National Disability Insurance Scheme (NDIS Practice Standards)

Re-certification Audit Report
Core Module with:

- **Module 4**

Organisation:

Prioletti Consultants Pty Ltd
Trading as Catalyst Training & Disability Services

290 Manningham Road, Lower Templestowe, VIC, 3107, Australia
108 Cramer St, Preston, VIC, 3072, Australia
20 Ebdale St, Frankston, VIC, 3199, Australia

Scope:
0136 Group and Centre-Based Activities 0132 Support Coordination 0125 Participation in Community, Social, and Civil Activities 0117 Development of Daily Living and Life Skills 0116 Innovative Community Participation 0106 Assistance in Coordinating or Managing Life Stages, Transitions and Supports 0102 Assistance to Access and Maintain Employment or Higher Education

Audit date: **3/10/2022 - 6/10/2022**

Application ID:
4-433C-1964

Audit Team Member(s):
Marisa McCague - Lead Auditor and Fran Cant - Auditor

Work Item Number:
WI-1132402, WI-1503251 and WI-1503252

Date of report: **10/10/2022 revised 12/10/2022**

Version Number: ***01***

BACKGROUND INFORMATION

SAI Global conducted an audit of **Prioletti Consultants Pty Ltd** on **4/10/2022 - 610/2022**

The purpose of this audit report is to summarise the degree of compliance with relevant criteria, as defined in this report, based on the evidence obtained during the audit of your organisation. This audit report considers your organisation's policies, objectives, and continual improvement processes. Comments may include how suitable the objectives selected by your organisation appear to be in regard to maintaining client satisfaction levels and providing other benefits with respect to policy and other external and internal needs. We may also comment regarding the measurable progress you have made in reaching these targets for improvement.

SAI Global audits are carried out within the requirements of SAI Global procedures that also reflect the requirements and guidance provided in the international standards relating to audit practice such as ISO/IEC 17065, ISO 19011 and other normative criteria. Auditing is based on a sampling process of the available information. SAI Global Auditors are assigned to audits according to industry, standard or technical competencies appropriate to the organisation being audited. Details of such experience and competency are maintained in our records.

In addition to the information contained in this audit report, SAI Global maintains files for each client. These files contain details of organisation size and personnel as well as evidence collected during preliminary and subsequent audit activities (Documentation Review and Scope) relevant to the application for initial and continuing certification of your organisation.

Please take care to advise us of any change that may affect the application/certification or may assist us to keep your contact information up to date, as required by SAI Global Terms and Conditions.

This report has been prepared by SAI Global Limited (SAI Global) in respect of a Client's application for assessment by SAI Global. The purpose of the report is to comment upon evidence of the Client's compliance with the standards or other criteria specified. The content of this report applies only to matters, which were evident to SAI Global at the time of the audit within the audit scope. SAI Global does not warrant or otherwise comment upon the suitability of the contents of the report or the certificate for any particular purpose or use. SAI Global accepts no liability whatsoever for consequences to, or actions taken by, third parties as a result of or in reliance upon information contained in this report or certificate.

Please note that this report is subject to independent review and approval. Should changes to the outcomes of this report be necessary as a result of the review, a revised report will be issued and will supersede this report.

Executive Overview

The purpose of this Independent Review was to determine implementation of your organisation's systems and implemented processes for conformance against the NDIS Practice Standards and related quality indicators; the capability and effectiveness of the management system in ensuring continual compliance with client, statutory and regulatory requirements and in meeting its specified objectives and improvement plans.

NDIS Practice Standards Modules applicable include:

- Core Module
- Module 4: Specialised support coordination.

Specific evidence viewed during the audit is documented against each standard.

Changes to the organisation, scope and plan included:

- The Frankston site tour was conducted remotely 6/10/2022 with staff and a participant, based on availability of people onsite.
- Audit was originally planned remotely; auditors were onsite at head office and Preston 4/10/2022.

This audit was conducted remotely utilising the ICT tools detailed in the feasibility review. The audit outcomes were **successfully achieved.**

The audit revealed that provider had systems in place proportional to scope of registration, with some opportunities for improvement identified in the report:

- The provider's performance was effective proportional to scope of audit, and consistent over the three-year audit cycle.
- The service was effective in achieving outcomes for NDIS participants in line with the practice standards. They provided SLES related supports to people with an intellectual disability and higher support needs than some SLES providers, working with individuals to achieve meaningful employment outcomes. They noted the level of support required and standardised unit cost made this program potentially unsustainable. The provider also offered specialist support coordination, resulting in outcomes for participants.
- The provider was extremely committed to quality and continuous improvement. The word compliance was mentioned consistently across staff interviews. The versioning on documents showed frequent review of higher-risk and changing areas. While there had been no non-conformities at stage 1, provider had taken on board audit feedback and made some changes between audits.

Strengths of the organisation and systems include:

- Provider had a strong focus on continuous improvement.
- Provider had high expectations for participants with an outcomes focus. This resulted in high levels of employment outcomes, e.g., one school leaver soon to leave the program was moving on to two paid roles. These outcomes reflected individual skills and preferences, for example one participant had mentoring with a screen writer, as that was something they aspired to, but also had more routine work placements as they recognized there may be limited options in their preferred area.
- As the provider also included an RTO and strong links with employers, there were a range of work 'tasters' on offer. The provider also had a food truck, which offered food handling experience. The provider noted the food van had gone to provide food at the school leaver's past school, enabling them to show the school how they had progressed, and show future school leavers the options open to them.

Recommendation

The recommendation from this audit is that the organisation **complies** with the requirements of the NDIS Practice Standards.

