Quality Policy and Procedure Audit Report

Version 3.3

Audit of service provider compliance with the National Standards for Disability Services (Standards) 1-6

Audit details	
Organisation	
Organisation trading name (if applicable):	Directions Disability Support Services
Chief Executive Officer/Director:	Alison Kelly, Chief Executive Officer
Assignment name:	Quality Policy and Procedure Audit
National Standards for Disability Services assessed:	Comprehensive: Standards 1-6
Evaluation team*:	Natalie Georgeff
Final report date:	7 September 2020
Report Endorsement	
Endorsed by:	Mary McHugh Quality and Safeguarding Manager

*This report was prepared by a member of the Panel Contract of Team Leaders and Evaluators, managed by Disability Services.

Executive summary

Introduction

This report describes the findings of the Team Leader Evaluator who visited Directions Disability Support Services from July to September 2020. A desktop audit of policies and procedures was completed, and feedback from management and staff was sought, to assess compliance with the National Standards for Disability Services 1-6.

An opening meeting was held on 20 July 2020. A closing meeting was held on 2 September 2020.

Assessment of compliance with the Standards	
The rating scale used to assess the Standards is **met/not met.**	
Standard 1: Rights	Met
Standard 2: Participation and inclusion	Met
Standard 3: Individual outcomes	Met
Standard 4: Feedback and complaints	Met
Standard 5: Service access	Met
Standard 6: Service management	Met

Required Actions (RA)

Where noted, RAs refer to a major gap in meeting **Standards (NSDS)** and identified **Indicators of Practice (IoPs)**. They identify action necessary to address matters that have serious implications for the rights, safety, wellbeing and dignity of individuals with disability; or may relate to legal requirements and duty of care issues. RAs are required to be addressed by the compliance date.

No.	**NSDS**	**IoP(s)**	**RA statement**	**Compliance date**
No Required Actions were identified.				

Service Improvements (SI)

Where noted, SIs refer to opportunities for continuous improvement. They identify actions to enhance outcomes for individuals with disability and compliance with **Standards (NSDS)** and their relevant **Indicators of Practice (IoPs)**.
Progress on SIs is reported in the annual Self-assessment (every April).

No	**NSDS**	**IoP(s)**	**SI statement**
No Service improvements were identified.			

Self-assessment (SA): Standards 1-6	
The Self-assessment is completed by the organisation each year in April, for verification of evidence during the audit.	
SA completed by:	Alison Kelly, CEO
Is the Self-assessment evidence verified; and of sufficient quality to adequately demonstrate the organisation's knowledge of the Standards and their indicators of practice?	Yes. The Self-assessment (2019) demonstrates the organisation's knowledge of the Standards.

Code of Conduct	
The Code of Conduct is prepared by the service provider as part of Registration; and is made available to the evaluator for their review during the assessment.	
Does the service provider's Code of Conduct articulate values built around the service and the people for whom services are/to be provided?	Yes. Directions Disability Support Services ("Directions") has a Code of Conduct with key components of: • Abiding by the vision, purpose and values of Directions. • Observing the Constitution, policies and procedures of the organisation. • Acting with fairness, honesty, integrity and openness. • Treating everyone with respect, courtesy, equality and dignity while recognising their rights, safety and welfare. • Respecting privacy and confidentiality. • Creating an environment that is free of discrimination, harassment and victimisation. • Fully involving the people supported, their families, carers and advocates in all decision-making and planning. There is a Constitution and a Service Charter with principles of access, quality service, equal opportunity, qualified workers, honesty, confidentiality, clear communication, support services, safety, community partnerships, feedback and complaints, and upholding the National Standards. The indicative elements of the NDIS Code of Conduct are recognised. The Human resources policy includes the concept of ethical practice, with universal principles of equity and justice, respect, and professional and personal responsibility.

Service profile

Service profile	
Service description (in brief)	
The services provided	• Directions offers a full range of services. Predominantly support with daily living, personal care and community participation; but also, therapy and behaviour support interventions, support coordination and host family arrangements.
The resources	• Services are offered across the Perth metropolitan area. The organisation budget for the current financial year is $9,236,268 with 127 support workers (50 FTE) and 31 non-direct staff.
The people using services	• Directions supports around 387 clients aged between four months and 72 years, with a wide range of disabilities. Most clients are aged between fifteen and 25 years old. • The organisation uses the term **'individual'** or **'people'** to refer to individuals with disability, family member/s of people with disability and carers (consumers).

