|  |  |
| --- | --- |
|  | Quality Assurance Panel Outcome Summary Report |

**1.** **Panel meeting date: Choose date here.**

**2. Person with disability**

|  |  |
| --- | --- |
| Details | Required information |
| Full name | Enter text here. |
| Participant ID (Required in context of NDIS services only) | Enter text here. |
| Behaviour Support Plan ID (Required in context of NDIS services only) | Enter ID here or write NA. |
| Date of birth | Choose date here. |
| Address | Enter text here. |
| Suburb | Enter text here. |
| State | Choose |
| Postcode | Enter text here. |

**3.** **Implementing Provider(s)**

(Copy and paste tables below if required.)

|  |  |
| --- | --- |
| **Implementing Provider details** | **Required information** |
| Business Name | Enter text here. |
| Provider ID (Required in context of NDIS services only) | Enter text here. |

**4.** **NDIS Behaviour Support Practitioner – BSP author**

|  |  |
| --- | --- |
| **NDIS Behaviour Support Practitioner(BSP author)** | **Required information** |
| Name | Enter text here. |
| Practitioner ID | Enter text here. |
| Organisation | Enter text here. |

**5.** **Panel Attendance**

(Copy and paste tables to add decision-making members and other if required. As a minimum, the Quality Assurance Panel must include a senior manager or delegate of the Implementing Provider and independent external NDIS Behaviour Support Practitioner).

**Decision-making Panel Member**

|  |  |
| --- | --- |
| Senior Manager or Delegate | Required information |
| Name | Enter text here. |
| Job Title | Enter text here. |
| Organisation | Enter text here. |

**Decision-making Panel Member**

|  |  |
| --- | --- |
| Independent external NDIS Behaviour Support Practitioner  | Required information |
| Name | Enter text here. |
| Practitioner ID | Enter text here. |
| Organisation | Enter text here. |

**Other Attendees**

(This may include the person for whom the plan is about, author of BSP or key stakeholders as deemed appropriate.)

|  |  |
| --- | --- |
|  | Required information |
| Name | Enter text here. |
| Job Title/Role | Enter text here. |
| Organisation (if Applicable) | Enter text here. |

**6.** **Conflict of Interest Notification**

|  |  |
| --- | --- |
| Description of identified actual, potential and/or perceived Conflicts of Interest and Mitigation Steps Taken | Required Information |
| Identified perceived/potential or actual conflict of interest | Enter text here or indicate NA if not applicable. |
| Mitigation Steps Taken | Enter text here or indicate NA if not applicable. |

**7.** **Supporting documents**

(Delete or add rows as required.)

|  |  |
| --- | --- |
| Document name | Document description – include dates, type of BSP (interim or comprehensive) |
| BSP (required) | Enter text here. |
| Restrictive Practice(s) Elimination Plan (Required separately if not included in BSP) | Enter text here. |
| Outcome Summary Report from previous Quality Assurance Panel(s) (required) | Enter text here. |
| Enter text here. | Enter text here. |

**8. Authorisation decision(s)**

(Add tables as required. Each restrictive practice is to be in a separate table.)

|  |
| --- |
| Restrictive practice 1 |
| Regulated restrictive practice Category | Choose an item. |
| Describe restrictive practice here (as described in the BSP) | Enter text here. |
| Behaviour of concern (as detailed in the BSP) | Enter text here. |
| Implementing Provider(s)  | Enter text here. |
| Authorisation Decision  | Choose an item.  |
| Reason for decision/Recommendations – please detail in reference to the Principles for the use of restrictive practice outlined in [refer to section 4.1.2 of the Procedure Guidelines (Stage Two)]:**Principle 1 – Last Resort****Principle 2 – Least Restrictive** **Principle 3 – Reduces Risk of Harm****Principle 4 – Proportionality****Principle 5 – Shortest Possible Time** | **Reasons** (Provide details of reasons)Enter text here.**Recommendations** (Provide details for what is needed to support future authorisation review)Enter text here. |
| Authorisation expiry date [refer to section 4.2.3 of the Policy Procedure Guidelines (Stage Two)]. | Choose date here. |

**9. Documents required for next Quality Assurance Panel**

|  |  |
| --- | --- |
| Document details | Check if applicable |
| BSP | Required |
| Restrictive Practice(s) Elimination Plan (if not included in BSP) | Enter text here. |
| Outcome Summary Report from previous Quality Assurance Panel(s) | Required |
| Enter text here. | Enter text here. |

**10. Decision-Making Panel Member declarations**

(Add members if required.)

**Decision-making Quality Assurance Panel Member 1**

I declare that:

1. I have followed the requirements of the Authorisation of Restrictive Practices in Funded Disability Services Policy (the Policy), as detailed in the Procedure Guidelines (Stage Two, updated September 2023) and fulfilled my role as decision-maker on this Quality Assurance Panel accordingly.
2. I have considered and declared any conflicts of interest and recorded those and required mitigation steps within Table 6 of this QA Panel Outcome Summary Report.

Name: Enter text here.

Signature: Enter text here.

Date: Enter text here.

**Decision-making Quality Assurance Panel Member 2**

I declare that:

1. I have followed the requirements of the Authorisation of Restrictive Practices in Funded Disability Services Policy (the Policy), as detailed in the Procedure Guidelines (Stage Two, updated September 2023) and fulfilled my role as decision-maker on this Quality Assurance Panel accordingly.
2. I have considered and declared any conflicts of interest and recorded those and required mitigation steps within Table 6 of this QA Panel Outcome Summary Report.

Name: Enter text here.

Signature: Enter text here.

Date: Enter text here.

**Note**: Implementing providers must not change the formatting or integrity of this document.