The following registration group recommendations will be made:

Certification Recommendation	**Provisional Certification Recommendation (currently no participants)**
0132 Support Coordination 0102 Assistance to Access and Maintain Employment or Higher Education	0136 Group and Centre-Based Activities 0125 Participation in Community, Social, and Civil Activities 0117 Development of Daily Living and Life Skills 0116 Innovative Community Participation 0106 Assistance in Coordinating or Managing Life Stages, Transitions and Supports

Audit recommendations are reviewed and a Certification recommendation will be made to the NDIS Commission through the NDIS portal. If the review identifies amendments required to this report, an updated report will be issued.

Once a Certification Recommendation is made, the NDIS Commission will consider this as part of their overall Registration Decision.

This report was prepared by:

Marisa McCague and Fran Cant

Lead Auditor and Auditor

SAI Global Assurance Services

Meeting Attendance Register

Name	Position	Entry	Exit
Marisa McCague	Lead Auditor	✓	✓
Fran Cant	Auditor	✓	✓
Giuseppina (Josie) Prioletti	CEO	✓	✓
Jennifer (Jenny) Boulton	Quality and Compliance Manager	✓	✓
Stella Armstrong	Student Trainer and Administration Manager	✓	✓
Robert Donohoe	Quality and Compliance Officer	✓	X

Organisational Overview

Introduction and description of organisation / site (including services provided)	Provider was a Victorian based organisation, which provided services in the disability sector for the registration groups listed below. Prioletti Consultants had been operating since 2018. Their focus was on paid work outcomes for adults who had an intellectual disability/cognitive impairment. They also provided specialist support coordination, however, were phasing this out through natural turnover. SLES complemented their RTO offerings (RTO 41525), where they delivered accredited training through the Skills First Program Victoria. Catalyst employment options (CEO) had a focus on work readiness and capacity building for people with an intellectual disability. The organisation was working to build connections with schools to offer transitions and work options for school leavers through CEO. Business planning noted SLES was under review, with possible outcome being the withdrawal of NDIS registration, due to the lack of sustainability with the registration group funded on a singular unit cost, but a higher support needs target group. Provider had an office base in Lower Templestowe and ran NDIS groups in community sites in Preston and Frankston. More broadly the organisation offered training through at least 20 sites. There was no sub-contracting of training or assessment. Provider did have a partnership arrangement with Uniting more broadly on the RTO activities.
Does the organisation provide (or intend to provide) services to children (0-16 years)?	No

NDIS Staff numbers and Number of NDIS staff files audited *(NOTE: NDIS staff includes permanent, volunteers and contractors, and senior leadership, governance etc.)*	# of NDIS Staff: 12 RARs (13 non-NDIS trainers) # of NDIS Staff Files Reviewed: 6
Operating Hours / Shift Details Shifts covered during the audit	9am – 5pm All roles sampled
Total Number of participants	16
Minimum Number of Participants requiring interview ("High Risk" minus "Annex D Only") Reason/ Justification for not meeting min number of interviews	5 (minimum sample)
Number of participants who 'opted out' of the audit process. Reason/ Justification for Opting out (i.e. did not want to participate, felt ill)	2 One did not want to participate and one did not respond to calls, noting the latter was experiencing multiple health issues in the family.
Are any services outsourced to other providers?	No
Details of any external non-compliances or complaints raised since the organisation's last audit	N/A
Details of any Conditions of Registration from the NDIS Commission	N/A
Review of published information including the provider's website and use of Certification Documents, Marks/Logos and Statements	There was no evidence of use of the StandardsMark logo or claims of certification. The organisation may wish to consider promoting their certification achievement through using the relevant certification StandardsMark, as per the Rules Of Use. The website included information on the organisation, staff (key personnel profiles), services, policies (rights, privacy, feedback and client charter), partnership, outcomes, resources and contact details.

Registration Group Details and Participant interview methodology and file reviews
(Please note that a minimum of 5 participants are to be interviewed, if total participants is less than or equal to 5 then all participants are to be interviewed and files reviewed.

Registration Group	**Number of participants**	**Number of participants interviewed**	**Interview methodology** (e.g. phone, face to face, carer)	**Number of Files Reviewed**
0102	13	9	Phone	4
0106	0	0	N/A	0
0116	0	0	N/A	0
0117	0	0	N/A	0
0125	0	0	N/A	0
0132	3	1	Phone	1
0136	0	0	N/A	0
Total number of interviews and file reviews		**9/5**	**N/A**	**5**
*Please note: If participants receive multiple supports this should be noted in the above table. Participants should not be counted more than once when added to the total number of interviews and file reviews.				

Client and Stakeholder Feedback Summary

During interviews, clients and stakeholders gave both positive feedback and identified areas for improvement.

Positive feedback and comments included:

- Donna is terrific, she goes above and beyond.
- The information from Catalyst is clear and everything was explained.
- Can't praise Donna enough we rate her 15/10.
- We have provided feedback and we feel comfortable making contact with management.
- Everyone's really nice and helpful.
- The garden is nice.
- I do car wash and café.
- School was boring stuff. We do writing, but there's no boring stuff here. It's good.
- I give it a go – always 😊
- It's easy to get here (Preston).
- The structure works well.
- They are very supportive; I was hesitant to join the group but it's going really well.
- We had a discussion with Josie where we think X will do well at, and they focus on this.
- X comes home happy. It seems to be working. We don't have any concerns at this stage.
- The main contact was Josie. She advised us that we could always contact her if any issues. I don't know if I had any other contact numbers. We had a pretty good relationship with her. She's been pretty informative of what's happening. We're pretty happy with that.
- What we've liked the most is X being involved in a lot of activities. They have given a lot of work tasters. It's really good to get an understanding of what needs to be done and what X likes to do.

Opportunities for improvement included:

- It would be good to get regular feedback about what is being worked on and planned so that it can be reinforced at home (repeated)
- They have had a turnover of staff which has been disruptive
- It would be good to have equipment like computers supplied
- Communication is not great

Not stated specifically as an opportunity for improvement, but one person stated ‘I can’t recall privacy/ consent’.

