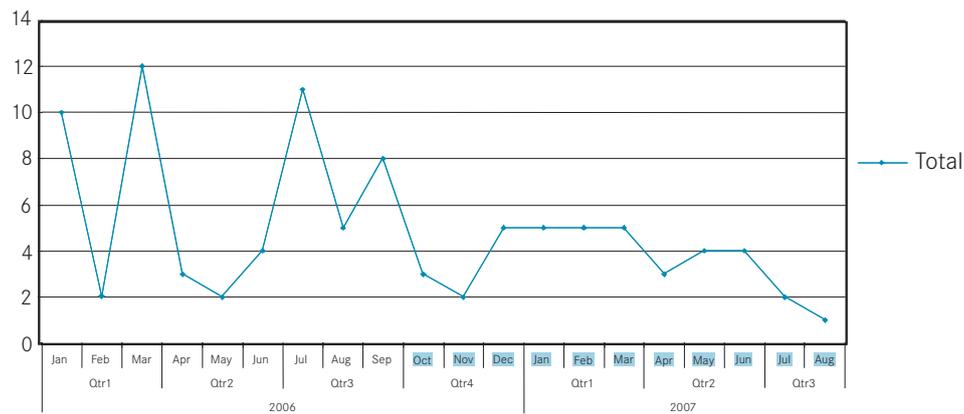
- ☑ In one house, few residents had contact with family members. Staff had gone to extensive lengths to source baby photographs of the people with a disability (to frame and hang around the house) and through this, one person with a disability had re-established contact with his elderly mother.

Incident reports and claims

Analysis of WorkCover claims for occupational violence and stress related to resident behaviours of concern across the 20 sample houses supports the staff perception that behaviours of concern had decreased since Person Centred Active Support was implemented.

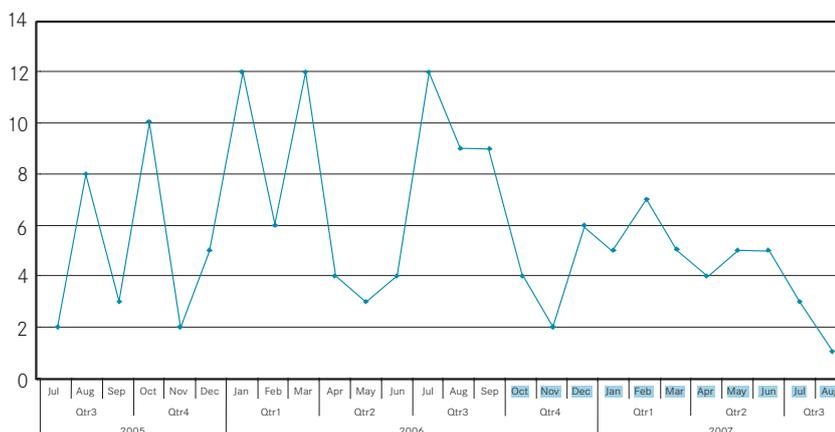
Table 11 shows the highest number of claims made were for the first two quarters of 2006, prior to Person Centred Active Support being introduced (March 2006 with 12 claims and July 2006 with 11 claims). Implementation of Person Centred Active Support began in two of the rural regions in October 2006, and was rolled-out in the remaining three regions by March 2007. Since implementation of the approach claims appear to have steadily declined.

Table 11: WorkCover claims – occupational violence



Analysis of DINMA reports related to occupational violence and stress, supports the WorkCover claims data and staff perceptions that behaviours of concern have reduced. Table 12 shows fewer DINMA reports being made in relation to occupational violence since the implementation of Person Centred Active Support.

Table 12: DINMA reports – occupational violence



From very limited data, an analysis of Category 2 incident reports related to resident behaviours of concern also demonstrates a decrease since Person Centred Active Support was implemented (see Table 13):

Table 13: Category 2 incident reports

Time period	May–Aug 06	May–Aug 07
Number	7	3

Source: Department of Human Services Disability Services Division, 2007

Key findings: Incident reports and claims

- ① Staff strongly believed Person Centred Active Support had contributed to a reduction in behaviours of concern. This perception was supported by reports of reduced use of PRN medication and early data indicating a reduction in the number of DINMA reports and WorkCover claims associated with occupational violence. However, while promising, further investigation is required to prove a definitive link.