Consultation	
Statistics	
Number of management and staff consulted	2

Summary of findings

Assessment of compliance with the Standards
Policies and Procedures (P&P)
The findings described below reference information provided to demonstrate the organisation's compliance with the policy and procedure component and Indicators of Practice (IoP) for each Standard. • For every Standard, the *Assessment summary* provides an overarching statement of the organisation's compliance; highlights good practice; and notes where there is opportunity for service improvement or a matter for the service provider's consideration. • For every Standard, the *Statement of qualitative evidence* records ratings of Yes (**Y**), No (**N**) or **N/A** against Policies and Procedures and each IoP. • **Yes:** the IoP describes and affirms the organisation's positive focus. • **No:** a *Reason for finding* provides the context for any gaps/ issues/ weaknesses in evidence and identifies where a Standard is not met resulting in a Required Action **(RA)**; or a Service Improvement **(SI)**; or an Other Matter **(OM)** for the organisation's consideration. • The *Legend for evidence information source* refers to: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other • The Legend identifies the sources of evidence that the evaluator has reviewed to determine the rating for each IoP. All findings triangulate using at least three (3) sources of evidence. • Findings against Indicators of Practice may be used by the organisation to develop its Action Plan to meet minimum Standards, or revise its Continuous Improvement Plan, to show how improvements will be made to enhance compliance with Standards and outcomes for individuals.

Standard 1: Rights
Standard for service: **The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm neglect and violence.**

Assessment summary against Standard 1: Rights
Standard 1 is met.
The Rights Policy demonstrates a commitment to upholding, protecting and promoting human rights and cites the United Nations Convention on the Rights of Persons with Disabilities. The Service Delivery Policy aims to ensure that the people Directions support retain maximum control over their lives. Decision-making and choice principles include, for example, non-judgmental and non-discriminatory interactions, collaboration and strength-based approaches. The Rights Policy explains how individual capacity to give informed consent will be determined. The Rights and Service Delivery policies and procedures address managing challenging behaviours though positive behaviour support (PBS) and the elimination of restrictive practices (RP) and refer to the Code of Practice for the Elimination of Restrictive Practices (WA), NDIS Quality and Safeguarding Framework and the PBS Competency Framework. A PBS Panel meets at Directions several times a year to audit relevant incident reports, PBS plans and processes; monitor, reduce and eliminate restrictive practices; and ensure that staff are adequately supported. The Terms of Reference for the Panel outlines their role (with internal and external representatives), responsibilities, membership, referral and appeal process and confidentiality. The Panel will be renamed the Restrictive Practice Panel from December 2020 to prepare for the NDIS Commission and the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. In addition, a PB Committee will be reintroduced to review training and development needs for staff, and to promote contemporary practice. The Care and Protection policy is about zero tolerance and prevention of any form of harm, maltreatment, neglect or abuse of individuals, with actions required to report any concerns. The Concerns of Harm, Maltreatment, Neglect or Abuse Procedure reinforce this process. The Incident Reporting Policy outlines all circumstances where an Incident report form is to be completed, including serious/reportable incidents. It is recommended that Directions' prepare for the NDIS (Incident Management and Reportable Incidents) Rules 2018. Other documents related to this Standard include the Records Management Policy, Privacy Dignity and Confidentiality Policy and the Personal Relationships and Sexuality Policy.

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 1 (stated in 'Standard for service' above):	Yes	1,2,6
1:1 The organisation, its staff and its volunteers treat individuals with dignity and respect.	Yes	1,2,6
1:2 The organisation, its staff and its volunteers recognise and promote individual freedom of expression.	Yes	1,2,6
1:3 The organisation supports active decision-making and individual choice, including the timely provision of information in appropriate formats to support individuals, families, friends and carers to make informed decisions and understand their rights and responsibilities.	Yes	1,2,6
1:4 The organisation provides support strategies that are based on the minimal restrictive options and are contemporary, evidence-based, transparent and capable of review.	Yes	1,2,6
1:5 The organisation has preventative measures in place to ensure that individuals are free from discrimination, exploitation, abuse, harm, neglect and violence.	Yes,	1,2,6
1:6 The organisation addresses any breach of rights promptly and systemically to ensure opportunities for improvement are captured.	Yes	1,2,6
1:7 The organisation supports individuals with information and, if needed, access to legal advice and/or advocacy.	Yes	1,2,6
1:8 The organisation recognises the role of families, friends, carers and advocates in safeguarding and upholding the rights of people with disability.	Yes	1,2,6
1:9 The organisation keeps personal information confidential and private.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other