Staff File Review Details

Staff Identifier and Role	Category	Worker Screening Checks	Qualifications & Training	HR Documentation
DW, Support Coordinator and trainer (RTO)	**Service Delivery - More than incidental contact with participants (not children)**	NDIS check 20416315 expiry 31/5/2026 WWCC expiry 6/3/2023	NDIS Worker Orientation module 2020 CV showed / training in social work and certificate IV in training Bachelor of Social Work was not retained or on RAR register - TAE40116 recorded on RAR register Multiple infection control/ hand hygiene / PPE/ waste modules Other training included SRV, understanding autism, audit, human rights, literacy, learning, training etc	CV showed experience in community services/ training Interview record for trainer Reference check for SC Passport, license and Medicare card Orientation and Induction Checklist Signed Code of Conduct Personnel File Checklist Vaccination certificate Signed PD Older supervision notes, trainer observation 2/6/2022 and email trail 9/2022 showing ongoing practice engagement with management
MS Support Worker and Trainer Assistant (listed on RAR only as Admin Assistant not support worker)	**Service Delivery - More than incidental contact with participants (not children)**	NDIS check 8013355 expiry 18/7/2027 RAR noted WWCC current	NDIS Worker Orientation module 2022 Emails completing TAE pending certificate Infection control hand hygiene, PPE, cleaning, waste, chain of infection and outbreaks modules	CV showed experience in administration training in Cert IV in training Reference check Internal complaints training Aus passport within two years of expiry and current Probationary Vic Driver License Contractor document Orientation and Induction Checklist Signed Code of Conduct

				Personnel File Checklist Vaccination certificate with booster (HIN visible) Signed PD
AB - CEO coordinator and Trainer Assessor (CEO facilitator but not coordinator was on RAR register as an assessed role)	**Service Delivery - More than incidental contact with participants (not children)**	NDIS check 65770117 – RAR	NDIS Worker Orientation module 2021 CV showed training in Diploma in Disability, Advanced Diploma Comm Services Management and Cert IV in Training and Assessment Training records included Cert IV in training and Assessment, Diploma of Nursing, Advanced Diploma Community Services (Management), Advanced Diploma Disability (Swinburne), managing challenging behaviour, WHS, bullying harassment, mental health, SRV and Auslan Expired first aid was on file - email 6/10/2022 showing staff booked in for refresher 15/10/2022 Multiple infection control/ hand hygiene / PPE/ waste modules	CV showed 20 years experience in disability Interview records Reference check Current Vic Driver License and Aus passport No Orientation and Induction Checklist but RAR records stated training completed including complaints and incidents (yes not a date for the latter two) Vaccination certificate Signed PDs Supervision notes 26/7/2022 WB outcomes progress session plans and PD)
AS (CEO facilitator and trainer assistant)	**Service Delivery - More than incidental contact with participants (not children)**	NDIS check 42319986 exp 1/3/2027	NDIS Worker Orientation module 2022 Resume showing Cert III in Disability and Aged Care, and qualifications in hospitality and	Resume showing experience in support, case management and leadership Interview records Reference check

			commerce, working to training qualification Training in teaching people with ID No infection control/ hand hygiene / PPE/ waste modules (still within first six months) but working with other staff (RAR register tracked other mandatory training but not infection control)	Expired Indian Passport, Aus Citizenship certificate and current Vic Driver License Orientation and Induction Checklist Personnel File Checklist Vaccination certificate with booster (HIN visible) Signed PDs Support meeting notes on template 2, 8 and 15/8/2022, and shared information emails 23/5/2022, 26/7/2022 and 13/9/2022
NC - Practical Placement Officer/ Administration	**Service Delivery - More than incidental contact with participants (not children)**	NDIS check 28381706 exp 26/7/2027	NDIS Worker Orientation module 2022 No infection control/ hand hygiene / PPE/ waste modules – based in the office with more incidental/ indirect contact and within four months of commencement	Resume showing exp in admin and business for admin role Interview records Reference check Internal complaints and incident management training Current Aus passport and license number on RAR Orientation and Induction Checklist but RAR records stated training completed 1/8/2022 Signed Code of Conduct Digital Vaccination certificate and immunisation history statement showing one booster (HIN visible) Signed PD Supervision 26/9/2022

				Vehicle usage form (internal)
SA – Student Trainer and Administration Manager	**Key Personnel (not Service Delivery)**	NDIS check 74774141 exp 4/1/2027	NDIS Worker Orientation module 2022 Multiple infection control/ hand hygiene / PPE/ waste modules	Resume showing exp in admin and management across disability and education No interview records but anecdotally multiple meetings and known to two key personnel Reference check Internal complaints and incident management training Aus passport within two years of expiry and current Vic Driver License No Orientation and Induction Checklist as commencement pre-dated form Personnel File Checklist Vaccination and booster recorded on RAR Signed PD KPIs and three supervision records e.g., 5/7/2022 and 2/8/2022 covering wellbeing, PD review and KPIs