Impact on staff

Staff job satisfaction

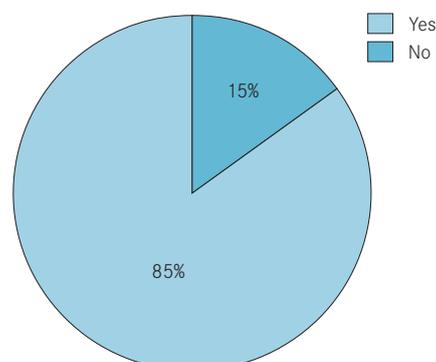
The second objective of the evaluation was to determine whether Person Centred Active Support had an impact on staff job satisfaction. It may be inferred that higher levels of job satisfaction result in lower rates of staff absenteeism, lower staff turnover and increased levels of achievement, and these links are well established in the literature:

- One study (across several industries) found 50 per cent of workers believed occupational stress leads to absenteeism and 41 per cent believed it caused poor work performance. In response to this, employers were recognising that a healthy workplace goes beyond the basic occupational health and safety (OHS) requirements: ‘a mentally healthy workplace is one in which employees feel a sense of security, support and accomplishment with their work and within their place of work. Mentally healthy workplaces experience high rates of employee satisfaction and retention and low rates of absence due to sickness and stress.’⁵
- Another recent study found that when employees were satisfied with their stress levels and work–life balance, 86 per cent were more inclined to stay with their company (versus 64 per cent when dissatisfied). ‘There’s no question that employees are more likely to leave or speak badly of their workplace if they feel overburdened. Companies which take steps to ensure that stress levels are not onerous will save money in the long run by reducing attrition.’⁶

Staff in the 20 sample houses were interviewed as a group and also given a brief confidential questionnaire to complete. Completing the questionnaire was voluntary. Ninety-seven of the 99 staff (98 per cent) responded. This is a very high response rate for surveys of this kind and may be indicative of the positive regard staff have for Person Centred Active Support.

The results of the questionnaire were compelling and show Person Centred Active Support had a significant positive impact on staff work satisfaction. Of the 97 responses, 82 (85 per cent) reported being more satisfied with their work since its implementation.

Table 14: Staff satisfaction after Person Centred Active Support (n=97)



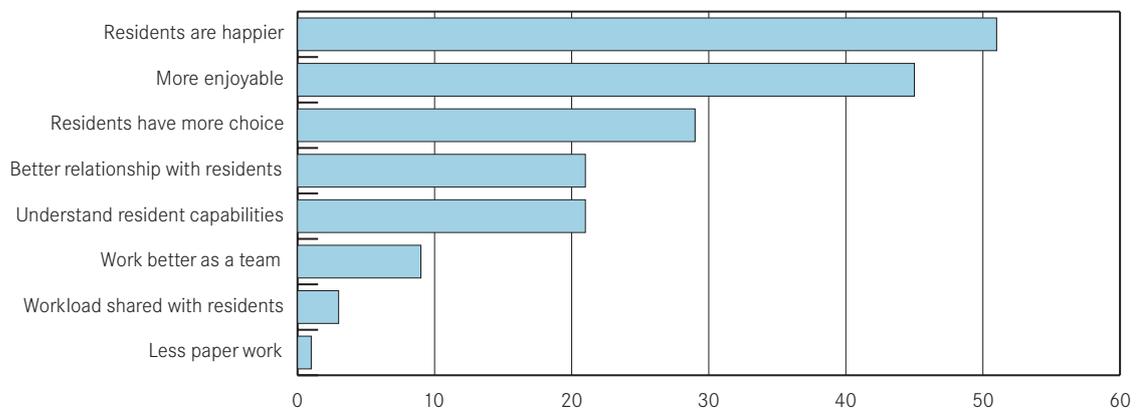
Staff gave a range of reasons why they were more satisfied (see Table 15), with many saying they thought people with a disability were happier. Staff would likely regard happier residents as proof that their efforts and dedication (particularly in implementing a new approach) were producing the desired outcomes.

