September 10, 2015

Joe Rudderham
Executive Director
Services for Persons with Disabilities
Department of Community Services
Province of Nova Scotia
Via email

Dear Joe,

I am pleased to provide you with a final Current State Assessment Report for the Quest Society for Adult Support and Rehabilitation.

This report is the result of a review of documents, key informant interviews and focus groups involving program participants, family members, program staff, management, Board members and the perspective of the regional office of DCS. Everyone who participated in focus groups was invited to review a draft of this report to ensure that the final version is a fair and accurate representation of their feedback. Their involvement was, without exception, both thoughtful and constructive.

I must acknowledge the tremendous assistance of Phyllis Williams, who has been providing interim management leadership to the organization and extended every support to me in the collection of information and connecting with stakeholders.

I hope that this report and recommendations helps this very important organization continue to move forward in fulfilling its mandate. Most importantly, I hope that the next phases of work build on the strength of positive relationships that defined this process.

Thank you for the opportunity to undertake this assignment.

Kindest regards,

Mary Jane Hampton

Quest Regional Rehabilitation Centre
Current State Assessment Report

Executive Summary

On July 11, 2014, Community Services Minister Joanne Bernard announced that Quest would be conducting a best practice review of their operations in response to concerns about the safety and support of individuals living at the facility. An external consultant was hired to provide a report on the organization's current state. The consultant was asked to examine the extent to which steps had been taken to address security concerns, whether progress is being made to strengthen Board governance and where there are opportunities to strengthen the role and performance of the organization in meeting the needs of program participants.

Through a review of documents, discussions with board, staff, clients and family members the consultant found that Quest RRC has put a plan in place to correct gaps in security, undertaken an overhaul of its governance model and bylaws and is focusing on board renewal. A scan of best practices of assessment and rehabilitation programming for persons with complex challenges due to their disabilities confirms that Quest is providing quality programs for its clients.

Staff is highly committed to quality service, and there is a need to invest in their training so that program participant goals for more independent living can be achieved. There is also a need for the Quest site on Memory Lane to focus on a primary mandate of assessment and stabilization. To do this, DCS needs to enter into a clear Service Agreement based on performance and outcomes, modernize its funding model and build capacity in the variety of supported living arrangements that persons with disabilities require to live at home.

About Quest

Quest Regional Rehabilitation Centre is located in Sackville, Nova Scotia. Quest RRC arose from an evolution that originated with government's move toward deinstitutionalization in 2001, which included the closure of the Halifax County Regional Rehabilitation Centre in Cole Harbour. That facility had a long and storied history, and many people regarded it as a classic example of a segregated, custodial institutional placement model.

The Quest Society has a more contemporary mandate, encompassing several aspects of services and supports for persons with disabilities. The Quest Regional Rehabilitation Centre is a purpose-built facility to provide assessment, stabilization and rehabilitation services for persons with disabilities who need help to transition to more independent living in the community. This building is also the permanent home to some residents. Five people who were residents at the original Halifax County institution call Quest RRC on Memory Lane their home.

Operationally, there are two units; Unit A and C. Unit A is currently comprised of twelve male program participants, ranging in age from 22 to 57 years, with intellectual disabilities in the mild to profound range. Two of these individuals are young males with a primary diagnosis of Autism. Some of these individuals have been in residential care for many years and have medical conditions as well. Most are non-verbal or have limited verbal skills and are dependent on staff support for basic activities of daily living.

The twelve individuals residing on Unit C range in age from 19 to 60 years. Two of these individuals have a primary diagnosis of Fetal Alcohol Syndrome, one individual has a primary diagnosis of Acquired Brain Injury and the remainder have a dual diagnosis; an intellectual disability coupled with a mental health diagnosis. Three of these individuals are under an adult protection order and one under a Conditional Sentence Order. Adaptive functioning ranges from requiring staff support for basic activities of daily living to being able to access the community independently.

The Quest RRC opened at its present location in Sackville in September 2008 and was at full capacity by 3 February 2009. (Eleven people were transferred from the Sunrise Manor site). Since 3 February 2009, there have been 26 admissions. Of those discharged, 4 went to hospital (2 of which subsequently passed away in hospital), one went to the Nova Scotia Hospital, 4 went to the Community Transition Program, 14 went to a small option home (2 of which were to the Quest operated small option home), 2 went with a family member and one to the Central Nova Scotia Correctional Facility.