Standard 2: Participation and inclusion
Standard for service: **The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.**

Assessment summary against Standard 2: Participation and inclusion
Standard 2 is met.
The vision for Directions is for the people they support to have a fulfilled life with healthy relationships, friendships and purpose; to be empowered to make choices; and to be part of an inclusive community. Directions' service provision model is relationship based, where the participant and family are at the centre of decision-making and in control of the support they receive. The Service Delivery Policy supports individuals to participate in community life in the way they choose, e.g. meaningful work, leisure, learning and/or relationships. Cultural security, where all individuals are offered the same quality of services, is promoted for Aboriginal and Torres Strait Islander people to build cultural and community connections. Directions are in the process of developing a Reconciliation Action Plan (RAP).

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 2 (stated in 'Standard for service' above):	Yes	1,2,6
2:1 The organisation actively promotes a valued role for people with disability, of their own choosing.	Yes	1,2,6
2:2 The organisation works together with individuals to connect to family, friends and their chosen communities.	Yes	1,2,6
2:3 Staff understand, respect and facilitate individual interests and preferences, in relation to work, learning, social activities and community connection over time.	Yes	1,2,6
2:4 Where appropriate, the organisation works with an individual's family, friends, carer or advocate to promote community connection, inclusion and participation.	Yes	1,2,6
2:5 The service works in partnership with other organisations and community members to support individuals to actively participate in their community.	Yes	1,2,6
2:6 The organisation uses strategies that promote community and cultural connection for Aboriginal and Torres Strait Islander people.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other

Standard 3: Individual outcomes
Standard for service: **Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.**

Assessment summary against Standard 3: Individual outcomes
Standard 3 is met.
The Service Delivery Policy states that Directions will respond to the unique skills, lifestyle preferences, personal aspirations and support needs of individuals accessing services. The policy describes person-centred planning, collaboration with relevant stakeholders, meeting individual needs and documenting goals and outcomes. The Service Access Procedure describes the steps of initial assessment, consent, profile and plan development; and is supported by Goal setting and Individual plan templates; and the NDIS Progress report, with goal attainment, barriers, enablers, risks and recommendations. The Therapy Services processes document details initial assessment and needs analysis, person-centred planning, equipment prescription, behaviour support and support worker education. Cultural security is promoted for people from culturally and linguistically diverse (CALD) backgrounds and other factors, such as age, disability, faith or sexuality. The Accessible Services Policy details strategies to facilitate cultural accessibility, including e.g. use of interpreters, alternative communication methods and easy English, staff undertaking cultural sensitivity training and community engagement.

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 3 (stated in 'Standard for service' above):	Yes	1,2,6
3:1 The organisation works together with an individual and, with consent, their family, friends, carer or advocate to identify their strengths, needs and life goals.	Yes	1,2,6
3:2 Organisation planning, provision and review is based on individual choice and is undertaken together with an individual and, with consent, their family, friends, carer or advocate.	Yes	1,2,6
3:3 The organisation plans, delivers and regularly reviews services or supports against measurable life outcomes.	Yes	1,2,6
3:4 Organisation planning and delivery is responsive to diversity including disability, age, gender, culture, heritage, language, faith, sexual identity, relationship status, and other relevant factors.	Yes	1,2,6

3:5 The organisation collaborates with other service providers in planning service delivery and to support internal capacity to respond to diverse needs.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other

Standard 4: Feedback and complaints
Standard for service: **Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.**