⁵ <http://www.hrmguide.net/australia/health/workplace-health.htm>

⁶ <http://www.humanresourcesmagazine.com.au/articles/20/oco51270.asp?Type=59&Category=917>

The second most frequent response from staff was closely tied to the first: when people with a disability were happier, workplaces felt more pleasant and enjoyable.

Table 15: Reasons for support staff increased work satisfaction* (n=82)



* Note: staff were able to give multiple responses in their survey

Staff provided more detail about why they felt more satisfied with work since Person Centred Active Support was introduced:

- *'Work is far more rewarding, positive – it has re-skilled support staff, given clients the opportunity to live their own life, be the main person in their life, given them rights that supposedly they should have had years ago.'*
- *'It creates a completely different atmosphere by being actively involved.'*
- *'More enjoyable working with clients rather than for them. Sharing their lives – sharing special times, laughing/crying.'*
- *'I love that active support has put the focus on to what the client wants in life, not what the support staff think is best.'*
- *'I now feel less like a cook and a cleaner and more like a facilitator.'*
- *'Active Support has made the home a more active, happy environment and great opportunity for staff to work as a team.'*
- *'The house is a calmer place and there is less tension now that they are better occupied.'*

Comments from staff also supported the view that Person Centred Active Support encouraged them to think and reflect on ways that they worked in the past and how they might do things differently in the future:

- *'Look right, look left – every moment is a participation opportunity.'*
- *'So many little things that we automatically did – it has made us think about what they can do.'*
- *'The training opened our eyes. We took for granted they couldn't do it. We are now allowing risk.'*

- *‘They used to do ironing at (the institution) but we just sort of took over without really thinking.’*
- *‘It makes us think more, is it a staff choice or a resident choice?’*
- *‘Staff had to re-learn ways of working.’*
- *‘We have to slow down to allow the clients to do things.’*

Good practice example

- ☑ In one house staff examined house routines and realised the floors were being washed during each shift – three times a day. They recognised this was unnecessary and restructured household tasks to enable people with a disability to be supported to carry out this task themselves. New lighter mops and buckets were purchased and people with a disability who were keen to do this task took an active role in washing the floors once a day at a time that fitted in with other activities.

Several staff spoke of their enjoyment at being able to bring their own skills and interests (craft, gardening and cooking) to the workplace, and integrating them into activities within the house. Staff spoke positively of their professional training and personal skills being valued and utilised in the workplace:

- *‘Gives all support staff a chance to excel, utilise their own skills.’*
- *‘By starting up the craft activities with clients its helped to bring out some of my own hidden talents.’*

Good practice example

- ☑ Two people with a disability expressed an interest in fishing after hearing a staff member talk about his own fishing experiences. The staff sourced fishing equipment and the three now fish regularly at a local dam. The staff has taught the people with a disability how to bait the hook and the technique for casting and reeling.

The group consultations with staff also provided some interesting comments on how workplaces had changed since the implementation of Person Centred Active Support:

- *‘Now have more confidence/support and encouragement with the team. Clients have grown with us and are empowered as a result.’*
- *‘Active Support took me back to the job I chose 14 years ago... work was thoroughly rewarding and enjoyable... Work was fun then and it is now.’*

Several staff also commented on a perceived shift in culture that has enabled Person Centred Active Support to be effectively implemented. Along with the level and ongoing nature of support (especially to house supervisors) from the department’s head office and regionally, this shift was identified as critical in supporting staff to implement the approach:

- *‘Past culture restricted activities. For example, we were not supposed to mix with other houses. There is now a culture of change... all support Person Centred Active Support.’*
- *‘Fear removed – supported in decisions even if something went wrong. Now given the OK to try different things.’*