The capacity for the Regional Rehabilitation Centre is 24 beds. It is currently at full census and generally this is the norm. As vacancies occur, there are always people on the wait list. A vacancy may occur for a short period (couple of weeks) until arrangements are made for the new admission. Recognizing that the organization must maintain a minimum staffing level to be able to take clients on an emergency basis, Quest does not lose funding because of empty beds.

Regional Rehabilitation Centres provide both rehabilitation and developmental programs to individuals with disabilities who require an intensive level of support and supervision related to complex behavioral challenges and skill development needs. Approved staffing is provided on a 24 hour / 7-day a week basis by on-site professional staff. On the second floor of the 70 Memory Lane site, the Department of Health and Wellness is responsible for the Community Transition Program (CTP). Although the Executive Director of Quest RRC has authority over both the RRC and the CTP

the programs are two separate legal entities and the CTP is co-managed with the Capital District Health Authority. The CTP mandate is "to use an Integrated Care Approach to transition individuals from inappropriate settings to the appropriate level of care within the established continuum of support in the community." The target population is "adults who have complex (mental and physical), behavioural and residential/social support needs. An individual is deemed to have Complex Health and Residential/Social Support Needs when the following apply:

- Individual has a chronic mental illness or intellectual/developmental disability, and in addition may have a chronic physical/medical condition, or serious behavioural challenges, which pose high risk to self and others
- All interventions/resources have been utilized
- Individual has been assessed to be appropriate for this level of support
- Require the expertise of an on-site inter-professional team to assess and address clinical and rehabilitation/life skills developmental needs
- Medical stability, whereby the acute phase of the illness is over, major diagnostic testing is completed, medical needs are not requiring daily medical intervention by a physician and nursing needs can be adequately addressed in community with available resources
- Require a 24/7 level of support in a highly structured environment.

The Community Transition Program opened with a 16 bed capacity; however, this was later reduced to 14 beds to allow additional space for programming (a games room and a computer room). Since the program opened in April 2013, there have been 12 admissions. There have been 6 discharges; 1 went to the Nova Scotia Hospital, 1 went to King's Regional Rehabilitation Centre, 4 went to newly opened small option sites to meet their specific needs.

Quest has a clinical team made up of occupational therapy, social work, psychology and nursing. Family doctors, psychiatry, physiotherapy and pharmacy are also part of team on a contracted basis. The clinical leads articulate the rehabilitation plan for each program participant and the Residential Rehabilitation Workers (RRWs) operationalize it. RRWs are required to meet seven core competencies for employment (CPR/First Aid, non-violent crisis intervention, non-aversive behaviour management, medication awareness, fire and life safety, individual program planning, and basic principles and practices of personal care). In addition, Quest provides training in the areas of ethics, personality disorder, Autism, brain injury, Fetal Alcohol Syndrome and the Assist program.

Quest has a general staffing ratio of 3:1. This can fluctuate up (when a program participant has augmented 1:1 support as part of the terms of their admission) or down (when a staff member calls in sick, or when there is a crisis on a unit requiring multiple-staff intervention). It also provides a Community Behavioural Support Service. This team consists of the Clinical Resource Nurse / Policy Manager, the Social Worker from the RRC site, and the Occupational Therapist.
The Psychologist position is currently vacant, but this position would have responsibilities to both the RRC site and the Community Behavioural Support Service.

For program participants transition planning to the community from the Regional Rehabilitation Centre, many require support in coping skills and learning to self-regulate their emotional and behavioural response to stress. The goal is to decrease verbal and physical aggression, manage anxiety and avoid the challenges that result from impulsive decision- making, poor communication and problem solving skills.

Quest supports people with some of the most challenging needs in the health and social services system (often those that other service providers have refused to accept). Rehabilitation for most clients is long-term and transition to the community depends on the capacity of service agencies to provide the continued level of often-specialized support that are needed for more independent living. In the absence of that alternative-model capacity, Quest RRC is the default and often long-term living option. While there is a general shortage of supported living settings in Nova Scotia, it is particularly difficult to find agencies with staff and facilities able to support persons with behaviour challenges associated with brain injuries and Autism. For some individuals, rehabilitation to more independent living is not the goal and QRRC is their permanent place of residence.

Quest's Current State

Over the past several months, there have been two significant developments undertaken by the organization to ensure its capacity to provide high quality services: the commissioning of a third-part review of security and safety, and a comprehensive review of governance practices.

