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How auditors assess compliance with NDIS Practice Standards

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In order to register (and remain registered) with the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission, a provider must be assessed by auditors as meeting the relevant standards and other requirements of the NDIS Practice Standards (Practice Standards).[1]

This article provides guidance on how information to demonstrate compliance with the NDIS Practice Standards is gathered, verified and evaluated.[2] An overview of the Practice Standards and quality indicators is first provided to give context.

What are the NDIS Practice Standards?

The NDIS Practice Standards are made up of a series of high level, participant focussed *quality outcomes*. Providers are assessed against the quality outcomes for the Practice Standards that apply to the type of supports they are registered to provide. [3]

Quality indicators

Within each outcome there are indicators that auditors use to assess whether the provider has demonstrated conformity with quality outcomes. The *NDIS Quality Indicator Guidelines* [4] (Quality Indicator Guidelines) describe the systems, processes (policy, procedures and guidelines), structures, skills and behaviours that are required to achieve the quality outcome. The quality outcomes cover:

- rights of participants and responsibilities of providers;
- governance and operational management;
- provision of supports;
- support provision environment; and

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[1] See *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* schs 1-8 (*'NDIS Provider Registration Rules'*).

Transitional arrangements apply to providers who were already registered by the National Disability Insurance Agency at the time their jurisdiction transitioned to the NDIS. These arrangements modify which Practice Standards apply during the period that providers are transitioning to registration with the NDIS Commission. See *National Disability Insurance Scheme Act 2013* ('*NDIS* Act') ss 26-29.

[2] See *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* ss 14-15 ('*Auditor Scheme Guidelines*').

[3] *Provider Registration Rules* (n 1) schs 1-8 set out the NDIS Practice Standards. Schedules 1-7 apply to specific classes of supports. Schedule 8 sets out the practice standards that apply to those providers who are registered to a provide those classes of supports which are identified as requiring audit using the less onerous 'verification' method: see *Provider Registration Rules* r 20(3).

[4] *National Disability Insurance Scheme (Quality Indicators) Guidelines 2018* ('*Quality Indicator Guidelines*').

- requirements for specialised (behaviour support, support accommodation, early childhood) and high intensity supports.

The indicators list the criteria for what is required to achieve each quality outcome. The indicators do not give detailed descriptions of how systems and processes are to be implemented; the means by which the requirements of each standard are established and maintained is determined by the provider according to the size and scale of the business and the scope and complexity of supports or services that are delivered.

Assessing compliance with outcomes and indicators

Auditors gather audit evidence to verify whether the required processes, systems and other requirements have been established, maintained and implemented in a way that is consistent with the Quality Indicator Guidelines. The NDIS audit processes are detailed in the *NDIS Approved Quality Auditor Scheme Guidelines.*[5] Process associated with auditing management systems are described in ISO 19011:2018 (Guidelines for Auditing Management Systems).[6]

The main things considered by the auditor are:

- what is documented (internal processes, policies, procedures, SOPs or work instructions);
- whether the systems that are required have been established and how they operate; and
- the applicable standards, criteria and requirements set out in the Quality Indicator Guidelines and NDIS Rules that are being audited.

The methods for gathering audit evidence depend on whether the audit is for *certification* or *verification*, the defined audit objectives, scope and criteria (as defined in the scope of audit), as well as the duration and location of the audit.[7]

Further commentary on certification and verification audits is available on the MPS Law website.

What kind of information will be collected?

The auditor will examine documents and records that are relevant to the scope of audit and the provider's responses to the self-assessment and audit history (prior outcomes, corrective actions and reports). The auditor may also gather information from interviews, observations or feedback. [8]

If required, information related to interfaces between functions, activities and processes, will be collected using the sampling methodologies set out the Quality Auditor Guidelines.[9]

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[5] *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018*.

[6] International Standard Organisation, 'Guidelines for Auditing Management Systems', ISO 19011:2018(E), [7.4] ('ISO 19011:2018').

[7] ISO 19011:2018 (n 6) Annex A, cl A1.

[8] Site visits are usually only required for 'certification' audits – these audits follow a sampling methodology and will corroborate audit evidence that is triangulated (wherever possible) form a variety of reliable sources: *Auditor Scheme Guidelines* (n 2) s 16(2). See also ISO 19011:2018 (n 6) [6.4.7]

[9] See *Auditor Scheme Guidelines* (n 2) Annex B. See generally, ISO 19011:2018 (n 6) [6.4.7].

Generally, only information that can be verified (to some degree) is acceptable as audit evidence.[10] Where possible, the auditor will corroborate evidence by triangulating for other reliable sources.[11]

Allowances for what is relevant and proportionate

The regulatory framework is designed to accommodate providers of varied size and scale. So, implementation of some standards will vary according to what is relevant and proportionate to the size and scale of the individual provider and scope and complexity of supports delivered. However, the nature of some quality indicators will require that processes or systems are implemented in a certain way. For example, the indicator for medication management requires that:

> *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*.[12]

This indicator, by its very nature, requires that written records are kept which contain information about dosage and enable identification of the individual. Others, such as '…*Each participant's legal and human rights are understood and incorporated into everyday practice*…' (person centred supports) could be met if staff demonstrate that they understand the legal and human rights that apply and there is evidence showing how staff incorporate those rights into service provision.[13]

Verifying information

The auditor will consider whether the information gathered provides sufficient, objective evidence to demonstrate that requirements are being met. The following factors are considered when assessing if the information is acceptable as audit evidence:

- *complete* – all expected content is contained in the documented information;
- *correct* – the content conforms to other reliable sources, such as standards and regulatory requirements;
- *consistent* – the documented information in itself and with related documents; and
- *current* – the content is up to date.[14]

Evaluating audit evidence and audit conclusions

After reviewing audit evidence, the auditor evaluates whether the provider has demonstrated "conformity" (compliance) with each applicable quality indicator. Audit conclusions will consider the following:

[10] ISO 19011:2018 (n 6) [6.4.7].

