NDIS Quality and Safeguards Commission

Fact sheet

Practice reviews:

# The continuous improvement continuum

## About this fact sheet

This fact sheet describes the most common range of continuous improvement activities that NDIS providers do, and explains where practice reviews fit amongst these activities.

It includes a case study that illustrates how these activities complement and interact with each other.

This fact sheet is one in a series of resources about practice reviews, and should be read in conjunction with other NDIS Commission fact sheets and publications about practice reviews. As a minimum, it is suggested that you also read the Practice Review Framework for NDIS Providers, and the What is a Practice Review fact sheet.

## Key messages

A practice review is a reflective process that examines a provider's engagement with a group of participants, and improvements that can be made to their experience of service, often with a focus on a particular practice area, a cluster of services, and/or a particular team of support workers.

Practice reviews do not replace or duplicate reportable incident obligations and incident management system requirements for managers and key personnel of registered NDIS providers, as required by the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018*. For more information go to our website.

## The continuum

Practice reviews are one activity in the continuum of continuous improvement activities NDIS providers use.

While there are many similarities with other activities, in terms of purpose and process, practice reviews have a broader focus than a single individual or event, and include a reflective aspect.

For example, following a series of events with negative consequences affecting a number of participants receiving a particular service, a provider might initiate a practice review to look at why the poor practice is occurring, and what can be done to improve it.

Practice reviews are a proactive activity that provide opportunity for providers to 'get on the front foot', with respect to preventing near misses and incidents arising from poor practice, and improving people's experience of service.

This differs from other activities, such as a post-incident review or a review following a participant's death. Those activities may follow a similar process to a practice review, but with a focus on the individual event or person, with a view to learning and making recommendations for improvement in relation to that individual or service activity. Providers can, and do, also take learnings from individual events and apply them more broadly.

Table 1 describes a range of activities organisations commonly do, and the driving purpose for each, in order to clearly outline what is different about practice reviews and how they fit within a continuum of continuous improvement.

It is important to note that some of these activities are regulatory requirements for **registered NDIS providers**, and must be undertaken according to the relevant Rules and other direction provided by the NDIS Commission. More information about the relationship between practice reviews and regulatory requirements for registered NDIS providers is included in the *Practice Review Framework for NDIS Providers*.

Where there are specific obligations for **registered NDIS providers** associated with a quality improvement activity in Table 1, this is indicated as a "**REGULATORY REQUIREMENT**".

*Table 1: Quality improvement activities*

| Activity | Purpose and Description |
|---|---|
| Practice Reviews | To understand factors contributing to peoples' experience of a service, with a view to learning and improving practice.<br>A reflective process that examines a provider's engagement with a participant or group of participants, and improvements that can be made to their experience of service, often with a focus on a particular practice area, a cluster of services, and/or a particular team of support workers. |
| Audits – external<br>**REGULATORY REQUIREMENT** | To seek independent assurance of compliance with legislation, standards, and contractual obligations.<br>Usually related to legislated obligations, such as NDIS registration status (certification etc). |
| Audits – internal | To ensure compliance with legislation, standards, contractual obligations, policy, and procedures.<br>Includes self-assessment (e.g. for NDIS registration processes) and regular, scheduled examination of operations, including high-risk areas. |
| Case reviews<br>Clinical reviews | To ensure an individual's support is meeting their needs.<br>Focussed on one person only, and often initiated in response to health and/or behavioural events. |
| Feedback mechanisms<br>participants<br>workers<br>external stakeholders | To gain firsthand reports of service experience, both positive and negative.<br>Proactive and reactive mechanisms that allow providers to gather, learn and apply stakeholder' suggestions, and to address issues of concern, in order to enhance service delivery (e.g. complaints processes, employee and customer surveys, positive feedback). |
| Governance committees | To provide visibility of operations, including high-risk areas, at a senior level in an organisation.<br>Periodical and high-level examination of specific aspects of an organisation's operations. |

| Activity | Purpose and Description |
|---|---|
| Incident reviews<br>- including review following a death<br>**REGULATORY REQUIREMENT** | To understand factors contributing to an incident with a view to learning and improving practice.<br>Examination of the circumstances surrounding an incident, and may have learnings that apply beyond the single event.<br>To understand factors contributing to a person's death with a view to learning and improving practice, and identifying opportunities to prevent recurrence.<br>Examination of the circumstances surrounding a person's death, and may have learnings that apply beyond the individual. |
| Investigations<br>• incidents<br>• complaints<br>• grievances<br>**REGULATORY REQUIREMENT** | To determine the root cause of an event so you can prevent it from happening again.<br>A fact finding process to establish and document relevant facts, reach appropriate conclusions based on the available evidence, determine a suitable response, and instigate preventative measures. |
| Organisational reviews<br>Functional reviews | To comprehensively evaluate how well an organisation – or function within an organisation – is performing, including an assessment of leadership and authority, and learn how to proactively deal with and address issues.<br>Not a regular occurrence, and usually in response to significant changes or events that impact multiple areas of an organisation. |
| Policy and procedure review | To ensure compliance and currency with legislation, standards, and good practice.<br>Regular review cycles, as well as in response to internal and external environmental changes. |