Governance Development

Board membership has dwindled significantly, with the organization only having four active members. Two members have been with the board since it early days with the municipality and have guided the organization through a considerable evolution. One board member is also the parent of a resident. All members are concerned about the challenge of board recruitment and retention. External consultants with expertise in governance development were engaged and have been working with the organization to come up with strategies to identify and attract talent to the board. There has also been a comprehensive review and update of the bylaws, and refresher training in the practical aspects of policy-governance.

The By-Laws and Board Governance package were sent to Quest's legal counsel for review and have been returned with some suggested changes. These were reviewed at the Board of Directors meeting scheduled in March 2014. In regards to board recruitment, Change Management Professionals provided a 1½ day workshop on recruitment, focusing on the qualities and talents required of board members and the approach to recruitment. A further ½ day workshop is being scheduled develop a plan of action.

The organization was further challenged by its Executive Director taking an extended leave, which required an interim management solution. While the quality of the interim leadership has been remarkable, getting clarity on the matter of a long-term leadership is extremely important for the health and future of the organization.

Security Review

In May of 2014, not long after a security review if the CTP on the 2nd floor, a tragic incident occurred on the 1st floor at the RRC. A program participant died from injuries suffered when he was pushed into a wall by another client, with the victim caught in the path of a pacing and flailing client, who was seeking a clear path for his behaviours. Paladin Security, an industry-recognized expert in such matters, was engaged and delivered a comprehensive reports and recommendations. The Quest RRC board has responded to each of the recommendations with specific action plans to address security deficiencies. A meeting with DCS was held to discuss the financial implications of a number of physical plant upgrades, including an improved duress alarm, electronic access control and video surveillance systems. One recommendation regarding the benefit of widening doorways leading to

quiet rooms (so there is room for two staff to manage a person who has physical aggression) does not appear to be practical to implement. Further staff training in de-escalation techniques and skills in non-violent physical intervention may contribute to a less stressful environment. A summary of the security consultants' recommendations and associated action plan is on file with DCS.

Interviews and Focus Groups

In order to understand Quest's current state, the consultant met with a variety of stakeholders to hear their opinions and perspective. The following summarizes the feedback from those groups.

What program participants had to say

Three clients from Unit C agreed to participate in a focus group and met with the consultant for approximately 90 minutes. All expressed a belief that they have benefitted significantly from their time at Quest. Their stay at the organization ranges from ten months to three years. All were emergency referrals; all look forward to transitioning to a supportive living arrangement in the community.

In terms of the quality of their rehabilitative programming, program participants did observe a frequent interruption in their ability to participate in supervised community-based activities due to a lack of availability of staff. This frustrates their need for routine and predictability, and can provoke angry disappointment. They said that, most days, they feel bored.

While productive employment is a personal goal for several program participants, lack of opportunity to develop job skills and gain work experience as part of their rehabilitative programming limits this possibility. They also noted the lack of opportunity to practice lifeskills while at Quest, such as meal preparation, because there are no kitchen facilities accessible for use. For those familiar with (and enjoying) cooking their own food, this loss of independence feels like a regressive step in their goal of more independent living.

The physical location of the facility between a highway, an exit ramp and a main thoroughfare makes such things as taking a walk outside stressful (even dangerous), although for some it has forced confidence in the use of public transit. The building's design itself poses some limitations to a sense of privacy and personal space. The behavior of other clients who are prone to aggression is often disruptive (particularly shouting, physical outbursts and slamming doors). This is true at night, when they are trying to sleep, and in the day, when there is congregation in relatively small common areas and some people who need to pace.

The program participants felt no affinity with the residents in Unit A. Moreover, they feel stigmatized by their peers as a result of being at Quest because of the reputation of the facility as a long-term care facility that houses extremely high needs and/or dangerous residents. In the words of one person "who wouldn't go crazy living here?" The program participants were aware of a shortage of small option vacancies and are concerned that this will delay or prevent their ability to transition from Quest. And while they are keen to move on, each expressed conflicted feelings about the prospect of leaving what has clearly become a strong and supportive community of friends and deep bonds, with fellow program participants and staff members alike.