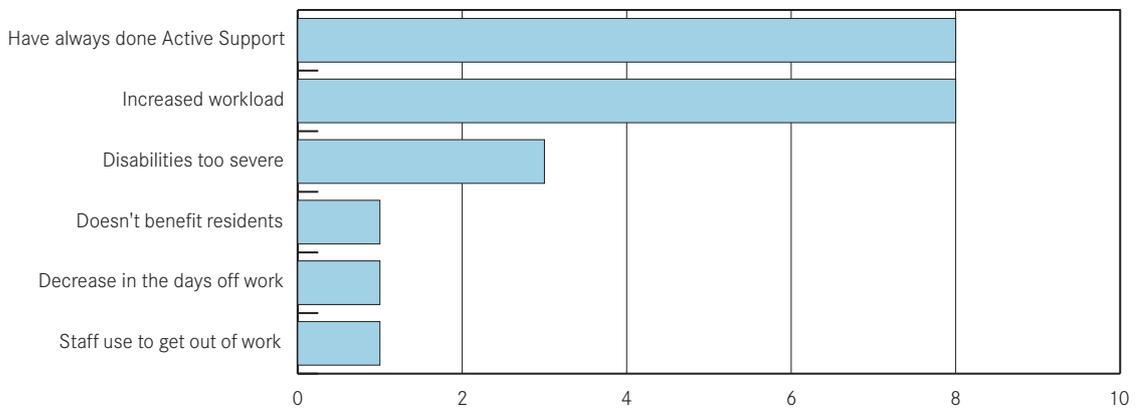
Of those staff who did not report increased work satisfaction (15 per cent), just over half (eight) indicated there had been no change in their level of satisfaction (it had not deteriorated), as typified by the comment:

- *‘No change – I have always done Active Support.’*

Only seven respondents (7 per cent) indicated they were less satisfied with their work, due mainly to perceived increased workloads under Person Centred Active Support and additional associated paperwork. Two staff thought their workload had increased due to the amount of time required to engage people with a disability, compared with the time it took to complete the task themselves. Three staff queried the value of Person Centred Active Support for people with very complex care needs, indicating they did not believe that people with very high level needs benefited.

Table 16 below summarises reasons given by staff as to why they had not experienced increased satisfaction with their work.

Table 16: Staff reasons for no increased work satisfaction (n=15)



Note: staff were able to give multiple responses in their survey

A small number of houses indicated they had received little follow-up from regional representatives since the initial training. In one house there had been significant turnover and several new staff were unfamiliar with Person Centred Active Support. It is important that ongoing support, training and mentoring is provided as this is important in maintaining interest and enthusiasm for the approach.

Key finding: Staff job satisfaction

- ① The vast majority of staff experienced increased work satisfaction as a result of their involvement in Person Centred Active Support and remain very positive and enthusiastic about the approach.

Some barriers and issues

Consultations with staff and responses to the questionnaire indicated the biggest increase in workload was attributed to increased paperwork and data collection:

- *'More paperwork, double up on writing same things.'*
- *'Documentation repetitive.'*
- *'No time for all the paperwork.'*

In particular, the following data collection issues were identified:

- Given the comprehensive nature of Person Centred Active Support (to include people with a disability in as many day-to-day activities as possible) staff stated it was too difficult to capture on paper every initiative of every day. The data collected therefore does not provide a true indication of the amount of activity undertaken.
- Having to record information on an hourly basis is not feasible in some houses, especially during times of high activity such as early mornings. Many staff stated they filled in forms retrospectively, at the end of their shift; however, by then, some indicated they had forgotten many of the tasks and activities undertaken with individual residents.
- Recording multiple activities is difficult using the current template. (Several houses had modified the recording process to better suit their needs.)
- There is some duplication in paperwork, with staff having to record the same or similar information in several places (such as client files, support plans and communication books). Staff indicated the completion of house documentation takes considerable time and non-mandatory data collection receives a lower priority. Staff also commented that spending time completing very detailed activity reports detracted from time available to spend with people with a disability engaging in activities.

These issues need to be addressed in order to support the attractiveness of the initiative for staff and, at the same time, provide a thorough and valid platform for program review and evaluation. There is an opportunity for the department to review and simplify the type of information required and method of recording, in order to minimise input from staff and maximise time available for interaction with people with a disability. Any review should be undertaken in conjunction with house staff.

