



Able to serve Community

National Disability Insurance Scheme (NDIS Practice Standards)

CERTIFICATION AUDIT STAGE 1 AUDIT REPORT

Audit Date: 23-24 May 2022

Version Number: 4.0

Trading as	Able to serve Community
Legal Name	OUJANI, SABER
NDIS ARN Number	4-FZ0GR5P
ABN	35 277 149 776
Head Office/Other Sites	Suit 1A L2/802-808 Pacific Highway, Gordon, NSW 2072
Name of Client/Key Personnel	Saber Oujani
Position of Key Personnel	Not Specified
Audit Type	<i>National Disability Insurance Scheme (NDIS Practice Standards)</i> Certification Audit – Stage 1
Scope of Audit	• Core Module • Core Module 4.3 (Removed) • Module 2
Registration Groups	• 0128 Therapeutic Supports • 0125 Participate Community • 0110 Specialist positive behaviour support • 0108 Assist-Travel/Transport • 0107 Assist-Personal Activities (Removed) • 0106 Assistance in coordinating or managing life stages, transitions and supports,
Number of Staff	1
Use of ICT during Audit	Zoom App
Effectiveness of ICT	Effective in achieving the audit objectives
JPS Activity Reference	6893516581
Audit Company	JPS Audit Specialists Pty Ltd
Lead Auditor details	Li Lih Lam
Audit Date	23-24 May 2022
Recommendation	Recommended to proceed to Certification Audit Stage 2
Audit Attendance: Name and Position	Li Lih, Lam – Lead Auditor Barbara Merrigan – Auditor Saber Oujani - Director

Statement of Confidentiality

JPS is responsible for all information provided, obtained or created during the performance of any verification or certification process. We treat all information provided to us securely and in confidence, whether it be from the client or from other sources. If there is information about a client which is to be made publicly available, we will advise the client prior to this happening except, as required by the appropriate accreditation authorities.

Executive Summary

The purpose of this Certification Audit, Stage 1 is to review:

- the Self-Assessment responses completed by the NDIS provider as part of the registration application, or registration renewal process, and associated documentation submitted by the NDIS provider, available through the NDIS provider's application record accessed through the NDIS Commission's system
- the prior NDIS Provider Certification outcome, corrective actions and audit report, if applicable
- any additional requirements raised by the Commission
- to collect sufficient, verifiable information to contribute to Stage Two of the NDIS Provider Certification process such as to confirm the audit scope, registration groups, staff and participant numbers, and any information included in the Initial Scope of Audit document.

This Stage 1 Audit is to determine that a NDIS provider is suitably prepared for their Stage Two Audit which should commence within three months of the completion of the Stage 1 Audit.

Where an instance of non-conformity has been found, or the audit team suspects an instance is likely to be found, they will be described in each section of this report.

A draft of the Audit Schedule for the Stage 2 Certification Audit will be prepared during this Stage 1 Audit. This will clearly identify Able to serve Community's Registration classes/groups that will be included in the audit, key personnel and number of participants, and will propose how key personnel and participants are best involved in the audit.

Organisation Overview

The Provider, Able to Serve Community, is managed by the Director who is the Support Worker and the Specialist Behaviour Support Practitioner. The Provider is currently operating at *Suit 1A L2/802-808 Pacific Highway, Gordon, NSW 2072*. At the moment, there 3 participants. Supports to the Participants will be provided from their respective homes as well as at public places deemed safe and fit for the purpose.

The scope of this Stage 1 Audit includes the Core Module and Module 2. The Registration Groups consist of the list defined in page 2 above. The provider clarified that Core Module 4.3 and Registration Group 0107 are not applicable and hence, will be removed. A **Variation Form** is raised. The Variation Form has also included a change in the address of the provider.

Nine (9) minor non-conformities have been highlighted. Since 6 of the minor non-conformities came from *Core Module Division 2: Governance and Operational Management* and 3 of the minor non-conformities came from *Core Module Division 3: Provision of Support*, this has led to **two (2) major non-conformities**. Details of the non-conformities are updated in the **Corrective Action Plan**. Several comments for improvement of the system are documented in the Audit report. It is recommended that the Provider takes the necessary actions to address them before they lead to any non-conformity in future.

Based on evidence obtained from documents verified during the audit and Self-Assessments documents, JPS Audit Specialists is recommending Able to Serve Community to proceed to Stage 1 Certification Audit.

The Audit team would like to thank Able to Serve Community for their assistance and cooperation during the audit.

Able to serve Community

- We have sent you a Corrective Action Plan which outlines minor non-conformities found during the audit. The necessary corrective actions should be implemented in line with the timeframe for correcting non-conformities, found in Appendix 1 of this report.
- The report contains Opportunities for Improvement that were identified during the audit. While you are not obliged to implement the improvement opportunities, we ask that you consider them as suggestions and evaluate them against your systems and processes.

Technical Review of Report Completed by:

Name of Technical Reviewer	DONNA FOLEY
Name of Company	JPS Audit Specialists
Date	

Audit Report Endorsed by Audit Team:

Name of Lead Auditor	Li Lih Lam
Name of Auditor	Barbara Merrigan
Name of Company	JPS Audit Specialists
Date	26/5/2022

Compliance Status

Standard	Name	Rating
Division 1: Rights and Responsibilities		2
6	Person-Centred Supports	2
7	Individual Values and Beliefs	2
8	Privacy And Dignity	2
9	Independence And Informed Choice	2
10	Violence, Abuse, Neglect, Exploitation and Discrimination	2
Division 2: Governance and Operational Management		0
11	Governance And Operational Management	1
12	Risk Management	2
13	Quality Management	1
14	Information Management	2
15	Feedback And Complaints Management	2
16	Incident Management	2
17	Human Resource Management	1
18	Continuity Of Supports	2
18.A	Emergency And Disaster Management	1
Division 3: Provision of Supports		0
19	Access to Supports	2
20	Support Planning	1
21	Service Arrangements with Participants	1
22	Responsive Support Provision	2
23	Translations transitions To or From the Provider t	1
Division 4: Support Provision Environment		2
24	Safe Environment	2
25	Participant Money and Property	2
26	Management Of Medication	N/A
26.A	Mealtime Management	N/A
27	Management Of Waste	N/A
Module 2: Specialist Behaviour Support		2
38	Behaviour Support in the NDIS	2
39	Restrictive Practices	2
40	Functional Behaviour Assessments and Behaviour Support Plans	2

41	Supporting The Implementation of The Behaviour Support Plan	2
42	Behaviour Support Plan Monitoring and Review	2
43	Reportable Incidents Involving the Use of Restrictive Practice	2
44	Interim Behaviour Support Plans	2

COMPLIANCE RATINGS CHART

Rating	Commentary
3 ☐ Conformity with elements of best practice	The NDIS provider can clearly demonstrate conformity with best practice against the criteria. Best practice is demonstrated through innovative, responsive service delivery, underpinned by the principles of continuous improvement of the systems, processes and associated with the outcomes.
2 ☐ Conformity	The NDIS provider can clearly demonstrate that the outcomes and indicators are met as proportionate to the size and scale of the provider – evidence may include practice evidence, training, records and visual evidence. This would mean there was negligible risk and certification can be recommended.
1 ☒ Minor Non-Conformity	A rating of 1 will require a corrective action plan which reduces the likelihood of any risks identified occurring or impacting participant safety before certification or verification can be recommended – one of two situations usually exists in relation to Minor Non- Conformity: • There is evidence of appropriate process (policy/procedure/guideline etc.), system or structure implementation, without the required supporting documentation. • A documented process (policy/procedure/guideline etc.), system or structure is evident, but the provider is unable to demonstrate implementation review or evaluation where this is required.
0 ☒ Major Non-Conformity	The NDIS provider is unable to demonstrate appropriate process systems or structures to meet the required outcome and indicators and/or the gaps in meeting the outcome present a high risk – Three Minor Non- Conformities within the same module may also constitute a Major Non-Conformity A rating of 0 will preclude a recommendation for verification.

Registration Groups Audited

Registration Group Number	Registration Group Name	Number of Participants	Number of Participants Interviews and Files Reviewed
0128	Therapeutic Supports	0	To be verified at Stage 2
0125	Participate Community	2	"
0110	Specialist positive behaviour support	1	"
0108	Assist-Travel/Transport	2	"
0107	Assist-Personal Activities	2	"
0106	Assistance in coordinating or managing life stages, transitions and supports,	2	"

Staff/Workers Screening Documents Verified – *To be verified at Stage 2*

Name and Position of Employee	Qualifications / Experience / NDIS Worker Orientation	100 Points ID and Right to Work in Australia documents	National Police Check. WWCC / WWVP, DWEL (Vic)

NDIS PRACTICE STANDARDS

CORE MODULE DIVISION 1 – RIGHTS AND RESPONSIBILITIES

6. Person-Centred Supports	Outcome: Each participant accesses supports that promote, uphold and respect their legal and human rights and is enabled to exercise informed choice and control. The provision of supports promotes, upholds and respects individual rights to freedom of expression, self- determination and decision-making.	Rating 2
Indicator 6.1	Each participant legal and human rights are understood and incorporated into everyday practice.	2
Indicator 6.2	Communication with each participant about the provision of supports is responsive to their needs and is provided in the language, mode of communication and terms that the participant is most likely to understand.	2
Indicator 6.3	Each participant is supported to engage with their support network and chosen community as directed by the participant.	2

Auditor Evidence and Comments:

The Able to Serve Community **Participant Rights and Responsibilities Policy and Procedure** and the **Service Delivery** – Able to serve Community states that the provider respects and fully commits to upholding the rights of all people and that participant rights and responsibilities will be discussed with them during intake and assessment.

The **Service Agreement** will be provided outlining the rights and responsibilities of both the participant and the worker regarding the provision of supports in response to their needs. Access to interpreters or advocates is provided where required. The participant's family /support representatives are engaged closely throughout all information sharing. Services are provided and delivered in a person-centred way to enable participant choice and control through the provision of clear, transparent, and well-documented service delivery options.

The **Service Agreement** includes information regarding how the provider will interact with the participant, including the right to be communicated with openly, and in an honest and timely manner, and be treated with dignity, courtesy and respect.

Supporting Documentation

- Abuse-Neglect and Exploitation Policy and Procedure
- Privacy and Confidentiality Policy and Procedure
- Diversity and Inclusion Policy and Procedure.

Opportunities for Improvement:

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Non-Conformity

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7. Individual Values and Beliefs	Outcome: Each participant accesses supports that respect their culture, diversity, values and beliefs.	Rating 2
Indicator 7.1	At the direction of the participant, the culture, diversity, values and beliefs of that participant are identified and sensitively responded to.	2
Indicator 7.2	Each participant's right to practice their culture, values and beliefs while accessing supports is supported.	2

Auditor Evidence and Comments:

The Able to Serve Community **Participant Rights and Responsibilities Policy and Procedure** states that Able to serve Community is committed to valuing the cultural ethnicity and diversity of its staff and participants. Able to serve Community strives to ensure that culture and ethnicity is no barrier to any area of service provision, and that Able to serve Community's relationships with participants and stakeholders surpass contemporary practice for service inclusion.

Services are responsive to the needs of culturally diverse participants, communities and staff. There is respect and cultural support for cultural, religious and linguistic diversity.