What family members had to say

Nine family members accepted the invitation to participate in a focus group. They ranged in having children at Quest for three weeks to seven years. All were emergency referrals. One family member recalled being far from enthusiastic about Quest's appropriateness for her child, based on the

references given by other service providers about the facility. Now, she cannot speak highly enough about the organization and the quality of service and care it provides. Indeed, all family members indicated that Quest had been 'a God-send' for their child and the rest of their family.

For some parents, it is their expectation that their child will transition out of Quest RRC and into a more independent residential setting after a period of treatment and rehabilitation. For other families, it is the hope that their child will continue to live at Quest permanently. The latter group believes that a facility-based setting provides the best possible quality of life for their children as they age because it offers exceptional personal care and a social environment that is supportive and rewarding. They expressed a strong opinion that "anywhere can be an 'institution'" and that the sense of community, which has been achieved in the Quest setting, could not be recreated in a stand-alone housing environment.

Similar to the observation of program participants, most family members do perceive there to be a lack of staff, particularly to support client participation in community-based activities. They suggested that having more staff members licensed to drive the two vans may help with the situation, but if a staff member is sick or if there is an emergency on a Unit, supervision of a community outing falls down (and usually off) the list.

When excursions are planned and cancelled, it usually results in the program participant being angry and acting out with challenging behavior. As one parent put it, staff members need to distinguish between a client being 'mad, not bad', and understand that routine is vital to keeping an even keel.

Like the program participants, parents have noted the lack of opportunity for residents to get outside, with or without supervision. The courtyard was equipped with a swing by one family (who welcomed its general use) but it is not believed this space is optimized. The limitations of Quest's physical location pose practical reality, but the result is a program participant population confined to indoor activities.

All of the parents interviewed remain regularly involved with their child's care and visit the facility often. Most parents felt that the quality of communication by clinical and front line staff with them could be improved, while some felt comfortable with the type and frequency of information they receive about their child.

Staff turnover can challenge good, consistent communication and some parents are not always confident that front-line staff are equipped with the training they need to work in such a complex care environment. All parents believe that the quality of nursing care is exceptional and that the facility has been fortunate to engage the services of a very dedicated group of family doctors.

While some parents do not feel at all times valued for their input in the care of their child, most did cite examples of when staff rose above and beyond the call of duty. These include several staff taking a program participant on a weekend-long trip to PEI to attend a rock concert (it was the client's favourite performer), to a staff member making custom art-work for clients with particular interest in a sports team, to another staff member who has volunteered to take clients' clothing items home to custom alter. As one parent put it: "These staff are paid to work here. They are not paid to love my son, but they do."

The parents were both concerned and disappointed by the media events last summer, and felt that the reputation of the organization was harmed. While some do have objection to the way the justice system has been used in response to clients' aggressive behaviour, they did not believe the approach taken by other parents and advocates to affect change was widely productive. Moreover,

they felt lack of media/public understanding about the difference between the programs (and governance) of the 1st and 2nd (Capital Health Community Transition Program) made the situation worse. They do not believe that the public has a clear understanding about the role of Quest RRC or the clients it serves.

What staff and management had to say

The eleven front line and clinical staff who accepted the invitation to participate in focus groups are devoted to their work. They feel confident that the security review resulted in sound recommendations and that the work environment is safe for them and their clients.

While they acknowledge that their jobs can be very challenging, particularly when addressing the needs of very aggressive clients, for the most part they enjoy working at the organization. Staff turnover tends to be relatively high. Often, once they have gained experience and training at Quest, individuals are able to find positions in other sectors that are less demanding with better pay. This makes retention of skilled workers difficult. They agree that more staff training, particularly in the behaviour modification of individuals with Autism and Acquired Brain Injury is required. They feel that the seven core competencies as laid out by DCS are far from adequate in preparing staff for their job, and new staff rarely have the opportunity to get sufficient early-orientation.

The team-based approach to programming and support works well, and there was strong agreement that a strength of the organization is staff's ability to be creative and flexible in how they work together. They take considerable pride in the organization's reputation for refusing a referral by rare exception.

This flexibility comes at a price. A person with challenging behavior and who is not a good 'fit' with the rest of the facility population can compromise the progress of rehabilitation for everyone else on the Unit. A higher staff-to-program participant ratio is often funded, which helps, but does not completely address the impact of that admission on daily programming for all clients.

It was noted that decisions about admission and transition to the community can sometimes be emotionally charged, and that there are also times when a plan for a client is driven by the need to appease family demands. These plans can be extraordinarily expensive and are not based on a cost-benefit analysis or on an evaluation of outcomes for the individual.