While support for Person Centred Active Support was overwhelmingly positive, a number of other issues were also identified by staff that influenced the success of the approach in particular houses:

- Getting all staff in a house to embrace Person Centred Active Support was reported by a small number of people as sometimes difficult. A small number of staff were described as 'hanging on' to old work practices and were not able to see merit in engaging people with a disability in all activities.
- One staff person spoke humorously of the constant effort of delivering Person Centred Active Support: *'We are constantly trying to be creative - it's very tiring.'*
- While the majority of staff showed a high level of awareness as to how people with a disability could make choices and become involved in different activities, observations suggested that a small number needed additional training and ongoing reinforcement. In isolated cases, some staff missed opportunities to involve residents. Examples included:

- staff folding washing to ‘get it out of the way’ before residents got home, rather than engaging people in the activity
- staff cutting up cakes for afternoon tea prior to people coming home, rather than waiting for them and encouraging them to choose from a range of different snacks
- staff insisting people with a disability complete an entire household task (such as washing and hanging out clothes) when the person expressed a wish not to do the activity at that particular time. (The person with a disability could have been offered choices such as an alternative activity, encouraged to complete the activity at a different time or have another person assist them to finish it.)

Ongoing leadership from house supervisors, modelling appropriate behaviour, and encouraging staff to reflect on their work were cited by several staff as critical in maintaining the impetus of Person Centred Active Support and engaging those staff who were less keen on the approach. The high level of support provided by head office was also identified as having been a factor in the success to date, in particular ongoing promotion of good initiatives and sharing these across the regions to stimulate ideas and build a significant support base.

A common difficulty experienced by houses, especially those with people with complex care needs, was obtaining transport and additional staff to enable more community activities. The logistics of securing transport for more than three people in a wheelchair or bed-chair, mobility at the destination as well as assisting others at the same time, was cited by staff as a barrier to more frequent and spontaneous community outings. Several staff also spoke of concerns about taking people with a disability on outings with only two staff – should an emergency occur and one staff be required to leave the group, the other may be unable to provide the level of assistance needed by (sometimes up to five) people.

Key findings: Barriers and issues

- ① There are a number of program issues, particularly those relating to data collection and recording, that might be reviewed in order to maximise program impact.
- ① Staff identified the commitment of house supervisors and regional and head office support as key enabling factors.

Conclusion and recommendations

Person Centred Active Support builds on the strengths of individuals to provide a range of opportunities to live as independently and as actively as possible, both within their homes and the community.

Person Centred Active Support has demonstrated it enables people with a disability to have an improved quality of life through:

- having choices and being encouraged to make decisions that reflect individual interests and abilities – the majority of staff showed willingness and demonstrated initiative in identifying new and different ways to increase decision-making opportunities
- being engaged in many new everyday activities – while the level of engagement depends on relative abilities, all people with a disability in the 20 sample houses were involved in new or increased activity since the implementation of Person Centred Active Support
- experiencing fewer behaviours of concern as people with a disability were more actively engaged in meaningful pursuits and had more positive relationships with staff – this also resulted in a reduced number of DINMA reports made by staff related to behaviours of concern among residents and a corresponding reduction in the number of associated WorkCover claims.

The evaluation also suggests that staff have benefited from Person Centred Active Support. The majority of staff (85 per cent) indicated they were more satisfied with their work, attributing this to people with a disability being happier and the workplace more enjoyable.

Some further work is required to address administrative issues associated with data collection that may be impacting on the overall effectiveness of the initiative.

Continuing to support staff in their role, providing them with opportunities to share good ideas and initiatives and ensuring new staff are quickly trained in the approach, are all important in ensuring the sustainability of Person Centred Active Support. Further assistance to locate additional resources to facilitate community participation, especially for people with high support needs, would also be beneficial.