The **Service Delivery** – Able to serve Community includes the above information and state that Able to serve Community will comply with all relevant legislation and provide training to ensure participants are supported in their individual values and beliefs.

The Director has completed a Migration and Health Enhancing intercultural competence and diversity course in 2020.

The **Service Agreement** states the participant will be treated with dignity, respect and courtesy.

Support Documentation

- Participants Rights and Responsibility Policy
- Abuse-Neglect and Exploitation Policy and Procedure
- Privacy and Confidentiality Policy and Procedure
- Diversity and Inclusion Policy and Procedure.

Opportunities for Improvement:

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Non-Conformity

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8. Privacy and Dignity	Outcome: Each participant accesses supports that respect and protect their dignity and right to privacy.	Rating 2
Indicator 8.1	Consistent processes and practices are in place that respect and protect the personal privacy and dignity of each participant.	2
Indicator 8.2	Each participant is advised of confidentiality policies using the language, mode of communication and terms that the participant is most likely to understand.	2
Indicator 8.3	Each participant understands and agrees to what personal information will be collected and why, including recorded material in audio and/or visual format.	2

Auditor Evidence and Comments:

The Able to Serve Community **Participant Rights and Responsibilities Policy and Procedure** states that Able to Serve Community is committed to protecting privacy in accordance with the Privacy Act (1988), the Australian Privacy Principles.

The **Service Agreement** explained when Able to Serve Community will collect, use, hold and disclose participant information. This includes the gaining of consent and explains that the information may be used, amongst other purposes, to disclose information to doctors, other health professionals, to facilitate communication and provide the best possible care.

The **Privacy and Confidentiality Policy** includes the information on the Rights and Responsibilities and the policy further describes what is personal information; how and why it is collected, disclosure and use of personal information; access to personal information; recorded material in audio and/or visual format may be collected; security and relevant legislation and standards.

This includes the NDIS (Quality Indicators) Guidelines 2018 (Cth), Privacy Amendment (Notifiable Data Breaches) Act 2017 (Cth), NDIS (Provider Registration and Practice Standards) Rules 2019 (Cth) and Privacy Act 1988 (Cth).

Supporting Documentation.

- Participants Rights and Responsibility Policy
- Abuse-Neglect and Exploitation Policy and Procedure
- Privacy and Confidentiality Policy and Procedure
- Diversity and Inclusion Policy and Procedure.

Opportunities for Improvement:

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Non-Conformity

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9. Independence and Informed Choice	Outcome: Each participant is supported by the provider to make informed choices, exercise control and maximise their independence relating to the supports provided.	Rating 2
Indicator 9.1	Active decision-making and individual choice is supported for each participant including the timely provision of information using the language, mode of communication and terms that the participant is most likely to understand.	2
Indicator 9.2	Each participant's right to the dignity of risk in decision-making is supported. When needed, each participant is supported to make informed choices about the benefits and risks of the options under consideration.	2
Indicator 9.3	Each participant's autonomy is respected, including their right to intimacy and sexual expression.	2
Indicator 9.4	Each participant has sufficient time to consider and review their options and seek advice if required, at any stage of support provision, including assessment, planning, provision, review and exit.	2
Indicator 9.5	Each participant's right to access an advocate (including an independent advocate) of their choosing is supported, as is their right to have the advocate present.	2

Auditor Evidence and Comments:

The Able to serve Community **Participant Rights and Responsibilities Policy and Procedure** states that Able to serve Community is committed to protecting privacy in accordance with the Privacy Act (1988), and the Australian Privacy Principles.

The **Service Agreement** explained when Able to serve Community will collect, use, hold and disclose participant information. This includes the gaining of consent and explains that the information may be used, amongst other purposes, to disclose information to doctors, other health professionals, to facilitate communication and provide the best possible care.

The **Privacy and Confidentiality Policy** includes the information in the Rights and Responsibilities Policy and Procedure and goes into further detail on what is personal information; how and why it is collected; disclosure and use of personal information; access to personal information; recorded material in audio and/or visual format may be collected; security and relevant legislation and standards.

Supporting Documentation.

- Participants Rights and Responsibility Policy
- Abuse-Neglect and Exploitation Policy and Procedure
- Privacy and Confidentiality Policy and Procedure
- Diversity and Inclusion Policy and Procedure.
- Service Agreement

Opportunities for Improvement:

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Non-Conformity
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10. Violence, Abuse, Neglect, Exploitation and Discrimination	Outcome: Each participant accesses supports free from violence, abuse, neglect, exploitation or discrimination.	Rating 2
Indicator 10.1	Policies, procedures and practices are in place which actively prevent violence, abuse, neglect, exploitation or discrimination.	2
Indicator 10.2	Each participant is provided with information about the use of an advocate (including an independent advocate) and access to an advocate is facilitated where allegations of violence, abuse, neglect, exploitation or discrimination have been made.	2
Indicator 10.3	Allegations and incidents of violence, abuse, neglect, exploitation or discrimination, are acted upon, each participant affected is supported and assisted, records are made of any details and outcomes of reviews and investigations (where applicable) and action is taken to prevent similar incidents occurring again.	2

Auditor Evidence and Comments:

The **Abuse Neglect and Exploitation Policy and procedure** states that Able to serve Community is committed to responding to the needs of participants and stakeholders and delivers services that are individualized to protect their safety and ensure their wellbeing. Services are provided in an environment free of abuse and neglect and people with high support needs and/or communication difficulty are well supported to enable detection and prevention of abuse and neglect. Staff complete mandatory training that meets the relevant legislative, regulatory, and legal requirements necessary to provide NDIS services. Staff must follow the NDIS incident management procedure in the event of allegations and incidents of violence, abuse, neglect, exploitation or discrimination. Reporting concerns about children and young people at risk is also described in this policy.

The **Participant Rights Policy** includes a statement that the Provider is freedom from violence, abuse, neglect, exploitation or discrimination.

The **Employment Contract Template** includes a section around misconduct, inclusive of violence/assault.

The **Participant Induction Pack** includes a simplified summary of participant's rights and responsibilities, including their right to be protected from violence, abuse or discrimination.

The **Advocacy Policy and Procedure** states that participants are supported if they choose to self-advocate, change advocates, or withdraw their authority. It is advised that the review of Service Agreements and Support Plans are used an opportunity to review advocacy needs with participants. Able to serve Community is committed to an

ongoing dynamic individual support planning process that is flexible and responsive to the person and their choices.

The **Worker Code of Conduct** includes the requirements to take all reasonable steps to prevent and respond to all forms of violence against and exploitation, neglect and abuse of people with disability.

Supporting Documentation.

- Participant Rights Policy and Procedure
- Employee Contract Template
- Participant Handbook
- Advocacy Policy
- Worker Conduct

Opportunities for Improvement:

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Non-Conformity

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CORE MODULE DIVISION 2 – GOVERNANCE AND OPERATIONAL MANAGEMENT

11. Governance and Operational Management	Outcome: Each participant's support is overseen by robust governance and operational management systems relevant (proportionate) to the size, and scale of the provider and the scope and complexity of supports delivered.	Rating 1
Indicator 11.1	Opportunities are provided by the governing body for people with disability to contribute to the governance of the organisation and have input into the development of organisational policy and processes relevant to the provision of supports and the protection of participant rights.	2
Indicator 11.2	A defined structure is implemented by the governing body to meet a governing body's financial, legislative, regulatory and contractual responsibilities, and to monitor and respond to quality and safeguarding matters associated with delivering supports to participants.	1
Indicator 11.3	The skills and knowledge required for the governing body to govern effectively are identified, and relevant training is undertaken by members of the governing body to address any gaps.	To be verified at Stage 2
Indicator 11.4	The governing body ensures that strategic and business planning considers legislative requirements, organisational risks, other requirements related to operating under the NDIS (for example Agency requirements and guidance), participants' and workers' needs and the wider organisational environment.	To be verified at Stage 2
Indicator 11.5	The performance of management, including responses to individual issues, is monitored by the governing body to drive continuous improvement in management practices.	2
Indicator 11.6	The provider is managed by a suitably qualified and/or experienced persons with clearly defined responsibility, authority and accountability for the provision of supports	To be verified at Stage 2
Indicator 11.7	There is a documented system of delegated responsibility and authority to another suitable person in the absence of a usual position holder in place.	To be verified at Stage 2
Indicator 11.8	Perceived and actual conflicts of interest are proactively managed and documented, including through development and maintenance of organisational policies.	2
Auditor Evidence and Comments: Governance and Operational Management Standard / Policy is documented. Feedback, complaints and any form of inputs from participants/their carers/parents and staff will be responded to and will be used as inputs for continuous improvements to the policies and processes relevant to the provision of supports and the protection of participants' rights. Inputs will be channelled via the Complaint Report Form . The Complaints Register will be		

updated and maintained. According to the provider, feedback via the **Participant Survey Form** will be solicited on an on-going basis as well.

An **Organisation Chart** is sighted with the roles/positions identified as: Chief Executive, Administrative Support, Sales and Marketing Director, Operations Director and Finance Director. Position Descriptions are available for the Support Worker and Specialist Positive Behaviour Support Worker. However, the roles of the Support Worker and Specialist Positive Behaviour Support Worker are not in the Organisation Chart. Also, the Position Description of the Specialist Positive Behaviour Support Worker is incomplete. The professional qualification and experience as pre-requisites for the role has not been defined. **(See Non-conformity)**

Human Resources Policy and Procedure describe the necessary skills and knowledge as well as the mandatory checks that all staff and support workers would need to fulfill in order to operate/govern effectively. Training needs analysis will be carried out and the skills gaps will be identified during the performance appraisals. **Training Matrix** will be prepared. Competency documents of existing staff will be verified at Stage 2 Certification Audit.

A **Business Plan**, *not dated*, is sighted. The plan, besides providing an overview of the Company's services, it provides a description of the provider's financial, legislative, regulatory and contractual responsibilities, in delivering supports to participants. Implementation and monitoring of the plan will be verified at Stage 2 Certification Audit.

The provider explained that information from various sources of the operations will be used as inputs to monitor the performance of management. The information includes KPIs, outcome of the 6-monthly performance reviews, training and development, resource requirements, complaints, incidents, etc. Periodical meetings will be carried out using the information mentioned. Meeting Agenda is available. Inputs into the meetings will include Financial, Human Resources requirements, Risks Management, Quality/Continuous Improvements, Complaints and Feedback, Incidents & Information Management, new businesses and other operational issues. Evidence of management meetings to review the performance of the management will be verified at Stage 2 Certification Audit.

The qualifications and/or experienced as well as the responsibility, authority and accountability of the staff/ support workers for the provision of supports are defined in the Position Descriptions for all the roles / positions defined in the Organization Chart, as mentioned above.

Delegation of Responsibility and Authority Register will be maintained to identify the delegation to other suitably qualified worker in the absence of a usual position holder. This register will be verified at Stage 2 Certification Audit.

Conflict of Interest Policy and Procedure ensures any perceived or actual conflicts of interest are managed. The record to be maintained is the **Conflict-of-Interest Register**.

Opportunities for Improvement:

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Non-Conformity

An **Organisation Chart** is sighted with the roles/positions identified as: Chief Executive, Administrative Support, Sales and Marketing Director, Operations Director and Finance Director. These roles are not supported with the respective Position Descriptions.