It is also sometimes the case that the hospital system fails to provide the type of care and support that a complex-needs client requires. They believe that the health care system is frankly incapable of dealing with the management of individuals with very aggressive behaviours, even when that person has medical needs. Referring to Quest as a 'dumping ground' was a harsh but candid assessment of the repeated failure of interjurisdictional relationship.

There is mixed understanding of the type of services that are provided by the CTP, and seemingly little interaction among staff between floors. They feel that the distinction between the 1st and 2nd floor programming and governance is unclear in the minds of the public and the media, and that Quest needs some 'rebranding' to stake its role and identity.

What the Board and the Department of Community Services staff had to say

Four board members and six DCS regional office staff participated in focus groups (there were, in fact, two separate meetings with the board). Quest's board undertook a governance review last fall and has worked with consultants to update its bylaws and develop a board recruitment strategy. There are presently only four board members who together form the board executive. In addition to board recruitment, the organization has had to temporarily fill the Executive Director position while the incumbent has been on extended health leave. Senior management saw further change

with the retirement of their lead nurse (although the organization was successful in recruitment in March).

Quest is funded annually by a grant from the Department of Community Services, based primarily on the formula from Rate Review. The DCS regional office does appear to have a high degree of involvement financial management of the organization through such controls as spending approvals and funding awards as individuals are referred. As a result, the Board does not appear to have the mandate to do long-term financial planning, nor can management make strategic investments in programming. There is no formal Service Agreement or measures for organizational performance. The Board does not feel that it is able (or even expected) to set goals beyond yearly cycles, as it does not have a strategic plan.

Individuals who are referred may come with funding to support a one-to-one staff ratio. DCS observed that this level of support has been requested more frequently by the organization, perhaps reflecting its reluctance to accept a level of risk that would have been tolerated before the media attention around security issues last year. Both the board and DCS feel that Quest's accountability for the use of resources is very good. It would appear however that the DCS regional office has a high level of involvement in the fiscal management of the organization based on the levels of approval that are required to make purchasing decisions. As a result, the organization's fiscal culture is described more as being the recipient of a grant against which costs are applied, as opposed to having stewardship of a budget that it manages.

Recruiting and retaining staff is a challenge, due to the shortage of skilled talent and a very competitive local labour market. Even when positions have been filled, building and maintaining staff competencies is a further challenge, mostly because staff training/professional development is neither standardized across the ARC/RRC sector, nor part of their core budget. Costs for training either need to be covered through a reallocation of programming dollars or by one-time funding request of DCS.

The Board has seen a significant increase in the number of people with Autism and Acquired Brain Injury, an observation that is supported by the data estimating that 2,760 new individuals in NS suffer from an acquired brain injury each year[i] and one in 68 children will have a diagnosis of Autism Spectrum Disorder[ii]. These people can have behaviours that require specialized supports and settings which are not available in Nova Scotia. This often means that these people have nowhere to transition once their rehabilitation has progressed beyond their needing the level of service at an RRC. They believe that the need for long term residential support for people with disabilities, complex care needs and challenging behaviours will grow, and that specialized facilities and models of support to provide this care are needed.

Board members also noted benefit of focusing the role of the RRC on a primary mandate of assessment and rehabilitation. This is consistent with the direction of DCS in 2008 in its Residential Care Review: "As capacity is increased in the residential sector it is anticipated that larger facilities will transform into "Stabilization Centres" rather than long-term living arrangements for most people who require that level of service."[iii]

The Chair and Treasurer have both been involved with Quest since its early days a municipal institution and clearly see some gains and some losses as the organization has evolved. Even with its design limitations, it is agreed that the Quest RRC site is providing a high level of care and support. However,

the board shares the observation of program participants and families that a site located where it was possible to for clients to get outside in all seasons would be much preferred, particularly for those requiring life-long facility-based residency. The residential-support model should be designed and located for ease of living-integration with community activities, access to public transit, opportunities for skills-development and access to meaningful employment.

There is strong agreement that the public does not have a good understanding of the role of Quest or the population it serves, nor are people able to distinguish between Quest and the CTP upstairs. This lack of public understanding was amplified during the media attention last summer in response to a tragic death. The Board did not feel well supported by DCS during that time. The decision by government to accelerate a one-off community placement 'solution' was seen as reactionary to appease critics that left Quest to fend for itself. That said, the Board remains committed to maintaining its reputation with DCS as a service provider known to step up when a program participant requires an emergency referral, even when other agencies have refused.