[11] This is expected for certification audits: *Auditor Scheme Guidelines* (n 2) s 16(2)(c).

[12] *Quality Indicators Guidelines* (n 4) s 26(1).

[13] See *Quality Indicators Guidelines* (n 4) s 6(1)

[14] ISO 19011:2018 (n 6) Annex A, cl A5.

- the extent of any non-conformities with the audit criteria and robustness of systems, including the effectiveness of systems in meeting intended outcomes, identification of risks and effectiveness of actions taken by auditee to address risks;
- if the required system(s) are effectively implemented, maintained and improved;
- if the audit objectives were achieved, the coverage of the audit scope and fulfillment of the audit criteria; and
- similar findings made in different areas that were audited or from a joint or previous audit.[15]

If satisfied that the applicable requirements are met, the auditor issues a "certification" or "verification" decision and audit report to the NDIS Commission.[16] This information then forms part of the NDIS Commission's determination on registration under s 73E of the *NDIS Act*. Guidance on registration decisions under s 73E is available on the MPS Law website.

In order to recommend registration, the auditor must have assessed that all of the applicable quality indicators are met at the level of "conformity" (or higher).[17] Where there are a minor non-conformities the auditor can recommend registration, if the provider has put a corrective action into place (before the recommendation is made).[18] Conformity is evaluated using the rating scale listed in the table below.

NDIS Practice Standards rating scale

Rating	Attainment level	Interpretation
3	Conformity with elements of best practice	Clear conformity with best practice against criteria demonstrated.[19]
2	Conformity	Clear demonstration that outcomes and indicators are met (in manner proportionate to the size and scale of the provider). May be demonstrated by practice evidence, training evidence, records and visual evidence. Any risk that exists is negligible.
1	Minor non-conformity	Evidence of appropriate 'process' (policy, procedure, guideline etc.), system or structure implementation without required supporting documentation. 'Process' is evident, but provider is unable to demonstrate that implementation, review or evaluation has occurred. Corrective action plan required if minor non-conformity exists.

[15] ISO 19011:2018 (n 6) [6.4.9.2].

[16] *Auditor Scheme Guidelines* (n 2) s 16(6). In the case of verification, an update to the provider's registration record is given to the NDIS Commission in lieu of a report.

[17] *Auditor Scheme Guidelines* (n 2) s 16(4).

[18] *Auditor Scheme Guidelines* (n 2) ss 16(4)-(3)

[19] 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: *Auditor Scheme Guidelines* (n 2) Annex B, cl B.12.

Rating	Attainment level	Interpretation
		Three minor non-conformities within same module may constitute major non-conformity.
0	Major non-conformity	Unable to demonstrate appropriate processes, systems or structures to meet required outcome and indicators and/or gaps in meeting the outcome present a high risk. *Rating of major non-conformity precludes certification*.

The Auditor Scheme Guidelines identify how "minor" and "major" non-conformities are dealt with, the timeframes within which non-conformities must be downgraded or closed out.[20] Failure to downgrade or close out a non-conformity within the prescribed period results in automatic suspension of the certification decision.[21]

Actions to correct major non-conformities are verified by way of a desktop review within three months, with onsite follow ups if necessary.[22] Actions to close out a minor non-conformity are reviewed at recertification or surveillance (whichever occurs earlier) and must be closed within 12 months. Providers should be mindful of these potential costs when engaging an auditor and check the terms of the audit engagement to confirm additional costs for follow up activities, including desktop review.

Further guidance on non-conformities and corrective actions is available on the MPS Law website.

Critical risks

Any uncontrolled risk that may impact on participant safety is a "critical risk".[23] Critical risks are to be notified to the NDIS Commission within 24 hours, or if the risk relates to criminal acts or child protection, the Commission and the authorities must be notified immediately.[24]

A critical risk also includes "incidents that must be covered" in the provider's incident management system.[25] That is, incidents that occur (or are alleged to occur) in connection with the provision of supports that have (or could have) caused harm to a person with disability, reportable incidents and acts by a person with disability that have cause serious harm (or risk of serious) harm to another person.[26]

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[20] *Auditor Scheme Guidelines* (n 2) Annex C

[21] See *Auditor Scheme Guidelines* (n 2) Annex C, cls 5, 7, 8.

[22] Desktop reviews will examine documentation and may be supplemented by telephone interviews of workers and participants, to verify that the requirements of the applicable Practice Standards have been met: *Auditor Scheme Guidelines* (n 2) Annex C, cl 9

[23] *Auditor Scheme Guidelines* (n 2) s 4.

[24] *Auditor Scheme Guidelines* (n 2) ss 15(5), 16(7)-(8).

[25] *Auditor Scheme Guidelines* (n 2) s 4.

[26] See *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* s 9.