Position Descriptions are available for the Support Worker and Specialist Positive Behaviour Support Worker. However, the roles of the Support Worker and Specialist Positive Behaviour Support Worker are not in the Organisation Chart.

Also, the Position Description of the Specialist Positive Behaviour Support Worker is incomplete. The professional qualification and experience as pre-requisites for the role has not been defined.

12. Risk Management	Outcome: Risks to participants, workers and the provider are identified and managed.	Rating 2
Indicator 12.1	Risks to the organisation, including risks to participants, financial and work health and safety risks, and risks associated with provision of supports are identified, analysed, prioritised and treated.	To be verified at Stage 2
Indicator 12.2	A documented risk management system that effectively manages identified risks is in place and is relevant and proportionate to the size and scale of the provider and the scope and complexity of supports provided.	2
Indicator 12.3	The risk management system covers each of the following: (a) incident management; (b) complaints management and resolution; (c) financial management; (d) governance and operational management; (e) human resource management; (f) information management; (g) work health and safety; (h) emergency and disaster management.	2
Indicator 12.4	Where relevant, the risk management system includes measures for the prevention and control of infection and outbreaks.	2
Indicator 12.5	Supports and services are provided in a way that is consistent with the risk management system.	2
Indicator 12.6	Appropriate insurance is in place, including professional indemnity, public liability and accident insurance.	2
Auditor Evidence and Comments:		

Risk Management Policy and Procedure, Infection Control Policy and Procedure, COVID-19 Business Plan and Work Health and Safety Policy and Procedure are documented to:

- identify risks to the Company, to the Participants, to the Workers and all risks associated with the provision of supports services. The process with steps to be taken for identification, evaluation, ranking and treatment of risks are clearly described.

A **Risk Register** will be maintained to show implementation of Risk Management. The various risk management aspects that will be managed include Compliance, Strategic, Participants, Human Resources, Special Events, Work Health and Safety, Fraud, Financial and Key personnel succession. Identification of risks and treatment/ mitigation plans as well as the review, monitoring and follow-up will be verified at Stage 2 Certification Audit.

A **COVID-19 Business Plan** and the **Infection Control Policy and Procedure** describe measures for the prevention and control of infection and outbreaks.

The **Risk Management Policy and Procedure** as well as all the associated policies and procedures will be adhered to ensure that the supports and services are provided in a way that consistently considers potential risks and that the identified risks will be managed. The other policies and procedures include **Governance and Operational Standard / Policy, Information Security, Infection Control, Human Resources, Work Health and Safety, Incident Management, Complaint Management, Emergency Management Procedure and Plan and Support Provision**.

Insurances sighted include:

- Certificate of currency – Civil Liability Professional Indemnity, Public & Products Liability (Policy No. 82MAL1978365; Expiry: 25/6/2023)
- Certificate of Currency – Combined Malpractice, Public & Products Liability (Policy No. LPS019843889; Expiry: 25/6/2022)
- Certificate of Currency – Workers Insurance (Policy No. 224797201; Expiry: 31/3/2023)

Opportunities for Improvement:

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Non-Conformity

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13. Quality Management	Outcome: Each participant benefits from a quality management system relevant and proportionate to the size and scale of the provider, which promotes continuous improvement of support delivery.	Rating 1
Indicator 13.1	A quality management system is maintained that is relevant and proportionate to the size and scale of the provider and the scope and complexity of the supports delivered. The system defines how to meet the	2

	requirements of legislation and these standards. The system is reviewed and updated as required to improve support delivery.	
Indicator 13.2	The provider's quality management system has a documented program of internal audits relevant (proportionate) to the size and scale of the provider and the scope and complexity of supports delivered.	1
Indicator 13.3	The provider's quality management system supports continuous improvement, using outcomes, risk related data, evidence-informed practice and feedback from participants and workers.	2

Auditor Evidence and Comments:

The Quality Management System of the provider consists of policies and procedures supported with the standard forms / templates and makes references to relevant statutory, legislative and regulatory requirements.

Quality Management Policy and Procedure provide description on the principles of Quality Management Framework such as leadership, customer-focused, feedback & complaints monitoring, effective collaborative partnerships, continuous improvements, decision making based on evidence-informed practice as well as the internal, external and peer reviews.

The mechanism in the Quality Management System documentation, such as the policies and procedures as well as the standard forms/templates, will be reviewed and improved as and when the need arises, according to the provider this is outsourced to an external party – *Centro Assist*. It may be beneficial to clarify the process on how the documentation may be reviewed, updated, additions and/or deletions so as to prevent inadvertent use of obsolete documents. **(See Opportunity for improvement)**

An **Internal Audit Schedule** and an **Internal Audit Report** templates are available. The schedule will be used to plan the audits over a year and the Internal Audit Report details the areas to be audit as well as the checklist of requirements to review. Noted that the **Internal Audit Report** is incomplete as not all the processes within the scope of the supports that will be provided (e.g. Emergency and Disaster Management and Module 2) have been included. **(See Non-conformity)**

The Quality Management System will be implemented and maintained for continuous improvement. Feedback from participants and support workers will be used as part of the inputs for improvements. An **Improvement Report Form** will be maintained.

Opportunities for Improvement:

Suggest clarification on the document control (ie. review, update, additions and/or deletions) process to prevent inadvertent use of obsolete documents.

Non-Conformity

The **Internal Audit Report** is incomplete as not all the processes within the scope of the supports that will be provided (eg. Emergency and Disaster Management and Module 2) have been included.

14. Information Management	Outcome: Management of each participant's information ensures that it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.	Rating 2
Indicator 14.1	Each participant's consent is obtained to collect, use and retain their information or to disclose their information (including assessments) to other parties, including details of the purpose of collection, use and disclosure. Each participant is informed in what circumstances the information could be disclosed, including that the information could be provided without their consent if required or authorised by law.	2
Indicator 14.2	Each participant is informed of how their information is stored and used, and when and how each participant can access or correct their information and withdraw or amend their prior consent.	2
Indicator 14.3	An information management system is maintained that is relevant and proportionate to the size and scale of the organisation and records each participant's information in an accurate and timely manner.	2
Indicator 14.4	Documents are stored with appropriate use, access, transfer, storage, security, retrieval, retention, destruction and disposal processes relevant and proportionate to the scope and complexity of supports delivered.	2

Auditor Evidence and Comments:

Information Security Policy and Procedure and the **Privacy and Confidentiality Policy and Procedure** provide details on the consent from the participants that will be required for the collection of their personal information, including reasons for collection, use, store, disclose and dispose will be done. A **Consent Form** and a **Participant Information Consent Form** are sighted. *(See Opportunity for improvement 1)*

Staff / workers will be required to sign the **Privacy and Confidentiality** as demonstrate compliance to the privacy and confidentiality of participants' information and the non-disclosure of Participants' information to unauthorized parties.

With reference to the **Privacy and Confidentiality Policy and Procedure, Participant Information Consent Form / Consent Form** and the **Information Security Policy and Procedure**, the participants will be informed of their right to withdraw their original consent and/or decide on changes to how the information may be used or who may access. According to the provider, the participants will also be informed that they are automatically enrolled in the NDIS audit with the opt-out option each time prior to the audit so that evidence of consent or non-consent will be obtained.

The documented policy and procedure **Information Security** describe the medium for the storage and controls for the access and use of participants information. Measures to be taken in the event of any privacy or data breach/incident is defined.

Information Security Policy and Procedure describe the information and records management system that the provider will implement, including the controls for access, disclose, archive, retention, dispose of data/records or information. The provider is reminded to define the retention period of the participants' information. *(See Opportunity for improvement 2)*

Opportunities for Improvement:

- 1) Suggest a review of the **Consent Form** and the **Participant Information Consent Form** to remove duplication.
- 2) The provider is reminded to define the retention period of the participants' information.

Non-Conformity

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15. Feedback and Complaints Management	Outcome: Each participant has knowledge of and access to the provider's complaints management and resolution system. Complaints and other feedback made by all parties are welcomed, acknowledged, respected and well-managed.	Rating 2
Indicator 15.1	A complaints management and resolution system is maintained that is relevant and proportionate to the scope and complexity of supports delivered and the size and scale of the organisation. The system follows principles of procedural fairness and natural justice and complies with the requirements under the National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018.	2
Indicator 15.2	Each participant is provided with information on how to give feedback or make a complaint, including avenues external to the provider, and their right to access advocates. There is a supportive environment for any person who provides feedback and/or makes complaints.	2
Indicator 15.3	Demonstrated continuous improvement in complaints and feedback management by regular review of complaint and feedback policies and procedures, seeking of participant views on the accessibility of the complaints management and resolution system, and incorporation of feedback throughout the provider's organisation.	2
Indicator 15.4	All workers are aware of, trained in, and comply with the required procedures in relation to complaints handling.	To be verified at Stage 2

Auditor Evidence and Comments:

Complaint Management Policy and Procedure is in place to ensure the requirements under the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* are adequately addressed. Details include the receiving of complaints, recording of complaints, acknowledging, resolution and communication of resolution to relevant parties.

Participants will be informed of their right to make complaints and/or provide feedback, including their right to get access to an advocate. Details to the participants on how make a complaint to the NDIS Commission will be

provided. Anonymous complaints will be supported. The **Complaint Report Form** and the **Complaints Register** will be maintained.

The information captured in the register will be reviewed to decide if there is any possibility for continuous improvement. Suggestions for continuous improvements will be updated in the **Improvement Report Form**.

All staff / support workers will be educated about the complaint policy and procedure, their responsibilities and how to support participants and carers with making complaints. Education will occur when staff / support workers commence working through the induction / orientation program and subsequently through periodic training.

Induction Checklist is sighted. Evidence of training on Complaints Handling will be verified at the Stage 2 Certification Audit.

Opportunities for Improvement:

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Non-Conformity

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16. Incident Management	Outcome: Each participant is safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, respond to, well-managed and learned from.	Rating 2
Indicator 16.1	An incident management system is maintained that is relevant and proportionate to the scope and complexity of supports delivered and the size and scale of the organisation. The system complies with the requirements under the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.	2
Indicator 16.2	Each participant is provided with information on incident management, including how incidents involving the participant have been managed.	2
Indicator 16.3	Demonstrated continuous improvement in incident management by regular review of incident management policies and procedures, review of the causes, handling and outcomes of incidents, seeking of participant and worker views, and incorporation of feedback throughout the provider's organisation.	2
Indicator 16.4	All workers are aware of, trained in, and comply with the required procedures in relation to incident management.	To be verified at Stage 2
Auditor Evidence and Comments: Incident Management Policy and Procedure complying with the requirements under the <i>National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018</i> is in place to so that:		

- the requirements / rules under the NDIS (Incident Management and Reportable Incidents) 2018 are addressed.
 - all accidents and incidents (including critical incidents) related to the provision of supports or services will be acknowledged, recorded, responded, investigated, resolved and reviewed. Root cause(s) will be identified and suitable corrective actions will be implemented.

- participants will be informed of Incident Management process during the initial assessment via the Participant Handbook. This will be verified at Stage 2 Certification Audit.

Steps to be taken with regards to reportable Incidents and the timelines involved for reporting to the NDIS Commission via the NDIS portal, as described in the **Incident Management Policy and Procedure**.

Records of incidents which will be recorded in the **Incident Report** and the **Incidents Register**. The information will be used in for continuous improvement. The **Improvements Report Form** will be used to keep track of the improvements identified and actions taken.