Best Practice: What the literature says

A component of the Current State review involved a scan of the literature to determine best and promising practices in delivery of assessment, stabilization and rehabilitation of persons with disabilities who have highly complex needs – and in the management of organizations that provide those services. Using an adapted quality framework applied in the operational review of similar organizations[1], best practice domains fall into five categories: Strategy, Structures, Organizational Culture, People and Processes.

Strategy: the organization needs a clear, long-term direction established by its vision, mission, values, goals and a strategic plan – supported by the vision of the Department and its methods. This would include having a strategic plan, an understanding of how the organization fits within the broader system of services for persons with disabilities in Nova Scotia and long term plans marked by objectives, targets and milestones. This demands clarity of role and purpose, and discipline in pursuing it.

Structures: the organization needs division of labour, authority, decision-making and accountability that is clear and supportive of the organization's objectives. Best practice in this domain includes having a board of directors with a broad and renewing composition of membership, good governance practices and succession planning. Staffing practices and standards of service that align with the organization's model of support. It also requires that management has the flexibility to assign staff based on operational need and unique program participant support needs. Moreover, the Department needs to exercise oversight and monitoring the performance of the service provider based on clear accountability, standards and expectations for program participant service, with a formal Provider Service Agreement in place.

Organizational Culture: includes the values, norms, decision-making patterns, leadership behaviours, reward system and policies of the organization, and that they align with best practices in services for people with disabilities. This culture must align with the UN Convention on the Rights of Persons with Disabilities and reflect a culture of support (participative living) rather than a 'model of care' (custodial service). Program participants/residents have specific goals for independent

[1] Deloitte & Touche, Operational Review of Braemore Home Corporation, 2011)

living (e.g. transition plans for residents who could live in a less supported setting) and staff support them in achieving those goals with as much independence and motivation as possible.

People: having the right people with the right skills available at the right time to deliver quality program participant services. This means having the right competencies (and training to acquire and maintain them) for the services that program participants need to achieve their goals of independence. The question of best practice in the staff-to-program participant ratio is a recurring theme in the literature. Evidence-based opinion is that having sufficient staff is important, but that there is no straightforward relationship between more resource intensive services and quality of outcome. Rather, it is the level of training of staff that is a far more relevant proxy for effective programming. "Staff training may be the 'missing link' between resource input and quality of outcome."[2] Current research concludes that positive behavioural support planning, structured teaching and structured / learning / work activities for people with disabilities yield the best outcomes – and reduce the rate of behavioural incidents provoked by boredom. A team approach to individual goal setting that includes the program participant (and family, where appropriate) and all professional disciplines is essential.

Processes: having necessary supports in place to allow services to be delivered efficiently and effectively based on Individualized Program Plans that detail intervention and support strategies leading to maximum personal independence. Once created, those Individual Program Plans are implemented, monitored and revised as required.

In terms of best practice in **performance and accountability**, the Association of Adult Residential Centres and Regional Rehabilitation Centres of Nova Scotia produced an excellent report on October 2012 called 'Quality Evaluation for Providing Supports and Services to Persons with Disabilities' that lays out a framework for establishing standards, setting targets and measuring performance. This framework was developed using the *Canadian Council on Health Services Accreditation's Accreditation Program, 5th Edition* (2006), and *The Certification Standards of the Alberta Association of Rehabilitation Centres, Creating Excellence Together* (2005) and addresses the key areas of governance, leadership and organizational structure, service provision and processes, and individual outcomes.

Similarly, best practice has been demonstrated in the development and implementation of staff **training programs** for those working in this increasingly specialized field, right here in Nova Scotia. The Braemore (Breton Abilities) Centre worked with the Nova Scotia Community College to develop two programs: Understanding and Managing Challenging Behaviour and Creating a Community of Learners, which have had a positive impact on program outcomes. They are also training staff in the "TEACCH Program for Autism" (University of North Carolina) and in "Low Arousal" (Studio 3, UK).

[2] David Felce, Welsh Centre for Learning Disabilities, Cardiff University: Building competent support for people with severe learning disabilities and challenging behaviour

Key findings and recommendations

Based on the review of documents, stakeholder interviews and best practice scan, the Quest Regional Rehabilitation Centre is a well-performing organization.