Assessment summary against Standard 4: Feedback and complaints
Standard 4 is met.
The Complaints and Feedback Policy encourages participants and their families to provide feedback as a source of identifying ways to improve the way Directions delivers services. A culture of open communication that is non-threatening is promoted. Examples of strategies listed to support people to give feedback include being informed in multiple formats of their rights to make a complaint, training staff to effectively manage feedback and complaints, giving clear timelines and avenues of external complaints offices. The Complaints Handling Procedure is brief and there is an Easy Read version. The Welcome Pack includes a Complaint form, Feedback form and the Service Charter and information about making a complaint. In addition, there is an Annual survey, Complaints and feedback register and a proposed Customer Reference Group with draft Terms of Reference. The Change Management Policy states strategies to transition to new ways of working and effective change. This is practically supported by the Continuous Improvement spread sheet in response to feedback, incidents and other identified issues. For example, the OSH Action Plan related to an internal audit, the establishment of a COVID taskforce and a review of performance metrics and KPI dashboards. There is also a Gap Analysis spread sheet with timelines and priorities for operational improvements. The Human Resources Policy includes standards for equal employment opportunity, responding to harassment and bullying and worker grievance procedures.

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 4 (stated in 'Standard for service' above):	Yes	1,2,6
4:1 Individuals, families, friends, carers and advocates are actively supported to provide feedback, make a complaint or resolve a dispute without fear of adverse consequences.	Yes	1,2,6
4:2 Feedback mechanisms including complaints resolution, and how to access independent support, advice & representation are clearly communicated to individuals, families, friends, carers and advocates.	Yes	1,2,6
4:3 Complaints are resolved together with the individual, family, friends, carer or advocate in a proactive and timely manner.	Yes	1,2,6

4:4 The organisation seeks and, in conjunction with individuals, families, friends, carers and advocates, reviews feedback on service provision and supports on a regular basis as part of continuous improvement.	Yes	1,2,6
4:5 The organisation develops a culture of continuous improvement using compliments, feedback and complaints to plan, deliver and review services for individuals and the community.	Yes	1,2,6
4:6 The organisation effectively manages disputes.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff; **4** discussion with external stakeholders **5** annual self-assessment **6** other

Standard 5: Service access
Standard for service: **The service manages access, commencement and leaving a service in a transparent, fair, equal and responsive way.**

Assessment summary against Standard 5: Service access
Standard 5 is met.
The Accessible Services Policy outlines how access to Directions will be clear and transparent, so that all people are treated fairly. The policy details principles of equitable access including non-discrimination, flexibility, responsiveness, collaboration and referral networks. The Service Access procedure describes referral processes, eligibility, assessment of needs and the development of a plan, costs and Service Agreement with relevant stakeholders. Other documents related to this Standard include the: • Welcome pack, consisting of, for example, a Service Agreement and Consent form • Therapy Services processes • Closure of Directions Policy and Procedure that includes transitional/alternative service arrangements and exit planning. • Service Exit procedure, that supports people to exit Directions if an alternative is identified and preferred. • Clinical governance model, including transparent and equitable service access approaches. • Directions website is currently being updated to improve accessibility https://www.directions.asn.au/

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 5 (stated in 'Standard for service' above):	Yes	1,2,6
5:1 The organisation systematically seeks and uses input from people with disability, their families, friends and carers to ensure access is fair and equal and transparent.	Yes	1,2,6
5:2 The organisation provides accessible information in a range of formats about the types and quality of services available.	Yes	1,2,6
5:3 The organisation develops, applies, reviews and communicates commencement and leaving a service processes.	Yes	1,2,6
5:4 The organisation develops, applies and reviews policies and practices related to eligibility criteria, priority of access and waiting lists.	Yes	1,2,6

5:5 The organisation monitors and addresses potential barriers to access.	Yes	1,2,6
5:6 The organisation provides clear explanations when a service is not available along with information and referral support for alternative access.	Yes	1,2,6
5:7 The organisation collaborates with other relevant organisations and community members to establish and maintain a referral network.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other

Standard 6: Service management
Standard for service: **The service has effective and accountable service management and leadership to maximise outcomes for individuals.**

Assessment summary against Standard 6: Service management

Standard 6 is met.

The vision for Directions is to have a reputation for quality and to keep their unique, values-based approach, recruit, develop and retain the best people and build strong links with government and community. Their values include working together, being creative and flexible, having energy and enthusiasm, being compassionate, making a difference and being honest.

The Human Resources Policy and Procedure is detailed and contains components of workforce planning, recruitment, mandatory pre-employment checks, induction, probation, supervision, professional development and performance management. Supporting documents include the Employee Training and Competencies log, Annual review template and Supervision contract. (It is recommended that Directions prepare for the NDIS (Practice Standards – Worker Screening) Rules 2018.)