All staff/workers will be trained on procedures on incident management during the on-boarding / induction. A **Staff Induction Checklist** which is used for the induction is sighted. Evidence of induction will be verified at Stage 2 Certification Audit.

Opportunities for Improvement:

Non-Conformity

17. Human Resource Management	Outcome: Each participant's support needs are met by workers who are competent in relation to their role, hold relevant qualifications, and who have relevant expertise and experience to provide person-centred support.	Rating 1
Indicator 17.1	The skills and knowledge required of each position within a provider are identified and documented together with the responsibilities, scope and limitations of each position.	1
Indicator 17.2	Records of worker pre-employment checks, qualifications and experience are maintained.	To be verified at Stage 2
Indicator 17.3	An orientation and induction process is in place that is completed by workers including completion of the mandatory NDIS worker orientation program.	To be verified at Stage 2
Indicator 17.4	A system to identify, plan, facilitate, record and evaluate the effectiveness of training and education for workers is in place to ensure that workers meet the needs of each participant. The system identifies training that is mandatory and includes training in relation to staff obligations under the	1

	NDIS Practice Standards and other National Disability Insurance Scheme rules.	
Indicator 17.5	Timely supervision, support and resources are available to workers relevant to the scope and complexity of supports delivered.	2
Indicator 17.6	The performance of workers is managed, developed and documented, including through providing feedback and development opportunities.	2
Indicator 17.7	Workers with capabilities that are relevant to assisting in the response to an emergency or disaster (such as contingency planning or infection prevention or control) are identified.	2
Indicator 17.8	Plans are in place to identify, source and induct a workforce in the event that workforce disruptions occur in an emergency or disaster.	To be verified at Stage 2
Indicator 17.9	Infection prevention and control training, including refresher training, is undertaken by all workers involved in providing supports to participants.	To be verified at Stage 2
Indicator 17.10	For each worker the following details are recorded and kept up to date: (a) contact details (b) details of their secondary employment (if any)	2

Auditor Evidence and Comments:

Human Resources Policy and Procedure describe the steps and controls taken for the recruitment and selection of staff/workers as well as training identification, planning and facilitation, ensuring:

- skills and knowledge required, the responsibilities, scope and limitations are documented in the Position Descriptions. As mentioned in Indicator 11 above, not all roles are identified in the Organisation Chart and supported with the respective Position Descriptions. **(See Non-conformity)**
 - necessary pre-employment checks and screening will be done (i.e. 100 points ID, rights to work in Australia, police check and work with children check) in line with the NDIS Commission requirements. Evidence of staff / worker records will be verified at Stage 2 Certification Audit.
 - induction will be carried out for new recruits. The checklist of items to be covered is outlined in the **Staff Induction Checklist**. Evidence of implementation of the induction will be verified at Stage 2 Certification Audit.
 - essential as well as mandatory training will be identified and documented in the **Training Matrix**. The provider will ensure all support workers complete the training, as needed. Identification of mandatory training, refresher training and essential training for staff development will be verified at Stage 2 Certification Audit.
- The evaluation of the effectiveness of the training attended and subsequent / appropriate action(s) to be taken to address any gaps, has not been addressed in the documented policy and procedure. **(See Non-conformity)**
- all workers will be provided with supervision, support and resources needed to facilitate effective operation/ provision of services as described in the **Human Resources Policy and Procedure**.
 - performance reviews on an annual basis (or as and when deemed necessary) and management of workers' performance will be carried out to ensure that any ineffectiveness or weakness will be addressed accordingly, as

described in the **Human Resources Policy and Procedure**. A **Worker Performance Assessment Form** will be maintained.

An **Emergency Management Plan** template is sighted. It is mentioned that staff/workers will be trained so that they are capable to respond to an emergency or disaster. The provider clarified that in the event if any of the workers are not able / capable for the role, alternative arrangements will be made.

The provider explained that plans are in place with other support providers and/or agencies who will provide the necessary workforce as back-up in the event of any workforce disruptions which may occur in an emergency or disaster. This will be verified at Stage 2 Certification Audit.

The **Training Matrix** will be updated to show that training on infection prevention and control will be provided. Refresher training will also be planned and provided to all workers involved in providing supports to participants. This will be verified at Stage 2 Certification Audit.

Staff Records Policy outline the requirements for staff/workers records to be maintained such as details of their identification, proof of right to work, pre-employment checks, qualifications and experiences, training attended and details of continuing professional development. Information of the staff/workers will be recorded in the **Worker Information Form**. As for the information of secondary employment, if any, the provider mentioned that this will be updated in the software system – *Brevity*.

Opportunities for Improvement

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Non-Conformity

The evaluation of the effectiveness of the training attended and subsequent / appropriate action(s) to be taken to address any gaps, has not been addressed in the documented **Human Resources policy and procedure**.

18. Continuity of Supports	Outcome: Each participant has access to timely and appropriate support without interruption.	Rating 2
Indicator 18.1	Day-to-day operations are managed in an efficient and effective way to avoid disruption and ensure continuity of supports.	2
Indicator 18.2	In the event of worker absence or vacancy, a suitably qualified and/or experienced person performs the role.	2
Indicator 18.3	Supports are planned with each participant to meet their specific needs and preferences. These needs and preferences are documented and provided to workers prior to commencing work with each participant to ensure the participant's experience is consistent with their expressed preferences.	2

Indicator 18.4	Arrangements are in place to ensure support is provided to the participant without interruption throughout the period of their service agreement. These arrangements are relevant and proportionate to the scope and complexity of supports delivered by the provider.	2
Indicator 18.5	Alternative arrangements for the continuity of supports for each participant, where changes or interruptions are unavoidable, are: (a) explained and agreed with them; and (b) delivered in a way that is appropriate to their needs, preferences and goals.	2

Auditor Evidence and Comments:

Continuity of Supports Policy and Procedure address the need to ensure:

- that appropriate support is provided to the participants without interruption and in a timely manner. Where changes or interruptions are unavoidable, alternative arrangements are explained and agreed by the participant.
- define the manner in which support will be provided to the participants in the event of worker's absence or when there is a vacancy. All replacement support workers must be qualified / competent to undertake the role and at the same time, the participants' preferences, as recorded in the **Participant Intake Form** will be considered.
- needs and preferences of the participants are documented in the **Participant Intake Form** and the **Initial Assessment and Support Plan** with the **Schedule of Supports**. The latter will be made available to workers prior to commencing work.

Participants with complex needs will be identified and managed. Critical planning and contingency plans are described in the procedure to ensure continuity in supports to all participants. Where changes are unavoidable, participants will be informed of alternative arrangements, as documented in the Service Agreement.

In the event of any unavoidable changes or interruptions, the provider is aware that the participants will be informed, their agreement will be required and efforts will be made to ensure needs, preferences and goals of the participants will be taken into consideration.

Opportunities for Improvement:

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Non-Conformity

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18A Emergency and Disaster Management	Outcome: Emergency and disaster management includes planning that ensures that the risks to the health, safety and wellbeing of participants that may arise in an emergency or disaster are considered and mitigated,	Rating 1
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	and ensures the continuity of supports critical to the health, safety and wellbeing of participants in an emergency or disaster.	
Indicator 18A.1	Measures are in place to enable continuity of supports that are critical to the safety, health and wellbeing of each participant before, during and after an emergency or disaster.	2
Indicator 18A.2	The measures include planning for each of the following: (a) preparing for, and responding to, the emergency or disaster; (b) making changes to participant supports; (c) adapting, and rapidly responding, to changes to participant supports and to other interruptions; (d) communicating changes to participant supports to workers and to participants and their support networks.	2
Indicator 18A.3	The governing body develops emergency and disaster management plans (the plans), consults with participants and their support networks about the plans and puts the plans in place.	To be verified at Stage 2
Indicator 18A.4	The plans explain and guide how the governing body will respond to, and oversee the response to, an emergency or disaster.	2
Indicator 18A.5	Mechanisms are in place for the governing body to actively test the plans, and adjust them, in the context of a particular kind of emergency or disaster.	1
Indicator 18A.6	The plans have periodic review points to enable the governing body to respond to the changing nature of an emergency or disaster.	1
Indicator 18A.7	The governing body regularly reviews the plans, and consults with participants and their support networks about the reviews of the plans.	To be verified at Stage 2
Indicator 18A.8	The governing body communicates the plans to workers, participants and their support networks.	To be verified at Stage 2
Indicator 18A.9	Each worker is trained in the implementation of the plans.	To be verified at Stage 2

Auditor Evidence and Comments:

Emergency Management Policy and Plan, COVID-19 Safe Business Plan, Infection Control Policy and Procedure and Work Health and Safety Policy and Procedure:

- provide information of measures that will be taken to enable continuity of supports that are critical to the safety, health and wellbeing of each participant before, during and after an emergency or disaster.

Measures described for the preparation and respond to an emergency and disaster include emergency planning, management of emergencies, preparing and supporting the participants and support workers ensuring participants are prepared and understand protocols and receiving emergency information so that the response to the participant supports / interruptions may be adapted promptly.

- explain that if and when there are changes to the participants' supports, the latter will be carried out and changes will be communicated to the participant, their support network and the workers.

The relevant policies and procedures and/or **Emergency Management Plan and Policy** mentioned above address the following:

- the need to consult the participants and their support networks in the development of the emergency and disaster management plan.
- to provide a guide on how the provider will respond to oversee the response, to an emergency and disaster.
- mechanism that will be put in place to test the plans for effectiveness / suitability and adjust them to suit the nature of the emergency and/or disaster. **(See Non-conformity)**
- identify periodic review points in the plans to allow for changing nature of an emergency or disaster. **(See Non-conformity)**
- staff/ support workers will be trained in the implementation of the plans. This will be verified at Stage 2 Certification Audit.

The implementation of the above will be verified at Stage 2 Certification Audit.

Opportunities for Improvement:

Non-Conformity

With reference to the Emergency Management Plan and Policy, the following have not been addressed:

- mechanism that will be put in place to test the plans for effectiveness / suitability and adjust them to suit the nature of the emergency and/or disaster.
- identify periodic review points to enable response to the changing nature of an emergency or disaster.