SUMMARY OF AUDIT FINDINGS

CORE MODULE	RATING
1. Rights and Responsibilities	**2 - Conformity**
1.1 Person Centred Supports	2 - Conformity
1.2 Individual Values and Beliefs	2 - Conformity
1.3 Privacy and Dignity	2 - Conformity
1.4 Independence and Informed Choice	2 - Conformity
1.5 Violence, Abuse, Neglect, Exploitation and Discrimination	2 - Conformity
2. Provider Governance and Operational Management	**2 - Conformity**
2.1 Governance and Operational Management	2 - Conformity
2.2 Risk Management	2 - Conformity
2.3 Quality Management	2 - Conformity
2.4 Information Management	2 - Conformity
2.5 Feedback and Complaints Management	2 - Conformity
2.6 Incident Management	2 - Conformity
2.7 Human Resource Management	2 - Conformity
2.8 Continuity of Supports	2 - Conformity
2.9 Emergency and Disaster Management	2 - Conformity
3. Provision of Supports	**2 - Conformity**
3.1 Access to Supports	2 - Conformity
3.2 Support Planning	2 - Conformity
3.3 Service Agreements with Participants	2 - Conformity
3.4 Responsive Support Provision	2 - Conformity
3.5 Transitions To or From a Provider	2 - Conformity
4. **Support Provision Environment**	**2 - Conformity**
4.1 Safe environment	2 - Conformity
4.2 Participant Money and Property	2 - Conformity
4.3 Management of Medication	2 - Conformity
4.4 Mealtime Management	2 - Conformity
4.5 Management of Waste	2 - Conformity
MODULE 4 - SPECIALIST SUPPORT CO-ORDINATION	**2 - Conformity**
1. Specialised Support Co-ordination	2 - Conformity
2. Management of a Participant's NDIS Supports	2 - Conformity
3. Conflict of Interest	2 - Conformity

SUMMARY OF AUDIT FINDINGS

CORE MODULE

Core Module 1. Rights and Responsibilities

These NDIS Practice Standards set out the rights of participants and the responsibilities of providers that deliver supports and services to them.

1.1 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** Conformity
Each participant's legal and human rights are understood and incorporated into everyday practice.	Conformity
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.	Conformity
Each participant is supported to engage with their support network and chosen community as directed by the participant.	Conformity

EVIDENCE:

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including having information in an appropriate format, cultural and religious development, privacy and confidentiality, independence and autonomy, life free from abuse, neglect, discrimination and exploitation, consultation on needs, preferences and decisions, making complaints and access to advocates. It was written with reference to UN Conventions, the Disability Act, Charter of Human Rights and NDIS Standards. This was supported by the Participant Charter, Participant Handbook, Information and Welcome Packs, and the Service Agreement.

The Service Delivery Policy and Procedure committed to supporting person-centred participation, and collaborative services.

The Physical Accessibility Policy and Procedure required website, signage and participant information to be in a range of formats including easy read.

The Decision-Making and Choice Policy and Procedure stated surveys would assess participant and stakeholder understanding of rights and support to exercise them.

The Policy Manual required key policies be available on the website including Your Rights and Responsibilities, and the Client Charter, which was observed.

The Participant Handbook V12 15/2/2022 provided information on rights and responsibilities. These were separately documented as Your Rights and Responsibilities V4 15/2/2022 and the Client Charter V7 21/1/2021. The Charter was written with reference to the Charter of Human Rights and responsibilities Act and the state Disability Act. It promised fair services. Staff induction presentation V2 covered the Client Charter.

The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 detailed rights and responsibilities, with reference to the information pack and Participant Handbook.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in participant rights, information in easy read or alternative format, Client Charter, and support networks.

Staff interviewed were respectful of participant rights.

The Participant Welcome Packs were reviewed, and included:

- Service Agreement
- Participant Handbook
- Permission form (sharing information and medial permission)
- Consent to speak with Auditor
- Rights and Responsibilities acknowledgement form
- Client Charter
- Your Rights and Responsibilities
- Your Right to Advocacy
- Compliments and Complaints
- Protecting your Privacy
- Guarding against Potential or Real Conflict of Interest
- School Leaver Employment Support Flyer (School Leavers pack only)
- Support Coordination Rules (support coordination only).

Participants interviewed confirmed that the information provided about the service was clear and th at they understood their rights

The organisation explained that they have participants sign consent forms and the service agreement once they have had the opportunity to understand it and some files reflected those participants signed some forms more quickly on intake than others. The organisation requires that the consent forms are signed annually, and all files reviewed included consent forms signed within the last year.

Staff interviewed had a strong person-centred, rights and empowerment focus, based on the approach that everyone can learn. Staff training on file included Social Role valorisation.

Opportunities for improvement	N/A
Non- conformity	N/A

1.2 Individual Values and Beliefs Outcome: Each participant accesses supports that respect their culture, diversity, values and beliefs.	**Rating** Conformity
At the direction of the participant, the culture, diversity, values and beliefs of that participant are identified and sensitively responded to.	Conformity
Each participant's right to practice their culture, values and beliefs while accessing supports is supported.	Conformity
EVIDENCE: The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including cultural and religious development.	

The Service Delivery Policy and Procedure committed to respect for individual personal, gender, sexual, cultural, religious and spiritual identity, with culturally competent staff. Interpreter details were to be included in the Handbook. The Decision-Making and Choice Policy and Procedure affirmed the right to maintain personal, gender, sexual, cultural, religious and spiritual identity. The Physical Accessibility Policy and Procedure required use of interpreters and resources to accommodate cultural needs. The Assessment Planning and Review Policy and Procedure described planning in the context of the person and their identity. The Client Charter V7 21/1/2021 promised fair services, with response to diversity and sexual preferences. The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 rights included response to cultural beliefs and lifestyle preferences. The Goal Achievement Plan V4 11/8/2022 included prompts to consider cultural and religious context. The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in individual planning, ATSI, and interpreter access. Email footers included acknowledgement of country. Staff interviewed talked to understanding the individual's preferences and working with this. All participants and the family members interviewed confirmed that they felt that the services were being provided in a culturally appropriate way, all indicated that the staff treat the participants and their families with respect and that they felt comfortable with the service and the staff. Participant files reviewed included basic information about the participants such as contact details background. All staff interviewed spoke with respect about the participants and their families, the staff had a good understanding of the participants and their preferences and needs.