In order to sustain the gains made by Person Centred Active Support to date, the following recommendations are made:

Recommendations

1. Assist houses to access specialist advice and support on aids and equipment to improve the independence of people with a disability, especially those with high support needs.
2. Provide opportunities for houses to share their successes, tips and ideas about different ways that Person Centred Active Support can be applied, including through an electronic newsletter and statewide forums.
3. Encourage houses to link with other programs designed to improve community access (for example, Access for All Abilities, Companion Card and rural access workers). These initiatives may provide strategies to address resource issues such as transport and volunteer availability. Other strategies to increase community access – especially for people with a disability with high support needs – should also be explored at a regional level (for example, sharing staff and vehicles across CRUs when planning outings and activities).

4. Review requirements to determine scope for Person Centred Active Support data to be incorporated within existing records (for example, case notes). Electronic data collection could also be investigated, where data is entered once and activity reports generated from the database.
5. Provide ongoing training and support for staff to reinforce and ensure understanding of the principles of Person Centred Active Support and ability to implement it on a day-to-day basis.
6. Continue to provide a high level of head office support to regions and ensure regional offices remain actively engaged in the initiative.

Appendix 1: Methodology

Department of Human Services project managers

Preliminary and ongoing consultation was undertaken with project managers from Disability Services, Wellbeing and Practice Unit, to confirm methodology, ensure compliance with the department's ethics committee requirements and report on evaluation progress.

Department of Human Services Human Research Ethics Committee

The evaluation fell within criteria requiring ethics committee approval prior to commencement. Participant information and consent forms were developed from templates provided by the ethics committee for people with a disability (in easy read pictorial formats), house supervisors and staff, and next-of-kin (in the case of residents who did not have capacity to consent to participate in the evaluation).

Quantitative and qualitative data collection tools were developed and submitted as part of the ethics committee application. The project was granted ethics committee approval on its first application subject to clarification of issues related to recruitment of participants and additional information to be included in participant information and consent forms.

Selection of CRUs

Four houses in each of the department's five rural regions (total of 20 CRUs) in which support staff had been trained in Person Centred Active Support were randomly selected.

Recruitment of participants

Ethics committee approval required that the recruitment of staff and people with a disability should not be undertaken by any person with a direct relationship with them, defined as a supervising role for staff and direct care relationship for people with a disability. Department of Human Services regional representatives who had completed the Person Centred Active Support training, but had no relationship with staff or people with a disability were coopted to assist in recruiting staff and people with a disability. The representatives had a comprehensive knowledge of Person Centred Active Support and were skilled in communicating with people with an intellectual disability. The regional representatives explained the project to people with a disability or contacted next of kin where people with a disability were unable to consent themselves.

The regional representatives visited each CRU and spoke with house supervisors about the evaluation and requested their involvement. Where possible, the regional representatives also attended house meetings and spoke with staff to explain the evaluation and seek participation. Participant information and consent forms were distributed to house supervisors and staff who contacted the consultants or the regional representatives directly to consent to participating.

Data collection

Qualitative and quantitative data was only collected for people with a disability and staff where consent to participate in the evaluation had been obtained. Some consents for people with a disability were obtained after the house visits had been conducted and data collected. This explains the discrepancy between the number of consents obtained and number of people for whom data was collected.

Quantitative data

Quantitative data collected in relation to people with a disability included:

- number of activities undertaken in the house and community as recorded in people with a disability' activity and support plans – where activity support plans were not available, other data sources such as case notes and house communication books were reviewed (data was collected on a daily basis for the month of August 2007 and on a monthly basis for July 2007, for each resident)
- range of activities noted in activity support plans for a one-week period
- number of incident reports relating to resident behaviour of concern for the period May to August 2006 (pre-program) and May to August 2007 (post-program implementation) – this information was provided by head office in de-identified format.

Staff were also asked to estimate the amount of time each day that people with a disability spent doing new activities since Person Centred Active Support was introduced.

Quantitative data collected related to staff included:

- a questionnaire relating to work satisfaction since implementing Person Centred Active Support
- WorkCover claims relating to stress and occupational violence by staff employed in the 20 CRUs (pre- and post-program implementation) (the department provided data in an aggregated and de-identified format)
- DINMA reports from the 20 CRUs related to occupational violence (pre- and post-program implementation) (the department provided data in an aggregated and de-identified format).