CORE MODULE DIVISION 3 – PROVISION OF SUPPORTS

19. Access to Supports	Outcome: Each participant accesses the most appropriate supports that meet their needs, goals and preferences.	Rating 2
Indicator 19.1	The supports available, and any access / entry criteria (including any associated costs) are clearly defined and documented. This information is communicated to each participant using the language, mode of communication and terms that the participant is most likely to understand.	To be verified at Stage 2
Indicator 19.2	Reasonable adjustments to the support delivery environment are made and monitored to ensure it is fit for purpose and each participant's health, privacy, dignity, quality of life and independence is supported.	2
Indicator 19.3	Each participant is supported to understand under what circumstances supports can be withdrawn. Access to supports required by the participant	To be verified at Stage 2

	will not be withdrawn or denied solely on the basis of a dignity of risk choice that has been made by the participant.	
Auditor Evidence and Comments: Participants will be able to access the supports that meet their needs, goals and preferences. The exit and entry requirements are described in the Support Provision Policy and Procedure. The policy and procedure define the rights and responsibility of both participants and provider and the circumstances under which the participants are allowed to withdraw their supports. The supports available, the entry requirements and the associated costs will be communicated to the participants in simple, easy to understand language via the Participant Handbook. This will be confirmed / verified with the participants at the <u>Stage 2 Certification Audit</u>. Participants will receive services in safe and secured environment. This can be facilitated with implementation of measures such as risk management, incident management and quality management. Reasonable adjustments to the support delivery environment will be made and monitored to ensure it is fit for purpose and each participant's health, privacy, dignity, quality of life and independence is supported. The Home Risk Assessment Form will be used. Information pertaining criteria for entry to services, service refusal, cancellation, service withdrawal and service termination are defined in the policy and procedure, the Service Agreement and the Participant Handbook. This will be confirmed / verified with the participants at the <u>Stage 2 Certification Audit</u>. Opportunities for Improvement: Non-Conformity		

20. Support Planning	Outcome: Each participant is actively involved in the development of their support plans. Support plans reflect participant needs, requirements, preferences, strengths and goals, and are regularly reviewed.	Rating 1
Indicator 20.1	With each participant's consent, work is undertaken with the participant and their support network to enable effective assessment and to develop a support plan. Appropriate information and access is sought from a range of resources to ensure the participant's needs, support requirements, preferences, strengths and goals are included in the assessment and the support plan.	2
Indicator 20.2	In collaboration with each participant: (a) risk assessments are regularly undertaken, and documented in their support plans; and	2

	(b) appropriate strategies are planned and implemented to treat known risks to them.	
Indicator 20.2A	Risk assessments include the following: (a) consideration of the degree to which participants rely on the provider's services to meet their daily living needs; (b) the extent to which the health and safety of participants would be affected if those services were disrupted.	1
Indicator 20.3	Periodic reviews of the effectiveness of risk management strategies are undertaken with each participant to ensure risks are being adequately addressed, and changes are made when required.	2
Indicator 20.4	Each support plan is reviewed annually or earlier in collaboration with each participant, according to their changing needs or circumstances. Progress in meeting desired outcomes and goals is assessed at a frequency relevant and proportionate to risks, the participant's functionality and the participant's wishes.	2
Indicator 20.5	Where progress is different from expected outcomes and goals, work is done with the participant to change and update the support plan.	2
Indicator 20.6	Each participant's support plan is: (a) provided to them in the language, mode of communication and terms they are most likely to understand; and (b) readily accessible by them and by workers providing supports to them.	To be verified at Stage 2
Indicator 20.7	Each participant's support plan is communicated, where appropriate and with their consent, to their support network, other providers and relevant government agencies.	To be verified at Stage 2
Indicator 20.8	Each participant's support plan includes arrangements, where required, for proactive support for preventative health measures, including support to access recommended vaccinations, dental check-ups, comprehensive health assessments and allied health services.	To be verified at Stage 2
Indicator 20.9	Each participant's support plan: (a) anticipates and incorporates responses to individual, provider and community emergencies and disasters to ensure their safety, health and wellbeing; and (b) is understood by each worker supporting them.	2
Auditor Evidence and Comments: Participants, and with their consent, their support network are actively involved in the development of their own support plans. Support plans must reflect the participant's needs, requirements, preferences, strengths and goals and must be regularly reviewed. Participants will be at the centre of the decision-making process to enable them		

to participate in the community, to follow their goals and interests. The needs, requirements, preferences, strengths and goals of the participant are captured in the **Participant Intake Form** and the **Initial Assessment and Support Plan**.

The **Initial Assessment and Support Plan** template is evident. information about the participants such as the participant's personal details, contact details, emergency contact details, preferences (including communication and environment) and health information will be noted.

Risk assessment for risks that may occur during care / service provision are determined during the initial assessment and recorded in the **Participant Risk Assessment Form** and the **Initial Assessment and Support Plan**. Risks identified will be managed in line with the **Risk Management Policy and Procedure**. *(See Opportunity for improvement 1)*

The need to regularly review, at least once every 12 months or when deemed needed, the identified participants risks, the effectiveness of the risk management strategies as well as how changes, if any, to risk management strategies will be implemented. However, it is not clear as to when the reviews will take place and where the changes to risk management strategies (if any) will be recorded. *(See Opportunity for improvement 2)*

The need to ensure that the risk assessments take into consideration the degree to which participants rely of the provider's services to meet their daily needs and the extent to which their health and safety would be affected if services were disrupted have not been addressed. *(See Non-conformity)*

The **Initial Assessment and Support Plan** will be reviewed periodically, and changes will be made to the **Service Schedule** if progress differs from expected goals and outcomes. Progress notes will be updated in the software system – *Brevity*, throughout the provision of supports.

With the consent of the participant, information on the **Initial Assessment and Support Plan** may be communicated to family members, carers, other providers and relevant government agencies using **Consent Form**.

With reference to the **Initial Assessment and Support Plan**, suggest that the provider clarifies whether information for proactive support for preventative health measures, including support to access recommended vaccinations, dental check-ups, comprehensive health assessments and allied health services are applicable and if so, where would such information be recorded. *(See Opportunity for improvement 3)*

The **Initial Assessment and Support Plan** will make reference to the **Emergency Management Plan** to ensure the health, safety and well-being of the participant are considered.

Opportunities for Improvement:

- 1) Suggest a review of the **Participant Risk Assessment Form** and the **Initial Assessment and Support Plan** to remove duplication.
- 2) Clarification on when the reviews of risk management strategies and where the changes to risk management strategies (if any) will be recorded would be necessary.
- 3) With reference to the **Initial Assessment and Support Plan**, suggest that the provider clarifies whether information for proactive support for preventative health measures, including support to access recommended vaccinations, dental check-ups, comprehensive health assessments and allied health services are applicable and if so, where would such information be recorded.

Non-Conformity

The need to ensure that the risk assessments take into consideration the degree to which participants rely of the provider's services to meet their daily needs and the extent to which their health and safety would be affected if services were disrupted have not been addressed.

21. Service Agreements with Participants	Outcome: Each participant has a clear understanding of the supports they have chosen and how they will be provided.	Rating 1
Indicator 21.1	Collaboration occurs with each participant to develop a service agreement which establishes expectations, explains the supports to be delivered, and specifies any conditions attached to the delivery of supports, including why these conditions are attached.	2
Indicator 21.2	Each participant is supported to understand their service agreement and conditions using the language, mode of communication and terms that the participant is most likely to understand.	To be verified at Stage 2
Indicator 21.3	Where the service agreement is created in writing, each participant receives a copy of their agreement signed by the participant and the provider. Where this is not practicable, or the participant chooses not to have an agreement, a record is made of the circumstances under which the participant did not receive a copy of their agreement.	2
Indicator 21.4	Where the provider delivers supported independent living supports to participants in specialist disability accommodation dwellings, documented arrangements are in place with each participant and each specialist disability accommodation provider. At a minimum, the arrangements should outline the party or parties responsible and their roles (where applicable) for the following matters: (a) How a Participant's concerns about the dwelling will be communicated and addressed (b) How potential conflicts involving participant(s) will be managed	N/A

	(c) How changes to participant circumstances and/or support needs will be agreed and communicated (d) In shared living, how vacancies will be filled, including each participant's right to have their needs, preferences and situation taken into account. (e) How behaviours of concern which may put tenancies at risk will be managed, if this is a relevant issue for the participant	
Indicator 21.5	Service agreements set out the arrangements for providing supports to be put in place in the event of an emergency or disaster.	1

Auditor Evidence and Comments:

Service Agreement Management Policy and Procedure and **Support Provision Policy and Procedure** ensure that participants understand the supports they have chosen, how and when they will be provided. Developing service agreement and support plans will be done in collaboration with the participants so that their expectations and needs will be considered. A **Service Agreement** template is available which provides details such as:

- the kind of support will be provided to the participant, location and time of the service provision and how the services will be provided
- the support duration
- how the upcoming problems will be dealt
- responsibilities of the provider and the participant
- the notice required by both parties for changing and ending this agreement
- fee for supports provision.

Participants will be briefed about the Service Agreement using mode of communication, language and terms which the Participants understand. This will be verified at Stage 2 Certification Audit.

Participant will receive a signed copy of the service agreement and a copy of the signed agreement will be kept in the Participant's File. Where this is not practicable, or the participant chooses not to have an agreement, a record is made of the circumstances under which the participant did not receive a copy of their agreement. This is also defined in the **Service Agreement**.

The provider does not plan to deliver supported independent living supports to participants in specialist disability accommodation dwellings.

The **Service Agreement** template have no mention of the arrangements that will be in place for providing supports to the participant in the event of an emergency or disaster. **(See Non-conformity)**

Opportunities for Improvement:

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Non-Conformity

With reference to the **Service Agreement**, there is no description on the arrangements that will be in place for providing supports to the participant in the event of an emergency or disaster.

22. Responsive Support Provision	Outcome: Each participant accesses responsive, timely, competent and appropriate supports to meet their needs, desired outcomes and goals.	Rating 2
Indicator 22.1	Supports are provided based on the least intrusive options, in accordance with contemporary evidence-informed practices that meet participant needs and help achieve desired outcomes.	2
Indicator 22.2	For each participant (with their consent or direction and as agreed in their service agreement) links are developed and maintained by the provider through collaboration with other providers, including health care and allied health providers, to share their information, manage risks to them and meet their needs.	2
Indicator 22.3	Reasonable efforts are made to involve the participant in selecting their workers, including the preferred gender of workers providing personal care supports.	2
Indicator 22.4	Where a participant has specific needs which require monitoring and/or daily support, workers are appropriately trained and understand the participant's needs and preferences.	To be verified at Stage 2

Auditor Evidence and Comments:

Support Provision Policy and Procedure, Referral Policy and Procedure and Working with Support Network Policy and Procedure ensure that participants access responsive, timely, competent and appropriate supports to meet their needs, desired outcomes and goals which:

- are of the least intrusive options and in accordance with contemporary evidence-informed practices.
- are developed and maintained through collaboration with other providers to share information and meet participant needs, if needed and when agreed in the **Service Agreement**.
- efforts will be made with participants' involvement, in selecting workers, including the preferred gender of workers, when providing personal care supports as captured in the **Participant Intake Form**.

Consent will be needed from the participants for any sharing of information with other providers. This will be done via the use of the **Participant Information Consent Form / Consent Form** as described in **Privacy and Confidentiality Policy and Procedure** and **Information Security Policy and Procedure**.

Collaboration with other service providers (including health care and allied health providers) is described in the **Working with Support Network Policy and Procedure**.

Suitably trained workers will be in place to look after participants who have specific needs which require monitoring and/or daily support. The **Training Matrix** will be maintained. Evidence of training will be verified at Stage 2 Certification Audit.

Opportunities for Improvement:

Non-Conformity

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23. Transitions to or from a Provider	Outcome: Each participant experiences a planned and coordinated transition to or from the provider.	Rating 1
Indicator 23.1	A planned transition to or from the provider is facilitated in collaboration with each participant when possible, and this is documented, communicated and effectively managed.	2
Indicator 23.2	Risks associated with each transition to or from the provider are identified, documented and responded to, including risks associated with temporary transitions from the provider to respond to a risk to the participant, such as a health care risk requiring hospitalisation.	1
Indicator 23.3	Processes for transitioning to or from the provider (including temporary transitions referred to in subsection (2)) are developed, applied, reviewed and communicated.	2

Auditor Evidence and Comments:

Entry and Exit Policy and Procedure describe the transition planning activities in the event when any participant decides to exit or transfer their support to or from a provider. Transition planning will be done in close consultation with the participant and where appropriate with the family, carer or the support network.