Opportunities for improvement	N/A
Non- conformity	N/A

1.3 Privacy and Dignity Outcome: Each participant accesses supports that respect and protect their dignity and right to privacy.	**Rating** Conformity
Consistent processes and practices are in place that respect and protect the personal privacy and dignity of each participant.	Conformity
Each participant is advised of confidentiality policies using the language, mode of communication and terms that the participant is most likely to understand.	Conformity

Each participant understands and agrees to what personal information will be collected and why, including recorded material in audio and/or visual format.	Conformity

EVIDENCE:

The Privacy and Confidentiality Policy and Procedure:

- expected participants (or representative where applicable) be informed of why information was being collected and how it would be protected, used, disclosed, accessed, changed and disposed of through access to the easy read Privacy Information Flyer with full policy available on request
- stated staff were to explain the above in a manner each participant would understand
- required informed participant/ representative consent for collection of information, including audio visual images.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including and confidentiality.

The Physical Accessibility Policy and Procedure required participant information to be in a range of formats.

The Policy Manual required key policies be available on the website including Privacy and Confidentiality.

The Participant Handbook V12 15/2/2022 provided information on rights and responsibilities, and the Client Charter. The Client Charter V7 21/1/2021 promised privacy, confidentiality and consent.

Protecting Your Privacy V5 19/7/2022 covered privacy and consent, reading at a grade 12.9 level.

The Personal Information Release Permission Form V3 21/1/2021 was available to document blanket consent to share information and use of photos in media; there was not a separate option to select for program use only.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in privacy and consent, and accessible information.

A camera was observed in the Frankston site tour, but not signage related to this. Staff indicated it was not operational.

All participants and family member interviewed confirmed that they were happy with how their information was managed. Specialist Support Coordination and School Leavers all confirmed that when staff contacted and communicated with other parties it was with their consent.

All files reviewed included the Permission form, Consent to speak with Auditor and Rights and Responsibilities acknowledgement form signed within the last twelve months. It was noted that the organisation encouraged participants rather than their representatives to review, understand and sign the forms and they are resigned each year to ensure that the information remains current.

Staff interviewed talked to the need for photo consent, and were respectful of participant privacy.

Opportunities for improvement	Consents were not as easy read as they could be, and did not offer as much flexibility as they could.
Non- conformity	N/A

1.4 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** Conformity
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.	Conformity
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.	Conformity
Each participant's autonomy is respected, including their right to intimacy and sexual expression.	Conformity
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.	Conformity
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.	Conformity

EVIDENCE:

The Decision-Making and Choice Policy and Procedure was written with reference to the Guardian and Administration Act. It committed to supporting decision-making and dignity of risk, as well as advocacy. It affirmed the right to maintain personal, gender, sexual, cultural, religious and spiritual identity. Information on advocates, guardians and administrators was provided. Staff were to have training in this. Surveys were to assess participant and stakeholder understanding of rights and support for choice.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including independence and autonomy, dignity of risk, consultation on decisions, and access to advocates.

The Physical Accessibility Policy and Procedure required use of accessible information and advocates as required.

The Client Charter V7 21/1/2021 promised choice and control, response to sexual preferences, and with the right to complaint to the Commission of have the support of an advocate.

Your Right to Advocacy V34 19/7/2022 provided related information and contacts.

The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 rights included engaging an advocate, and response to lifestyle preferences.

The Goal Achievement Plan V4 11/8/2022 included prompts to consider any advocacy required.

Participants and family members interviewed, confirmed that the organisation was focused on understanding the participant's preferences and supports them to make their own choices.

The Participant Welcome Packs were reviewed, and included information about the rights and responsibilities and the participant's right to access an advocate

The organisation explained that they have participants sign consent forms and the service agreement once they have had the opportunity to understand it and some files reflected those participants signed some forms more quickly on intake than others.

Staff induction presentation V2 covered organisational expectations for participant independence and work outcomes. The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in choice and control, advocates, information in easy read or alternative format, independence, choice, dignity of risk, time to make decisions, and advocates. Staff interviewed talked to individual choices and supporting these. Staff gave examples of creating a picture position description to support someone who was not literate and struggled with remembering sequences.	
Opportunities for improvement	N/A
Non- conformity	N/A

1.5 Violence, Abuse, Neglect, Exploitation and Discrimination Outcome: Each participant accesses supports free from violence, abuse, neglect, exploitation or discrimination.	**Rating** Conformity
Policies, procedures and practices are in place which actively prevent violence, abuse, neglect, exploitation or discrimination.	Conformity
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.	Conformity
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.	Conformity

EVIDENCE:

The NDIS Protecting Participants from Harm Policy and Procedure offered a detailed framework proportional to group education and employment focused services:

- Comprehensive definitions were given.
- Proactive prevention strategies were outlined, including skilled, screened, risk-assessed roles.
- Response, reporting and investigation strategies were detailed, including investigation concurrent with police involvement. It covered capacity for consent and advocacy support. Scenarios were given for participant and staff as potential victim and as perpetrator.
- It was written with reference to the Crimes Act and a range of other legislation, as well as NDIS incident reporting in the general sense, not the specific rules.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including life free from abuse, neglect, discrimination and exploitation, making complaints and access to advocates.

The Physical Accessibility Policy and Procedure required participants be informed of feedback procedures, and use of advocates as required.

The Policy Manual required key policies be available on the website including Your Rights and Responsibilities, as well as Compliments and Complaints.

Other supporting documents included:

• Equity, Anti-Discrimination and Workplace Harassment Policy and Procedure • Your Right to Advocacy V34 19/7/2022 provided related information and contacts. Refer to the Incident management section of this report for further information. The Client Charter V7 21/1/2021 promised skilled staff delivering services with freedom from abuse, neglect, and exploitation, with the right to have the support of an advocate. The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 rights included freedom from abuse. The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of employers, including freedom from harassment and discrimination. The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in prevention of abuse, advocates and reporting. No participant files reviewed included incidents or complaints. All participants and family members interviewed confirmed that they felt very safe with the organisation and the staff and that there had been no complaints or incidents to report.