Qualitative data

Qualitative data was collected during interviews with people with a disability and staff. Residents were interviewed at the houses, individually and in groups. Where possible, people with a disability were interviewed without staff present, however the communication needs of some people required staff to be present to assist the consultants.

Staff were interviewed during scheduled house meetings as a group.

Staff were also provided with contact details for the consultants and encouraged to contact them with any additional information after the group consultation; several staff took this opportunity.

Data analysis

Quantitative data was collated and entered into Microsoft Excel spreadsheets. Data was analysed by count (number), frequency and range. Qualitative data was analysed using thematic categorisation.

Appendix 2: Staff questionnaire

Person Centred Active Support evaluation

Staff question

One of the objectives of this evaluation is to investigate whether Person Centred Active Support has had an impact on staff job satisfaction.



Please take the time to complete this questionnaire

We are not collecting any personal details and your responses will remain completely confidential.

Are you more satisfied with your work since Person Centred Active Support?

Yes, please provide examples

No, please provide details

Please hand this form to the Nucleus Consultant when completed

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Appendix 3: List of resources

Communication aids

- Communication boards with photographs of people with a disability completing activities at different times of the day
- ‘Who’s on’ board with photographs of staff and roster times
- Photograph boards/albums of people with a disability, staff and significant others engaged in activities in the house and the community
- ‘Chat/communication books’ for individual people with a disability that include photographs and text of people and activities that are important to the resident
- Outings folder containing information on where to go and accessibility
- Menu books with recipes cut from magazines, books and advertising material
- Large print, easy recipe cookbooks (published by RMIT)
- Selection of different take-away food packaging (such as a pizza box)
- Shopping catalogue photographs used for making shopping lists
- Birthday boards
- Whiteboards
- Talking photograph jukebox (several houses had these provided, but none were in use)

Recreation/activities

- Digital camera
- Laminator
- Label machine
- Video camera
- Computer
- Large playing cards
- Bicycle puncture repair kit
- Board and card games
- Trampoline
- Ball games, such as bocce and cricket
- Themed dance parties held at house
- Gardening tools
- Fish tank and equipment
- Picnic set
- Christmas decorations
- Craft materials

- CD player
- Worm farm
- Photograph frames and albums
- Shopping trolleys
- Musical instruments
- Whiteboard for people with a disability to draw on
- Birdseed for feeding wild birds
- Bubble mix
- Kite
- Totem tennis
- Balloons
- Footballs
- Music for dancing
- BBQ
- Outdoor rocking chair
- Organ
- Basketball ring
- Hen house
- Areas of garden landscaped to meet individual people with a disability' needs
- Planted vegetable garden
- Birdbath

Kitchen

- Larger kitchen table so people with a disability and support staff can sit more comfortably together
- Funnels, jugs and scoops to assist with pouring
- Serrated salad knife
- Sandwich holders to assist cutting
- Small bench top urn elevated off the bench to replace kettle
- Coffee sachets to assist people with a disability who have difficulty measuring quantities
- Cling wrap dispenser
- Electric can opener
- Trolley to bring shopping in from the car
- Wider handled utensils, such as a vegetable peeler, spatula and grater
- Plugs with large pull-rings

- Non-slip mats for crockery and mixing bowls
- Condiment and cutlery trays
- Chopping boards
- Onion cutter
- Cereal pourers
- Plate guard
- Cake tins
- Kettle tipper
- Non-slip bowls, plates and cups

Laundry

- Installation of lower washing line that people with a disability can reach
- Laundry trolleys
- Small mop and bucket
- Long-handled broom and dustpan
- Tongs to lift washing from machine
- Carpet sweeper
- Laundry hampers
- Upright vacuum cleaner

Personal care

- Hand-held shower rose
- Chairs in bedrooms to assist with dressing
- Safety razors
- Walking stick
- Beauty products
- Motorised tilt chair/beds

Staff resources

- Person Centred Active Support pens printed as reminders to support staff
- Themed newsletter produced for the region where initiatives are shared