A **Transition Plan** template is sighted. This form does not address the need to record and respond to the risk(s) that may be associated with the transition, including temporary ones that may include health care risk requiring hospitalisation. **(See Non-conformity)**

As for participants who transits from other Provider, they will be treated a new participant and all relevant policies and procedures (eg. initial assessment, service agreements, support planning, risk assessments, etc.) will be adhered to.

The process for transitioning to or from the provider is documented within the **Entry and Exit Policy and Procedure** and will be communicated to relevant staff/support workers and participants, including the consequences related to their decisions.

Opportunities for Improvement:

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Non-Conformity

The **Transition Plan** does not address the need to record and respond to the risk(s) that may be associated with the transition, including temporary ones that may include health care risk requiring hospitalisation.

CORE MODULE DIVISION 4: SUPPORT PROVISION ENVIRONMENT

24. Safe Environment	Outcome: Each participant accesses supports in a safe environment that is appropriate to their needs.	Rating 2
Indicator 24.1	Each participant can easily identify workers who provide supports to them.	2
Indicator 24.2	Work is undertaken with each participant, and others, in settings where supports are provided (including their home), to ensure a safe support delivery environment for them.	2
Indicator 24.3	Where relevant, work is undertaken with other providers (including health care and allied health providers and providers of other services) to identify and manage risks to participants and to correctly interpret their needs and preferences.	2
Indicator 24.4	For each participant requiring support with communication, clear arrangements are in place to assist workers who support them to understand their communication needs and the manner in which they express emerging health concerns.	2
Indicator 24.5	To avoid delays in treatments for participants: (a) protocols are in place for each participant about how to respond to medical emergencies for them; and (b) each worker providing support to them is trained to respond to such emergencies (including how to distinguish between urgent and non-urgent health situations).	2
Indicator 24.6	Systems for escalation are established for each participant in urgent health situations.	2
Indicator 24.7	Infection prevention and control standard precautions are implemented throughout all settings in which supports are provided to participants.	2
Indicator 24.8	Routine environmental cleaning is conducted of settings in which supports are provided to participants (other than in their homes), particularly of frequently touched surfaces.	2
Indicator 24.9	Each worker is trained, and has refresher training, in infection prevention and control standard precautions including hand hygiene practices, respiratory hygiene and cough etiquette.	2
Indicator 24.10	Each worker who provides supports directly to participants is trained, and has refresher training, in the use of PPE.	2
Indicator 24.11	PPE is available to each worker, and each participant, who requires it.	2
Auditor Evidence and Comments:		

Participants are introduced to the Behaviour Support Practitioner / Support Worker prior to commencing services. Behaviour Support Plans / Initial Assessment and Support Plan are developed with the consent and in collaboration with the participant or Advocate.

The **Infection Control policy and procedure** describes how to prevent cross infections and outlines how infections will be prevented such as the documentation of staff immunization, the provision of PPE to staff, which is cleaned and regularly maintained, and sterilization and handwashing audits. Staff are trained in managing the correct PPE for the situation and clinical rooms are maintained for safety.

The **Risk Management Policy** states that Able to serve Community conforms to legislative and due diligence obligations under the Work Health and Safety Act 2011 (WHS legislations).

The Director is responsible for the overall risk management leadership, strategy and for ensuring this policy is implemented.

Human Resources policy describes the importance of ongoing training for workers to ensure timely legislative responses, maintenance of industry competency levels and improved decision-making capacity. The policy states that Able to serve Community recognizes the special needs of vulnerable groups and develops planned approaches to ensure the needs of participants are met in relation to their safety, wellbeing, participation, dignity, and respect. Needs include safety, basic entitlements, physical care, emotional care, behavioural management, family, community, culture, personal and social development. Special entitlements of children and young people are further outlined in the Statement of Standards defined in the Child Protection ACT 1999 NSW.

In addition, Able to serve Community fosters collaborative working relations with peak bodies, departments, and agencies to ensure formal links are established and maintained to assist in working together to identify services required for participants based on their individual needs and cultural profiles.

Care planning is undertaken in an organized way to meet the needs, strengths and well-being of participants. Finally, there is identification of key risk factors relating to participants' specific cognitive and behavioural issues, with strategies developed to ensure their wellbeing and protection from harm. There is also the identification and management of the need for ongoing assistance through planning for transitioning and referral processes.

The **Participant Risk Assessment Tool** includes information such as the safety of the home environment and if risks have been identified. If risks are identified they are to be added to the **Risk Register /Matrix** and **Participant Risk Management Plan** outlined on the same document. This captures information about existing measures in place, recommended additional measures, and review dates.

The **WHS Policy** includes acknowledgement that staff have acknowledged their responsibilities providing a safe work environment. Workers will participate in safety training, report health and safety hazards, report all injuries and safety hazards and use safety equipment and PPE as instructed. Management will eliminate or minimize all workplace hazards as far as reasonably practicable and provide information, PPE equipment, instruction, and training to enable all workers can work safely. Workers will be consulted with on matters relating to health, safety and wellbeing.

The **COVID-19 Safety Plan** (includes implementation of cleaning and hygiene) and the COVID-19 Risk Register manage the mitigation of risk and the actions to follow in the case of an outbreak.

Supporting Documentation.

- Work Health and Safety policy and procedure.
- Participant Risk Assessment Tool
- Risk Management Policy and Procedure.

Opportunities for Improvement:

Suggestion:

Populate Training and Risk Registers

Non-Conformity

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25. Participant Money and Property	Outcome: Participant money and property is secure and each participant uses their own money and property as they determine.	Rating NA
Indicator 25.1	Where the provider has access to a participant's money or other property, processes to ensure that it is managed, protected and accounted for are developed, applied, reviewed and communicated. Participants' money or other property is only used with the consent of the participant and for the purposes intended by the participant.	NA
Indicator 25.2	If required, each participant is supported to access and spend their own money as the participant determines.	NA
Indicator 25.3	Participants are not given financial advice or information other than that which would reasonably be required under the participant's plan.	NA
Auditor Evidence and Comments: The Provider will not be managing participants' funds Opportunities for Improvement: - Non-Conformity -		
26. Management of Medication	Outcome: Each participant requiring medication is confident their provider administers, stores and monitors the effects of their medication and works to prevent errors or incidents.	Rating N/A
Indicator 26.1	Records clearly identify the medication and dosage required by each participant, including all information required to correctly identify the participant and to safely administer the medication.	N/A
Indicator 26.2	All workers responsible for administering medication understand the effects and side-effects of the medication and the steps to take in the event of an incident involving medication.	N/A
Indicator 26.3	All medications are stored safely and securely, can be easily identified and differentiated, and are only accessed by appropriately trained workers.	N/A
Auditor Evidence and Comments: Not in Scope		

Opportunities for Improvement:

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Non-Conformity

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26A. Mealtime Management	Outcome: Each participant requiring mealtime management receives meals that are nutritious, and of a texture that is appropriate to their individual needs, and appropriately planned, and prepared in an environment and manner that meets their individual needs and preferences and delivered in a way that is appropriate to their individual needs and ensures that the meals are enjoyable.	Rating N/A
Indicator 26A.1	Providers identify each participant requiring mealtime management.	N/A
Indicator 26A.2	Each participant requiring mealtime management has their individual mealtime management needs assessed by appropriately qualified health practitioners, including by practitioners: (a) undertaking comprehensive assessments of their nutrition and swallowing; and (b) assessing their seating and positioning requirements for eating and drinking; and (c) providing mealtime management plans which outline their mealtime management needs, including for swallowing, eating and drinking; and (d) reviewing assessments and plans annually or in accordance with the professional advice of the participant's practitioner, or more frequently if needs change or difficulty is observed.	N/A
Indicator 26A.3	With their consent, each participant requiring mealtime management is involved in the assessment and development of their mealtime management plans.	N/A
Indicator 26A.4	Each worker responsible for providing mealtime management to participants understands the mealtime management needs of those participants and the steps to take if safety incidents occur during meals, such as coughing or choking on food or fluids.	N/A
Indicator 26A.5	Each worker responsible for providing mealtime management to participants is trained in preparing and providing safe meals with participants that would reasonably be expected to be enjoyable and	N/A

	proactively managing emerging and chronic health risks related to mealtime difficulties, including how to seek help to manage such risks.	
Indicator 26A.6	Mealtime management plans for participants are available where mealtime management is provided to them and are easily accessible to workers providing mealtime management to them.	N/A
Indicator 26A.7	Effective planning is in place to develop menus with each participant requiring mealtime management to support them to: (a) be provided with nutritious meals that would reasonably be expected to be enjoyable, reflecting their preferences, their informed choice and any recommendations by an appropriately qualified health practitioner that are reflected in their mealtime management plan; and (b) if they have chronic health risks (such as swallowing difficulties, diabetes, anaphylaxis, food allergies, obesity or being underweight)—proactively manage those risks.	N/A
Indicator 26A.8	Procedures are in place for workers to prepare and provide texture modified foods and fluids in accordance with mealtime management plans for participants and to check that meals for participants are of the correct texture, as identified in the plans.	N/A
Indicator 26A.9	Meals that may be provided to participants requiring mealtime management are stored safely and in accordance with health standards, can be easily identified as meals to be provided to particular participants and can be differentiated from meals not to be provided to particular participants.	N/A
Auditor Evidence and Comments: Not in Scope Opportunities for Improvement: - Non-Conformity -		

MODULE 2: SPECIALIST BEHAVIOUR SUPPORT

38. Behaviour Support in the NDIS	Outcome: Each participant accesses behaviour support that is appropriate to their needs which incorporates evidence-informed practice and complies with relevant legislation and policy frameworks.	Rating 2
Indicator 38.1	The National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 are understood and applied.	2
Indicator 38.2	All NDIS behaviour support practitioners have been assessed as suitable to deliver specialised positive behaviour support, including assessments and development of behaviour support plans.	2
Indicator 38.3	Each NDIS behaviour support practitioner undertakes ongoing professional development to remain current with evidence-informed practice and approaches to behaviour support, including positive behaviour support.	2
Indicator 38.4	A specialist behaviour support clinical supervisor provides clinical supervision of each work practice of the NDIS behaviour support practitioner.	2
Indicator 38.5	Demonstrated commitment to reducing and eliminating restrictive practices through policies, procedures and practices.	2

Auditor Evidence and Comments:

The **Restrictive Practices Policy and Procedure** states that the provider understands and will apply the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 in practices. The policy further describes a comprehensive assessment of the state authorization process through the NSW Government, Department of Family and Community Services Restrictive practices authorisation system

The **Restrictive Practices Policy and Procedure** confirms that Able to serve Community ensures that all NDIS Behaviour Support Practitioner developing Behaviour Support Plans (BSPs) will have been assessed as suitable to deliver specialised positive behaviour support, including assessments and development of BSPs. The Director has been provisionally approved by NDIS as a Behaviour Support Practitioner. NDIS Practitioner Identification Number is: A6688.

Able to serve Community will make sure that the NDIS behaviour support practitioner will undergo ongoing professional development to remain current with evidence-informed practice and approaches to behaviour support, including positive behaviour support. Evidenced in current documentation – ongoing professional development it is a mandatory requirement that practitioners undertake continuing professional development and this is also a requirement of individual practitioners.