Opportunities for improvement	N/A
Non- conformity	N/A

Core Module 2. Provider Governance and Operational Management

These NDIS Practice Standards set out the governance and operational management responsibilities for NDIS Providers.

2.1 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** Conformity
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.	Conformity
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.	Conformity
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.	Conformity
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.	Conformity

The performance of management, including responses to individual issues, is monitored by the governing body to drive continuous improvement in management practices.	Conformity
The provider is managed by a suitably qualified and/or experienced persons with clearly defined responsibility, authority and accountability for the provision of supports.	Conformity
There is a documented system of delegated responsibility and authority to another suitable person in the absence of a usual position holder in place.	Conformity
Perceived and actual conflicts of interest are proactively managed and documented, including through development and maintenance of organisational policies.	Conformity

EVIDENCE:

Some staff h ad lived experience of disability. Surveys were undertaken and feedback was welcome.

The Governance Policy and Procedure required systems for compliance, risk management, staff development and quality service provision:

- Regular feedback was to be sought from stakeholders in line with the Feedback, Compliments, and Complaints Policy and Procedure.
- The Policy introduced the management team, and their responsibilities including planning, compliance and risk.
- It was noted the CEO met with reporting staff monthly, in line with the staff performance management system.
- Organisational performance was to be monitored and internal audits undertaken.
- Potential/ actual Conflict of Interest (COI) was to be managed in line with the model rules for Support Coordination. COI was to be avoided where possible or managed as required. Supporting guidance was included.
- The Policy was written with reference to legislated NDIS, disability, child and corporate compliance, as well as internal documents such as the organisation chart.

The Strategic and Business Planning Policy and Procedure stated there was a five-yearly Strategic Plan cycle, with the current plan established in 2019. Annual review was to be undertaken at EOFY, with participant, staff and stakeholder consultation. This was supported by the annual Business Plans that were subject to regular monitoring and quarterly review, including six-monthly service delivery and planning days. The Policy was set to the same policy references as the Governance Policy.

The Continuous Improvement Policy and Procedure required annual surveys. The Privacy and Confidentiality Policy and Procedure required privacy-related questions be included in the survey. The Decision-Making and Choice Policy and Procedure also detailed a range of areas the survey should assess understanding of and satisfaction with.

The Satisfaction Survey V2 11/8/2022 sought feedback on satisfaction, expectations, rights information, complaints, advocates and involvement in planning. It noted that annual surveys had not been conducted in COVID. Of 18 surveys sent eight were returned, with seven giving very good to excellent ratings, as pre report 2021-2022.

The Business Plan 2022 V2 covered vision, mission, services, SWOT, risks and mitigations. It indicated the provider had been successful in a Skills First contract for 2022, noting NDIS services were not viable on a small scale and there was a decision to withdraw from 10/2023. Aims included these actions and succession planning, detailed in the Operational Plan. The Plan also included an organisational chart that did not drill down to staff under managers. The Strategic Plan 2019 – 2023 V7 was aligned with this.

Pre-Strategy Planning Discussion and Outcome Notes 24/8/2021 and Strategy Planning Workshop Outcome Notes 16/10/2020 and 24/3/2022 fed into business planning, and showed review of risk management. The Delegation Register: Financial and Decision-Making 15/8/2022 included some absence delegations. The CEO and Quality and Compliance Manager had extensive experience across the disability and training sectors. The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in conflict of interest. The Participant Information Pack Contents V3 21/1/2021 included Guarding against Potential and Real Conflict of Interest. The provider offered SLES, support coordination and RTO courses. For SLES, The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 stated two certificate I options were offered but not required, and it was stated these were not from NDIS funding. External options for the course were also to be offered. It included a checklist to indicate people understood	
Opportunities for improvement	• Annual surveys were not conducted in line with policy during COVID. Valuable feedback about change and communication may have been missed. (It was noted provider recognised this retrospectively.) Related, policies stipulated questions on set topics were to be included, such as privacy, but these were not in the survey observed. • The organisational chart titles in the Business Plan did not always match other documents, e.g., the quality and compliance manager on the chart was referred to as the operations manager in another document provided.
Non- conformity	N/A

2.2 Risk Management Outcome: Risks to participants, workers and the provider are identified and managed.	**Rating** Conformity
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.	Conformity
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.	Conformity
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.	Conformity

Where relevant, the risk management system includes measures for the prevention and control of infection and outbreaks.	Conformity
Supports and services are provided in a way that is consistent with the risk management system.	Conformity
Appropriate insurance is in place, including professional indemnity, public liability and accident insurance.	Conformity

EVIDENCE:

The Governance Policy and Procedure required integrated systems risk management

The Risk Management Policy and Procedure required:

- identification and management of risks, including compliance, financial, OHS, environmental, operational and participant risks
- application of an identify, analyse, treat, monitor and report cycle
- a consultative, evidence-based and continuous improvement approach in line with vision/ mission
- use of the organisational Risk Management Plan, Business Continuity Pandemic Plan, Emergency Management Plan and Individual Risk Assessments for participants
- appropriate organisational insurances.

The Financial Management Policy and Procedure required:

- transparent accountable systems and financial delegations
- annual budget in collaboration with an accountant
- quarterly expenditure and annual financial reports
- regular monitoring to minimise potential for fraud
- use of Xero and the Chart of Accounts, Registers (Asset, Bank Account and Insurance), and the NDIS Service Agreement Template/s
- invoicing to inform participants of plan expenditure.

It was written with reference to Australian Accounting and Audit standards.

The OHS Policy and Procedure referred to the WHS Manual for greater detail.

The NDIS Risk Management Plan 2022 identified risks, mitigations, responsibility and ratings. Risks assessed included service viability, appropriate staff, continuity of support, quality of support, privacy, conflict of interest, choice and control, competition, fraud, and COVID-19. This was light on OHS and did not consider compliance risks, however there were considered elsewhere in the QMS.