Management systems include:

- The Occupational Health and Safety (OSH) Policy and Procedure, to promote health and safety, prevent workplace accidents and injuries and train staff in safe work practices. Relevant roles include an Occupational Safety and Health Coordinator, Fire Warden and First Aid Officer. There is an OSH Committee with Terms of Reference and a Workplace, Health and Safety plan. Procedures exist for home visits; no response; infection control; pandemic responses; medication management, administration and incident; vehicle accidents; injury management and workers' compensation. In addition, there is a COVID-19 Management and Recovery Plan with a taskforce team.
- IT database for training and documentation, including e.g. individual goals and progress notes, medication plans and incident reporting.
- A Financial Management Policy and Procedure including annual budgets, asset management, preventing fraud and mismanagement and supported by a Financial Committee.
- The Risk Management Policy and Procedure uses a risk management framework of reporting, identifying, analysing, treating and monitoring; and is supported by current a risk management plan and risk register.
- Clinical governance model of seven pillars, including: client and community participation, risk management, information management systems and technology, workforce development and credentialing and clinical accountability.
- The Monitoring Legal Compliance Policy enacted by the Board and reviewed bi-monthly.

Other relevant documents reviewed, include the:

- Organisation chart and proposed workforce plan (2020)
- Annual Report (2018-19)
- Strategic and Business Plan (2017-20). New plans are in development with four strategic goals of maintaining relationships; skilled and productive team; thriving linkages and partnerships; and growth of revenue with financial sustainability.
- Policy and Procedure Manual, which will be updated by the People and Culture Manager (a new position).
- Governance policies around the actions and functions of the Board and conflict of interest.

Statement of qualitative evidence		
Policies and Procedures (P&P)	**Yes/No or N/A**	**Info Source**
The organisation has policies and/or procedures that support the key intent of Standard 6 (stated in 'Standard for service' above):	Yes	1,2,6
6.1 Frontline staff, management and governing bodies are suitably qualified, skilled and supported.	Yes	1,2,6
6.2 Practice is based on evidence and minimal restrictive options and complies with legislative, regulatory and contractual requirements.	Yes	1,2,6
6.3 The organisation documents, monitors and effectively uses management systems including Work Health Safety, human resource management and financial management.	Yes	1,2,6
6.4 The organisation has monitoring feedback, learning and reflection processes which support continuous improvement.	Yes	1,2,6
6.5 The organisation has a clearly communicated vision, mission and values which are consistent with contemporary practice.	Yes	1,2,6
6.6 The organisation has systems to strengthen and maintain organisational capabilities to directly support the achievement of individual goals and outcomes.	Yes	1,2,6
6.7 The organisation uses person-centred approaches including the active involvement of people with disability, families, friends, carers and advocates to review policies, practices, procedures and service provision.	Yes	1,2,6

Legend for evidence information source: **1** documentation **2** discussion with management staff **3** discussion with direct care staff **4** discussion with external stakeholders **5** annual self-assessment **6** other

Acknowledgments

Thanks are extended to individuals, families, carers, management and staff for the assistance they provided throughout the evaluation visit.

Further information

Information about the National Standards for Disability Services and the WA Quality System can be accessed on the website:
http://www.disability.wa.gov.au/disability-service-providers-/for-disability-service-providers/quality-system

For further information about this report, please contact the Quality and Evaluation team: quality@dsc.wa.gov.au

Disclaimer

The quality audit assessment is necessarily limited by the following:

- The methodology used for the audit has been designed to enable a reasonable degree of assessment in all the circumstances.
- The assessment involves a reliance on feedback and written records provided by the organisation as sources of evidence. The accuracy of written records cannot always be completely verified.
- The assessment will involve the Team Leader Evaluator sourcing evidence and seeking feedback from relevant stakeholders. On some occasions, information gathered may not reflect the circumstances applying over the whole group.
- Some issues or required improvements within the organisation may not have been identified due to the time available during the assessment.

Confidentiality statement

The Team Leader Evaluator shall keep all information collected during this assessment, relating to the organisation, confidential; and shall not disclose any such information to any third party, except that as required by legislation or by Disability Services.

All Team Leader Evaluators have signed a confidentiality agreement and will only request and use confidential information provided by the organisation as per the requirements of the Standards being assessed.