Able to serve Community will ensure that a specialist behaviour support clinical supervisor will provide clinical supervision of all practices performed by NDIS behaviour support practitioner. Agreement in place for ongoing supervision.

ATSC **Restrictive Practices Policy and Procedure** demonstrates their commitment to reducing and eliminating restrictive practices through policies, procedures and practices.

In discussions with the Provider /Director was able to demonstrate knowledge regarding the authorisation process for Restrictive Practice in a Behaviour Support Plan, in addition the provider is a member Development Educators

Society and references cited by two physicians that have worked with and supervised the Behaviour Support Practitioners work..

Supporting Documents:

- Restrictive Practices Policy and Procedure
- Copies of Qualifications of the BSP.

Opportunities for Improvement:

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Non-Conformity

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39. Restrictive Practices	Outcome: Each participant is only subject to a regulated restrictive practice that meets any state and territory authorisation (however described) requirements and the relevant requirements and safeguards outlined in Commonwealth legislation and policy.	Rating 2
Indicator 39.1	Knowledge and understanding of regulated restrictive practices as described in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 and knowledge and understanding of any relevant state or territory legislation and/or policy requirements and processes for obtaining authorisation (however described) for the use of any restrictive practices included in a behaviour support plan.	2
Indicator 39.2	Each Behaviour Support Practitioner undertakes professional development to maintain an understanding of practices considered restrictive and the risks associated with those practices.	2
Indicator 39.3	Each participant and, with the participant's consent, their support network, providers implementing behaviour support plans, and other relevant stakeholders are engaged in discussions about the need for restrictive practices and they understand the risks associated with their use. Alternatives to the use of restrictive practices are promoted as part of these discussions.	2
Indicator 39.4	Each participant and, with the participant's consent, their support network, their providers implementing behaviour support plans and other relevant stakeholders are engaged in the development of behaviour support strategies that are proportionate to the risk of harm to the participant or others.	2
Indicator 39.5	Restrictive practices are only included in a participant's behaviour support plan in accordance with relevant Commonwealth legislation and/or policy	2

	requirements and relevant state or territory legislation and/or policy requirements for obtaining authorisation (however described) for the use of any restrictive practices.	
Indicator 39.6	Regulated restrictive practices in behaviour support plans comply with the conditions prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.	2
Indicator 39.7	Each participant's behaviour support plan or interim behaviour support plan includes strategies that will lead to the reduction and elimination of any restrictive practices included in the plan.	2
Indicator 39.8	Support is provided to other providers implementing a behaviour support plan, in delivering services, implementing strategies in the plan and evaluating the effectiveness of current approaches aimed at reducing and eliminating restrictive practices.	2

Auditor Evidence and Comments:

The **Restrictive Practices Policy and Procedure** confirms that Able to serve Community demonstrates knowledge and understanding of regulated restrictive practices as described in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 and knowledge and understanding of the relevant state NSW(Legislation)and/or policy requirements and processes for obtaining authorisation (however described) for the use of any restrictive practices included in a Behaviour Support Plan. In discussions with the Director – knowledge regarding Restrictive Practices and authorisation processes was acknowledged.

Able to serve Community will ensure that the Behaviour Support Practitioner undertakes professional development to maintain an understanding of practices considered restrictive and the risks associated with those practices according to the Restrictive Practices Policy and Procedure.

The **Restrictive Practices Policy and Procedure** states that each participant and, with the participant's consent, their support network, providers implementing BSPs, and other relevant stakeholders are engaged in discussions about the need for restrictive practices and they understand the risks associated with their use. Alternatives to the use of restrictive practices are promoted as part of these discussions.

The **Restrictive Practices Policy and Procedure** further describes that each participant and, with their consent, their support network, their providers implementing Behaviour Support Plans and other relevant stakeholders are engaged in the development of behaviour support strategies that are proportionate to the risk of harm to the participant or others.

Able to serve Community's policy describes those restrictive practices are only included in a participant's BSP in accordance with relevant Commonwealth legislation and/or policy requirements and relevant state NSW(Legislation)and/or policy requirements for obtaining authorisation (however described) for the use of any restrictive practices.

Regulated restrictive practices in behaviour support plans comply with the conditions prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, according to the Restrictive Practices Policy and Procedure.

The **Restrictive Practices Policy and Procedure** describes that each participant's BSP or interim BSP will include strategies that will lead to the reduction and elimination of any restrictive practices included in the plan.

Able to serve Community ensures that support is provided to other providers implementing a BSP, in delivering services, implementing strategies in the plan and evaluating the effectiveness of current approaches aimed at reducing and eliminating restrictive practices, according to the Restrictive Practices Policy and Procedure.

Supporting Documents:

- Restrictive Practices Policy and Procedure.
- Copies of Qualifications
- Functional Assessment
- Interim and Comprehensive Plans
- Incident report Procedure
- NDIS Monthly RP reporting form

Opportunities for Improvement:

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Non-Conformity

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40. Functional Behaviour Assessments and Behaviour Support Plans	Outcome: Each participant's quality of life is maintained and improved by tailored, evidence-informed behaviour support plans that are responsive to their needs.	Rating 2
Indicator 40.1	Work is undertaken with each participant and their support network to undertake a behaviour support assessment that identifies unmet participant needs, the function and/or purpose of behaviours, and identify strategies to address behaviours of concern.	2
Indicator 40.2	Behaviour support plans take into account all appropriate sources of information such as the behaviour support assessment, and with the consent of the participant, the participant's support network, the providers implementing behaviour support plans, and assessments carried out by other collaborating providers and mainstream service providers.	2
Indicator 40.3	Behaviour support plans are consistent with evidence-informed practice, including proactive strategies.	2
Indicator 40.4	The interface between a reasonable and necessary supports under a participant's plan and any other supports or services under a general system of service delivery that the participant receives, are considered, and strategies and protocols are developed to integrate supports/services as practicable.	2

Indicator 40.5	Behaviour support plans are developed in consultation with the providers implementing behaviour support plans, and the behaviour support plan is given to those providers for their consideration and acceptance.	2
Indicator 40.6	All behaviour support plans containing a regulated restrictive practice are provided to the Commissioner in the time and manner prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.	2

Auditor Evidence and Comments:

The **Restrictive Practices Policy and Procedure** states that Able to serve Community ensures that work is undertaken with each participant and their support network to undertake a behaviour support assessment that identifies unmet participant needs, the function and/or purpose of behaviours, and identify strategies to address behaviours of concern.

The **Restrictive Practices Policy and Procedure** states that Able to serve Community makes sure that the Behaviour Support Practitioner will take into account all appropriate sources of information such as the functional behaviour assessment, and with the consent of the participant, the participant's support network, the providers implementing BSPs, and assessments carried out by other collaborating providers and mainstream service providers. .

Behaviour support plans are consistent with evidence-informed practice, including proactive strategies. The interface between a reasonable and necessary supports under a participant's plan and any other supports or services under a general system of service delivery that the participant receives, are considered, and strategies and protocols are developed to integrate supports/services as practicable, as per the Restrictive Practices Policy and Procedure.

Able to serve Community ensures that **Behaviour Support Plans** are developed in consultation with the providers implementing the Behaviour Support Plan, and the Behaviour Support Plan is given to those providers for their consideration and acceptance, according to the Restrictive Practices Policy and Procedure.

The **Restrictive Practices Policy and Procedure** describes that Able to serve Community will ensures that all BSPs containing a regulated restrictive practice are provided to the Commissioner in the time and manner prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. To review further at Stage 2 Audit.

Supporting Documentation

- Restrictive Practices Policy and Procedure
- Copies of Qualifications
- Interim and Comprehensive Plans
- Incident report Procedure
- NDIS Monthly RP reporting form

Opportunities for Improvement:

-

Non-Conformity

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41. Supporting the Implementation of the Behaviour Support Plan	Outcome: Each participant's behaviour support plan is implemented effectively to meet the participant's behaviour support needs.	Rating 2
Indicator 41.1	Assistance is given to ensure that the providers implementing behaviour support plans understand the relevant state or territory legislative and/or policy requirements for obtaining authorisation (however described) for the use of a restrictive practice included in a behaviour support plan, including any conditions around the use of restrictive practices.	2
Indicator 41.2	Reasonable measures are taken to ensure the participant, and with the participant's consent, the participant's support network, and the providers implementing behaviour support plans, understand the rationale underpinning the behaviour support plan. Instructions and guidance are developed to support the participant, the providers implementing behaviour support plans and the participant's support network to effectively implement the behaviour support plan.	2
Indicator 41.3	Providers implementing behaviour support plans are made aware of the reporting requirements prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.	2
Indicator 41.4	Person-focused training, coaching and mentoring is facilitated or delivered to each of the providers implementing behaviour support plans, and, with each participant's consent, their support network (where applicable). It covers the strategies required to implement a participant's behaviour support plan, including positive behaviour support strategies.	2
Indicator 41.5	Development of behaviour support plans for each participant, in collaboration with the providers implementing the behaviour support plan.	2
Indicator 41.6	Where the specialist behaviour support provider recommends that workers implementing a behaviour support plan receive training on the safe use of a restrictive practice included in a plan, oversight is retained to ensure the training addresses the strategies contained within each participant's behaviour support plan.	2
Indicator 41.7	Ongoing support and advice is offered to providers implementing behaviour support plans, and, with the participant's consent, their support network (where applicable), to address barriers to implementation.	2

Auditor Evidence and Comments:

The **Restrictive Practices Policy and Procedure** states that Able to Serve Community will ensure that assistance is given to ensure that those implementing Behaviour Support Plans and understand the relevant state or territory legislative and/or policy requirements for obtaining authorisation (however described) for the use of a restrictive practice included in a BSP, including any conditions around the use of restrictive practices.

Reasonable measures will be taken by Able to Serve Community to ensure the participant, and with the participant's consent, the participant's support network, and the providers implementing BSPs, understand the rationale underpinning the BSP. Instructions and guidance are developed to support the participant, the providers implementing behaviour support plans and the participant's support network to effectively implement the BSP, as per the Restrictive Practices Policy and Procedure.

Those who implement BSPs are made aware of the reporting requirements prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, according to the Restrictive Practices Policy and Procedure.

The **Restrictive Practices Policy and Procedure** states that person-focused training, coaching and mentoring is facilitated or delivered to each of the providers implementing BSPs, and, with each participant's consent, their support network (where applicable). The policy further describes that it covers the strategies required to implement a participant's BSP, including positive behaviour support strategies.

Able to Serve Community will develop BSPs for each participant, in collaboration with the those who implement the BSP, according to the Restrictive Practices Policy and Procedure.

The **Restrictive Practices Policy and Procedure** recommends that workers implementing a BSP will receive training on the safe use of a restrictive practice included in a plan, supervision is retained to ensure the training addresses the strategies contained within each participant's BSP.

The **Restrictive Practices Policy and Procedure** states that on-going support and advice is offered to those implementing Behaviour Support Plans and, with the participant's consent, their support network (where applicable), to address barriers to implementation.