The board has taken all reasonable steps to address concerns regarding **safety and security.**
1. Recommendation: DCS should advise its stakeholders that it is confident that the Board of QRRC has acted upon a review of its security practices that was undertaken by a highly respected third-party industry leader (Paladin Security) and that it offers a safe, service environment for staff and program participants.

Quest RRC has undertaken comprehensive **governance development**.
2. Recommendation: The organization should launch an aggressive campaign to fill board vacancies based on deliberate recruitment for skills and diversity a clear approach to succession planning.

Best practice in delivery of service requires **clarity of role**. Quest RRC has two very distinct populations: [1] clients who are there for treatment and rehabilitation with the goal of transitioning to more independent community-based living, and [2] residents who live there. Both populations require services, but each would benefit from very different living and programming supports.

There is a key distinction between a residence and an institution. A residence, first and foremost, is where a person lives by choice – alone, with friends or family. An institution is a place of work where a person is assigned to live. By definition, a rehabilitation facility is not a home. Permanent residents neither require nor benefit from rehabilitation services that have the aim of more independent community-based living. Some people may actually be over-serviced by virtue of living in a treatment-oriented environment, impacting their capacity for independence. Second, occupying treatment space and resources with residential program participants reduces the capacity to provide rehabilitation services for people who need them. This also applies to the case of program participants who are ready to transition to more independent community-living but are 'stuck' at a rehabilitation facility on a waiting list to leave.
3. Recommendation: Quest RRC facility on Memory Lane should focus on a primary role of crisis stabilization, assessment and rehabilitation and be rebranded as a treatment facility, not a home.

4. Recommendation: DCS should consider supporting Quest in the development of a residential care model to provide a home for those RRC program participants whose goal is not rehabilitation-to-small option-transition. This would provide these program participants with the level of personal care and support they need, while letting the RRC site focus on rehabilitation.

5. Recommendation: DCS should invest in smaller community based arrangements *so that Quest program participants who are ready to transition to more independent community living can move on with their lives.*
Best practice in service delivery requires having the **right program delivered by the right people.** Quest has a dedicated team of clinicians and front line workers who feel they could do more with additional training, and with a full professional staff complement. Beyond the seven core competencies prescribed by DCS (which are regarded to be insufficient for the RRC environment), each service agency sets its own training standards and curriculum to achieve them. This results in ad hoc, one-off professional development for staff that is often expensive and difficult to maintain. At Quest, a significant focus of program participant engagement is recreational which, while valuable,

may not fully accelerate the path to a level of rehabilitation and readiness with life-skills to transition to more independent living.
6. Recommendation: Quest RRC should review best practice examples of staff training at other sites, including the Breton Abilities Centre, to build and maintain competencies.

7. Recommendation: DCS should consider updating and then standardizing core competencies for RRC staff, and support an agency to take the lead in designing and delivering training programs so that those competencies can be maintained.

8. Recommendation: *Quest should give priority to filling the psychologist and behavioural analyst positions as soon as possible.*

At present, a number of Unit A program participants have **Autism** or **Acquired Brain Injury**, with high levels of physical aggression. This poses additional rehabilitation and long-term residential challenges, particularly in a setting that is neither purpose-built nor staffed by personnel with special training to address these behaviour issues. The Paladin Security Report made some recommendations to address the limitations of facility design in this regard, but the need for specialized programming for these people, delivered by staff trained to provide it, remains. The need for this type of programming support is only going to grow given the rise in diagnoses of autism and the number of persons with acquired brain injury awaiting long term care support.
9. *Recommendation: DCS should consider supporting Quest in the development of a specialized residential care facility for program participants whose challenging behaviours make traditional small option or group homes unsafe for the clients and the community.*

Best practice in **performance and accountability** is based on clear expectations and deliverables. In the immediate term this requires three things:
10. Recommendation: Quest RRC should develop a strategic plan to chart it's course over the next 5-10 years, aligned with the Choices and Inclusion Implementation Plan underway by DCS.

11. Recommendation: DCS should enter into a formal Service Agreement with Quest RRC, detailing performance expectations and program outcomes. Appropriate roles and accountabilities for the Regional Office and Quest RRC in budget management must be practiced.