A Risk Assessment Form V3 27/9/2022 was available. The Risk Register analysed four risks identified by staff, relating to participant and staff safety.

The Business Plan 2022 V2 risks and mitigations considered contractual arrangements, staffing skills and NDIS viability. Pre-Strategy Planning Discussion and Outcome Notes 24/8/2021 and Strategy Planning Workshop Outcome Notes 16/10/2020 and 24/3/2022 showed review of risk management.

The Goal Achievement Plan V4 11/8/2022 included fields for risks and mitigations.

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including the identification of risk and NDIS provider public liability insurance coverage.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in risk identification.

Staff Meeting Agenda and Minutes 25/6/2021 and 30/11/2021 showed discussion of compliance, continuity plan, feedback, HR, WHS, services and internal audit. Feedback showed positive engagement with extended family.

Exec Meeting Agenda and Minutes 2/5/2022 showed discussion of compliance, feedback, incidents, HR, PD, WHS and services.

Staff interviewed indicated risk formed part of participant planning.

The four School Leaver Participant files reviewed included records of placements at workplaces. Prior to the placement an External Site Work Health and Safety Checklist is completed. The check included a review of basic safety such as fire safety systems, housekeeping, electrical, slips and trips, manual handling, amenities and first aid.

The organisation ran training from the West Preston Baptist Church and annually completed an External Site Checklist to ensure that the site is appropriate for their needs and the safety of the participants. The checklist was last completed for the site 15/12/2021 and included a review of housekeeping, fire safety, first aid and amenities.

Refer to governance, information management, complaints management, incident management, HR, emergency and disaster management, and safety sections of this report for further information.

The insurances Register showed building, public liability, professional indemnity and vehicle insurance as current.

Insurances were managed via a broker. Certificates observed included:

- WorkCover EML expiry 30/6/2023
- Public ($20m) and products liability QUAL expiry 11/4/2023
- Professional indemnity ($1m) and public liability ($20m) Dual expiry 11/4/2023
- Kia Cerrato receipt 2022.

Opportunities for improvement	It was noted that the West Preston Baptist Church kitchen included electrical equipment that had not been tested and tagged, the first aid kit included some expired items, and the evacuation map was not in perspective.
Non- conformity	N/A

2.3 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** Conformity
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 requirements of legislation and these standards. The system is reviewed and updated as required to improve support delivery.	Conformity
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.	Conformity

The provider's quality management system supports continuous improvement, using outcomes, risk related data, evidence-informed practice and feedback from participants and workers	Conformity

EVIDENCE:

The provider had developed their own QMS, and versioning showed ongoing continuous improvement, based on the NDIS Policy and Procedures Manual. V17 1/8/2022 was observed at stage one; it was noted the manual had been updated with stage one feedback and was at V18 31/8/2022 but given time constraints the manual was not fully reviewed for changes as it was not easy to determine what had changed. There was a separate Health and Safety Manual, which was made clear in the Policy Manual. The Policy Manual required key policies be available on the website including Your Rights and Responsibilities, Privacy and Confidentiality, Feedback, Complements and Complaints, and Client Charter. The Policy Manual required annual review. Documents reviewed showed clear versioning and examples of updates. Policies and procedures had been mapped to the standards V1 11/8 (not a year); this did not include the new emergency standard, however a self-assessment had been completed to the new standards. Feedback from stage 1 had been embedded by stage 2.

The Medication Management Policy clearly indicated this was not in scope. Behaviour Support stated only disability service providers that had the approval of the Secretary, Department of Health and Human Services could use restrictive interventions. The NDIS Module 2a requirements were not as clear, i.e., registered provider could be interpreted as NDIS registered, however the Policy did state the provider did not offer behaviour support. DHHS was not the current department name.

The Governance Policy and Procedure required systems for compliance and quality service provision, including internal audits undertaken.

The Compliance Policy and Procedure committed to a quality management system underpinned by compliance, with management responsibility and staff engagement. The CEO/ delegate was responsible for monitoring compliance requirements through legislative updates, NDS membership, government engagement, internal review and external audit. Triennial external audit and annual internal review were identified; surveillance/ mid-term audits were not mentioned.

Audit expectations were built into policies:

- The Records and Information Management Policy and Procedure included file audits.
- The Privacy and Confidentiality Policy and Procedure required privacy audits.
- The HR Policy and Procedure committed to staff file audits.
- The Physical Accessibility Policy and Procedure required an annual accessibility audit.

The Continuous Improvement Policy and Procedure committed to quality, innovation and continuous improvement with an integrated, evidence-based approach. It required:

- staff induction covering the responsibility to identify opportunities for improvement
- a standing item for quality on the agenda of executive and quarterly team meetings (including feedback)
- audits in accordance with the Internal review and External Audit Schedule
- use of the Continuous Improvement Register tracking improvements from feedback (including annual surveys), planning, incidents, internal review, and external audit.

Other policies also stipulated use of the Continuous Improvement Register to document change.

The NDIS Continuous Improvement Register 2022 showed 20 items completed this year. It documented th e action, responsibility, and timeline, with some notes. It was not always clear what the action was, e.g., 'Participant Handbook'. There was a comparable register for the RTO and governance. There was a tab for Internal Review and External Audit Schedule 2022. Actions included:

- Biannual Planning Workshop
- Business Plan
- Financial review

- Privacy audit
- Training calendar
- Satisfaction survey
- External audit.

Date completed column was not used but noted indicated actions were undertaken.

Internal audit records included:

- a Core Module review 3/3/2022 V1 by RK Audit et al showed what was reviewed and follow-up on previous opportunities for improvement
- documents missing from HR files (undated)
- privacy audit 8/2022 showing all bar one Media and Personal Information Form updated in the last 12 months.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in policy input.

Staff interviewed stated induction covered compliance, and that quality documents were readily available.