# Case study: how it all fits together

*An incident occurred where a participant choked on a piece of food, stopped breathing, and required resuscitation to recover.*

*The participant was known to have dysphagia (difficulty in swallowing), and had a mealtime plan that outlined specific instructions for how food should be prepared and what support was required at mealtimes.*

I. The **incident investigation** found:

- the worker appropriately administered first aid
- the worker did not follow the documented mealtime plan
- the participant's mealtime plan was not up to date
- the worker had not been trained as recommended in the mealtime plan.

The following recommendations were made:

- that the participant's mealtime plan be reviewed for currency
- that all current workers providing support to that participant receive training/refresher training in mealtime support.

II. A **review** was arranged of all mealtime plans for participants receiving this support by a suitably qualified clinician.

III. A senior manager in the organisation requested that an **audit** occur to determine the currency and completeness of mealtime plans for all identified participants receiving mealtime support.

The audit found 67% of the plans were not current and/or had elements missing, such as workers indicating training had been provided, and recommended all plans be immediately updated and training provided, as necessary.

IV. In response to the audit, the provider's Risk Management Committee requested a report on how many incidents of this nature had occurred in the organisation in the preceding 12 months, and found there had been 15 incidents reported that were related to mealtime support.

It recommended a practice review into how mealtime support was being provided throughout the organisation.

V. The CEO, Operations Manager, and Quality Manager of the organisation determined Terms of Reference for the practice review to be:

- desktop audits of:
    - risk profiles for identified participants requiring mealtime support, and
    - mealtime support procedures and processes to consider currency, compliance with standards, and best practice
- examination of other relevant information sources (e.g. reviews of feedback and complaints from participants and their supporters or representatives over a time period to identify relevant issues raised and any actions taken in response)
- examination of relevant incident reports and what had been done in response
- external audit by a suitably qualified speech pathologist who is a subject matter expert in dysphagia of the mealtime plans for all identified participants
- interviews with:
    - a selection of workers from across the organisation with a focus on their understanding of, and approach to, mealtime support, and their experience of training
    - a selection of participants to hear about their experience of mealtime support
    - a selection of participant representatives to hear about their experience of post-incident follow up.
- observation by the reviewer of mealtimes for a sample of participants (who were asked to provide consent for this to occur).

A practice review panel was convened that included:

- senior management representatives – to ensure consideration of system-wide improvements
- a frontline manager representative – to ensure the relevancy and practicalities of any recommendations
- a participant representative – to ensure consideration of customer experience.

The practice review found:

- procedures and processes were current, compliant with standards, and aligned with best practice in mealtime support
- procedures were not consistently reflected in participants' mealtime plans
- the clinician made specific recommendations about how participants' mealtime plans should be updated
- interviews with workers found varying degrees of understanding of, and confidence in, following mealtime plans
- participant representatives interviews found that those who had been involved in previous incidents said that they would have liked information about what action was taken post-incident, such as review of mealtime plan, as it would have given them confidence that the incident would not happen again.

The practice review made recommendations for improvement across a number of practice areas. For example:

i. All participants' mealtime plans should be reviewed as soon as possible (within four weeks), and updated to reflect existing procedures, and in line with clinical advice received.

ii. An internal audit should be undertaken in six months to ensure 100% compliance with mealtime management procedures and processes.

iii. All workers should receive refresher training in mealtime management or support as a priority (within three months).

iv. Incident management procedures should be updated to include provision of feedback to participants of actions resulting from incident investigations and reviews. Managers should receive advice of this change and directed to resources to assist them comply with this direction.

## Related resources

Refer to the *Practice Review Framework for NDIS Providers* for a complete list of documents related to this series.

Practice Review Framework for NDIS Providers

## Contact Us

**Call: 1800 035 544** (free call from landlines).

Our contact centre is open 9.00am to 5.00pm (9.00am to 4.30pm in the NT), Monday to Friday, excluding public holidays.

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