12. Recommendation: The Association of Adult Residential Centres and Regional Rehabilitation Centres of Nova Scotia 'Quality Evaluation for Providing Supports and Services to Persons with Disabilities' framework should be used as a foundational resource in establishing and monitoring program performance.

Appendix A

Review Scope and Methods

Mary Jane Hampton, President of Stylus Consulting Inc., was commissioned through a Request for Proposals to undertake a Current State Assessment of Quest Regional Rehabilitation Centre (Quest RRC). This assessment focused on the programming provided on the 1st floor, 70 Memory Lane site. Mary Jane brought to this assignment more than 25 years of experience in health and social service program governance, planning, management and evaluation. She was the principle consultant to the Nova Scotia Departments of Health and Wellness (DHW) and Community Services (DCS) in the development of policy options to harmonize services for persons with disabilities between the two provincial jurisdictions. In addition, Mary Jane was the consultant engaged by the Department of Community Services to help articulate its Transformation Map in modernizing the Services for Persons with Disabilities Program.

To complete the Current State Assessment, a review of documents was undertaken and key informant focus groups were facilitated. These information streams were further informed by literature regarding specific programming considerations to service the needs of the current and anticipated program participant population.

Documents reviewed included:

- NS Disability Support Program: Choice and Inclusion Implementation Plan
- Services for Persons with Disabilities Report of Residential Services (2008)
- Memorandum of Association of the Metro Residential Support for Adults Society
- Quest 30 Bed Proposal
- Quest RRC Annual Report 2012-2013
- Quest Governance Review and Change Management Report: George Savory and Stephen and Donna Doiron (Change Management Professionals)
- Paladin Security Review: Regional Rehabilitation Centre
- Paladin Security Review: Community Transition Program
- Deloitte Touche - Braemore Operational Review

Key Infomant Focus Groups included:

- Quest RRC Board members
- Program participants (identified by QRRC as individuals who would be comfortable participating in such a forum)
- Family members (identified by QRRC as individuals who would be comfortable participating in such a forum and who were within a reasonable distance to travel for the session)
- Front-line staff (an invitation was extended to all staff and the session planned to coincide with the end-of-shift to make it possible for greater participation)
- Clinical/management team (an invitation was extended to the clinical/management team and the session planned to coincide regular work hours to make it possible for greater participation)
- DCS regional staff (participants were identified by Head Office and an invitation to participate was extended by the consultant)

All focus group participants were informed by the consultant about the nature and scope of the Current State Assessment. Their involvement was voluntary and assurance was

given that no individuals would be identified, nor would any comments be attributed to their source. Feedback from all the focus groups was rolled up into themes. Participants were provided with draft summary findings to ensure that the consultant had captured fairly the points that were shared.

Current practice literature scan included:

- Primary Care of Adults with Developmental Disabilities: Canadian consensus guidelines
- Health Watch Table: Autism Spectrum Disorder (Surry Place Centre, Toronto)
- Acquired Brain Injury Model of Rehabilitation for South Australia
- Society for Cognitive Rehabilitation, Inc. Recommendations for Best Practice in Cognitive Rehabilitation Therapy: Acquired Brain Injury
- Evidence-Based Review of Moderate to Severe Acquired Brain Injury: Efficacy and Models of Care Following an Acquired Brain Injury
- Clinical Topics in the Psychiatry of Intellectual Development Disorders: Behaviour Problems (April 2013)
- National Disability Services: Measuring Outcomes for People With Disability (Australia)
- Quality Evaluation for Providing Supports and Services to Persons with Disabilities:Association of Adult Residential Centres and Regional Rehabilitation Centres of Nova Scotia
- Review of Community Living BC Efficacy and Progress to 2011: Queenswood Consulting Group
- Priorities for Persons with Developmental Disabilities and Their Families in 2006 A Three Part Series: Brian K.E. Hennen, M.D., M.A., C.C.F.P., F.C.F.P., F.R.C.G.P., Professor of Family Medicine, Dalhousie University & Professor Emeritus, University of Western Ontario
- Measuring Outcomes for People With Disability: National Disability Services (New South Wales, Australia) October 2012 (Dr. Ken Baker, Chief Executive)

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[i] L. Rees, A Review of Acquired Brain Injury Transitional Rehabilitation Programs in Nova Scotia, 2012, page 4.

[ii] Centres for Disease Control and Prevention, 2014

[iii] Residential Care review 2008 DCS