Supporting Documentation

- Restrictive Practices Policy and Procedure
- NDIS Documentation credentialing BSP
- Functional Assessment
- Interim and Comprehensive Plans
- Incident report Procedure

Opportunities for Improvement:

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Non-Conformity

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42. Behaviour Support Plan Monitoring and Review	Outcome: Each participant has a current behaviour support plan that reflects their needs, improves their quality of life and supports their progress towards positive change. The plan progresses towards the reduction and elimination of restrictive practices, where these are in place for the participant.	Rating 2
Indicator 42.1	The progress and effectiveness of implemented strategies are evaluated through regular engagement with the participant, and by reviewing, recording and monitoring data collected by providers implementing behaviour support plans.	2
Indicator 42.2	Modifications to the strategies contained in each participant's behaviour support plan are made based on engagement with the participant and the results of the information and data analysis, and with the participant's consent, these changes are communicated and training is provided (where required) to their support network on the modified strategies.	2
Indicator 42.3	Opportunities to reduce the use of restrictive practices based on documented positive change are pursued.	2
Indicator 42.4	The Commissioner is notified, and work is undertaken with the Commissioner to address such situations: (a) where effective engagement with providers implementing behaviour support plans is not possible for any reason; or (b) if the supports and services are not being implemented in accordance with the behaviour support plan.	2
Indicator 42.5	Each participant's behaviour support plan is reviewed at least every twelve months. Consideration is given to whether the participant's needs, situation or progress create a need for more frequent reviews, including if the participant's behaviour changes, or if a new provider is required to implement the plan.	2
Indicator 42.6	The Commissioner is notified of changes in each participant's behaviour support plan in the manner and timeframe prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.	2
Auditor Evidence and Comments: The Restrictive Practices Policy and Procedure describes that the progress and effectiveness of implemented strategies are evaluated through regular engagement with the participant, and by reviewing, recording, and monitoring data collected by providers implementing BSPs. The Restrictive Practices Policy and Procedure describes how those changes to the strategies contained in each participant's BSP are made based on engagement with the participant and the results of the information and data analysis, and with the participant's consent, these changes are communicated and training is provided (where required) to their support network on the modified strategies.		

The **Restrictive Practices Policy and Procedure** includes a statement that opportunities to reduce the use of restrictive practices based on documented positive change will be pursued by Able to Serve Community including:

The Commissioner is notified, and work is undertaken with the Commissioner to address such situations:

- (a) where effective engagement with providers implementing BSPs is not possible for any reason; or
- (b) if the supports and services are not being implemented in accordance with the BSP.

Able to Serve Community will ensure that each participant's BSP is reviewed at least every twelve months. Consideration is given to whether the participant's needs, situation or progress create a need for more frequent reviews, including if the participant's behaviour changes, or if a new provider is required to implement the plan.

Restrictive Practices Policy and Procedure demonstrates that Able to Serve Community will notify the Commissioner of changes in each participant's BSP in the manner and timeframe prescribed in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. This will be assessed further during *Stage 2 Audit*.

At this time the Provider has no participants with a Behaviour Support Plans with a Restrictive practice.

Supporting Documents:

- Restrictive Practices Policy and Procedure
- Best Practice Example RPA Submission Form
- Copies of Qualifications
- Functional Assessment
- Interim and Comprehensive Plans
- Incident report Procedure

Opportunities for Improvement:

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Non-Conformity

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43. Reportable Incidents involving the Use of a Restrictive Practice	Outcome: Each participant that is subject to an emergency or unauthorised use of a restrictive practice has the use of that practice reported and reviewed.	Rating 2
Indicator 43.1	Support is given to the providers implementing each participant's behaviour support plan in responding to a reportable incident involving the use of restrictive practices.	2
Indicator 43.2	Each participant, and with the participant's consent, their support network, the providers implementing behaviour support plans and other stakeholders are included in the review of incidents.	2 To be further evaluated at Stage 2.

Auditor Evidence and Comments:

The **Restrictive Practices Policy and Procedure** states that support will be given to those implementing each participant's Behaviour Support Plan in responding to a reportable incident involving the use of restrictive practices.

Each participant, and with the participant's consent, their support network, the providers implementing BSPs and other stakeholders are included in the review of incidents, according to the **Restrictive Practices Policy and Procedure**.

Supporting Documents:

- Restrictive Practices Policy and Procedure
- Best Practice Example RPA Submission Form
- Copies of Qualifications
- Functional Assessment
- Interim and Comprehensive Plans
- Incident report Procedure

Opportunities for Improvement:

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Non-Conformity

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44. Interim Behaviour Support Plans	Outcome: Each participant with an immediate need for a behaviour support plan receives an interim behaviour support plan which minimises the risk to the participant and others.	Rating 2
Indicator 44.1	When a participant develops an immediate need for behaviour support, the participant and the providers implementing behaviour support plans are involved in evaluating the risks posed to the participant and others by the participant's behaviour, and an interim behaviour support plan is developed that appropriately manages that risk.	2 To be further assessed at Stage 2
Indicator 44.2	Advice and guidance is given to the providers implementing behaviour support plans and, with the participant's consent, their support network on the effective implementation of the interim behaviour support plan.	2 To be further assessed at Stage 2

Auditor Evidence and Comments:

The **Restrictive Practice Policy and Procedure** states that when a participant develops an immediate need for behaviour support, the participant and the providers implementing **Behaviour Support Plans** are involved in evaluating the risks posed to the participant and others by the participant's behaviour, and an interim Behaviour Support Plan is developed that appropriately manages that risk.

The **Restrictive Practices Policy and Procedure** describes that advice and guidance is given to those implementing Behaviour Support Plans and, with the participant’s consent, their support network on the effective implementation of the interim BSP. In discussions with the provider, they were able to describe the above requirements.

Currently the provider has no participants with Behaviour Support Plans with a regulated restrictive practice.

Supporting Documentation

- Restrictive Practises Policy and Procedure
- NDIS Provisional Approval as a Behaviour Support Practitioner
- Interim Support Plan
- Incident Management Procedure
- Functional Behaviour Assessment and Interview Form
- Copies of qualifications
- Behavioural Support Plan

Opportunities for Improvement:

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Non-Conformity

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AUDIT SCHEDULE DRAFT FOR STAGE 2

Date	Approx. time	Auditors Team: (Li Lih Lam/ Barbara Merrigan)
		Remote Audit – Video conference – Zoom application
tbc	9.00-9.30am	Opening Meeting – Zoom/SKPE meeting <i>Attendees: Auditors and provider's staff</i> Review and confirm the client profile information including: • Business registration documents, ABN • Physical address and outlet sites, Number of sites • Organisational Structure/key personnel • Number of NDIS Workers and Effective Employees • Number of shifts, Number of participants • Review of Self-assessment and any other relevant information by the Commission and/or previous audit results
"	9.30am – 1.00pm	Participant Interviews <i>Barbara Merrigan</i> • Number of participants to be interviewed – 3 • Time to the interviews need to be planned to suite participants and their preferences
"	"	Core Module 1 - Rights and Responsibilities <i>Barbara Merrigan to Review relevant sections when interviewing the participant.</i> • Person Centred Supports • Individual Values and Beliefs • Privacy and Dignity • Independence and informed choice • Violence, Abuse, Neglect, Exploitation and Discrimination
"	"	Core Module 3 - Provision of Supports <i>Barbara Merrigan to Review relevant sections when reviews the participant's file.</i> • Access to Supports • Support Planning • Service Agreements with Participants • Responsive Support Provision • Transitions to or from a provider
"	"	Core Module 4 - Support Provision Environment <i>Barbara Merrigan to Review relevant sections when interviewing participants</i> • Safe environment • Participant Money and Property
"	2.00-3.00pm	Module 2 – Specialist Behaviour Support <i>Barbara Merrigan to Review relevant sections when reviewing participant's files.</i>

		• Behaviour Support in the NDIS • Restrictive Practices • Functional Behaviour Assessments and Behaviour Support Plans • Supporting the Implementation of the Behaviour Support Plan • Behaviour Support Plan Monitoring and Review • Reportable Incidents involving the Use of a Restrictive Practice Interim Behaviour Support Plans
“	9.30am-3.00pm	CORE Module 2 - Provider Governance and Operational Management <i>Li Lih to Review relevant records of implementation of the following sections:</i> • Governance and Operational Management • Risk Management • Quality Management • Information management • Feedback and Complaints Management • (NDIS Complaints Management and Resolution Rules 2018) • Incident Management • (NDIS Incident Management and Reportable Incidents Rules 2018) • Human Resource Management • NDIS Worker Screening Rules 2018 – NDIS Code of Conduct • Continuity of Supports • Emergency and Disaster Management
“	3.00-3.15pm	Auditors Debrief <i>Li Lih and Barbara Merrigan</i>
“	3.15-3.45pm	Closing Meeting Provide Statement of Audit Findings and Non-Conformity Corrective Action Plan (if applicable) <i>Attendees: Auditors and provider's staff</i>
“	3.45pm onwards	Preparation of Audit Report <i>Li Lih and Barbara Merrigan</i>

**** Lunch break: 1.00-2.00pm**

PLEASE NOTE: This schedule is only a general guide to assist in the coordination of staff time regarding their availability for interviews and can be adjusted throughout the audit to accommodate the needs of the provider and the audit team. Participants and/or their representatives will also be interviewed at allocated times throughout the audit (Stage 2).

APPENDIX 1

TIMEFRAME FOR CORRECTING NON-CONFORMITIES

1. The approved quality auditor shall require a registered NDIS provider to present a corrective action plan to it within seven calendar days of written notification of the non-conformity.
2. For a major non-conformity, the approved quality auditor shall undertake a desktop review of the implemented corrective actions within three calendar months of receiving the corrective action plan and shall, if necessary, conduct an on-site follow-up.
3. Critical risks or other serious matters would normally require an on-site follow-up or re-audit within three calendar months.
4. Major non-conformities shall be downgraded or closed within three calendar months of initial written notification of the non-conformity.
5. For major non-conformities identified as part of a mid-term or recertification audit, failure to downgrade or close a major non-conformity within three calendar months shall result in automatic suspension of the certification decision made by the approved quality auditor.
6. Minor non-conformities shall be closed out within eighteen calendar months of initial written notification at the mid-term or recertification audit (whichever comes first); otherwise the minor non-conformity shall be escalated to a major non-conformity.
7. If a minor non-conformity has been escalated to a major non-conformity, failure to close out the major non-conformity within three calendar months shall result in automatic suspension of certification decision made by the approved quality auditor (i.e. a non-conformity that has been escalated to a major non-conformity shall not be downgraded back to a non-conformity)
8. If a major non-conformity has been downgraded to a minor non-conformity, failure to close out the non-conformity within twelve calendar months from the date of issue of the original finding shall result in automatic suspension of the certification decision of the approved quality auditor (i.e. a major non-conformity downgraded to a minor non-conformity shall be closed out within the remaining nine calendar months and not be escalated to a major non-conformity again)
9. The approved quality auditor shall conduct a follow-up in the most cost-effective manner that ensures that major non-conformities have been properly downgraded or closed. This may entail a desktop review of documentation, supplemented by telephone interviews of workers and participants, to verify that the requirements of the applicable NDIS Practice Standards have been met.
10. Where the approved quality auditor has raised a major non-conformity or minor non-conformity, the relevant outcome or outcomes from the applicable NDIS Practice Standards will be audited at the mid-term or recertification audit (whichever comes first) to ensure that the processes developed as part of the corrective action plan have been put into practice.