Meeting minutes, Internal review and External Audit Schedule, internal audit records, and Continuous Improvement Register and to be reviewed at stage 2.

Opportunities for improvement	N/A
Non- conformity	N/A

2.4 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** Conformity
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.	Conformity
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.	Conformity
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.	Conformity
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.	Conformity
EVIDENCE: The Privacy and Confidentiality Policy and Procedure:	

- recognised the importance of privacy, consent and compliance
- defined personal, sensitive and health information
- expected participants (or representative where applicable) be informed of why information was being collected and how it would be protected, used, disclosed, accessed, changed and disposed of through access to the easy read Privacy Information Flyer with full policy available on request (exclusions to consent were specified but not in the points participants were to be informed of)
- stated staff were to explain the above
- required informed participant/ representative consent for collection, use and storage of information, including audio visual images
- required notification in event of a breach
- was written with reference to applicable legislation including the Vic Health Records Act.

The Records and Information Management Policy and Procedure:

- required secure record storage, back-up and retention in line with DHHS Record Retention Guide for Organisations Funded Under the Service Agreement or any longer legislated timeframe
- set parameters for use such as passwords and permission to take information off premises
- included file audits
- was written with reference to the Commonwealth and State privacy legislation.

The Policy Manual required key policies be available on the website including Privacy and Confidentiality.

The Staff Code of Conduct included privacy and use of ICT.

The Participant Handbook V12 15/2/2022 provided information on privacy, access, consent, and exclusions, as well as the Client Charter V7 21/1/2021 that promised privacy, confidentiality and consent.

Protecting Your Privacy V5 19/7/2022 covered consent forms, use of information, exclusion to consent, information access and correction, data breach, as well as compliance generally.

The Personal Information Release Permission Form V3 21/1/2021 was available to document blanket consent to share information to plan, provide and maintain services. There was a separate Feedback to Auditors Consent Form V4 19/7/2022 covering permission for interview.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in privacy and consent.

Information was stored online.

All files reviewed included the Permission form, Consent to speak with Auditor and Rights and Responsibilities acknowledgement form signed within the last twelve months. It was noted that the organisation encouraged participants rather than their representatives to review, understand and sign the forms and they are resigned each year to ensure that the information remained current.

All participants and family member interviewed confirmed that they were happy with how their information was managed. Specialist Support Coordination and School Leavers all confirmed that when staff contacted and communicated with other parties it was with their consent.

Staff interviewed were conscious of information privacy and record keeping.

Opportunities for improvement	• Some of the participant consent information could be clearer, e.g., Across the participant privacy information there was limited information on storage, and

	consent to audit was separate, limited to interview so did not identify the process entailed file review, as well as review of complaints and incidents. • The HIN number was visible on some staff vaccination records, noting the provider primarily relied on the summary record of what was sighted in the RAR register.
Non- conformity	N/A

2.5 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** Conformity
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.	Conformity
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.	Conformity
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.	Conformity
All workers are aware of, trained in, and comply with the required procedures in relation to complaints handling.	Conformity

EVIDENCE:

The Feedback, Compliments and Complaints Policy and Procedure:

- was written with reference to NDIS related rules for complaints management and procedural fairness
- committed to a positive complaints culture and continuous improvement based on feedback
- required accessible information for participants such as the Feedback Compliments and Complaints Flyer, Charter and Handbook
- outlined the process for feedback
- detailed the steps for complaints resolution including receive, record, acknowledge, resolve and communicate
- encouraged advocate access with reference to NDAP but not related contacts
- included escalation triggers to the incident system for abuse or criminal activity
- stated participants could complain to the NDIA or NDIS with their contact details
- required monitoring of the Feedback Register for trends.

Compliments and Complaints V4 15/2/2022 outlined the process for participants.

The Physical Accessibility Policy and Procedure required participants be informed of feedback processes and use of advocates as required.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including making complaints and access to advocates.

The HR Policy and Procedure committed to providing induction to compliance requirements including complaints management.

The Policy Manual required key policies be available on the website including Feedback, Compliments and Complaints.

The Decision-Making and Choice Policy and Procedure stated surveys were to assess participant and stakeholder with the complaints process.

The Participant Handbook V12 15/2/2022 provided information on rights and responsibilities, the Client Charter, compliments, complaints and suggestions. The Client Charter V7 21/1/2021 promised learning from feedback, with the right to complaint to the Commission of have the support of an advocate. Your Right to Advocacy V34 19/7/2022 also provided related information and contacts.

The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 rights and responsibilities included information on how to make a complaint and response to feedback, as well as engaging an advocate. There was information on what to do if there was a problem, with internal and Commission contacts.

Staff induction presentation V2 covered training in complaints management, with NDIS Complaints Management Staff Training V5 15/2/2022 detailing the requirements. A quiz was included.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in complaints management and advocates.

The Annual Satisfaction Survey Report 2021-2022 28/9/2022 included feedback from the Register in addition to survey comments. There was one complaint where a participant was left waiting for a taxi with site manager (non-Catalyst staff) that showed appropriate follow up.

For the whole organisation there were full Feedback Registers 2021 V2 and 2022 V1 that showed item and resolution for:

- seven compliments and three complaints in 2021
- two compliments and two complaints in 2022

The Register of Staff and RAR Register V3 showed all staff had completed complaints training. This was supported by the Employee Handbook V5.

All participants and family members interviewed confirmed that they received the Catalyst Information pack on intake and that they were informed of the complaints process.

Participants and family members interviewed had not made complaints to Catalyst, but they confirmed that they would feel comfortable contacting them if they had any issues or concerns.

Staff interviewed stated complaints management was covered at induction and they could detail the process, but had not had to respond to any specific complaints.

Opportunities for improvement	N/A
Non- conformity	N/A

2.6 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** Conformity
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.	Conformity
Each participant is provided with information on incident management, including how incidents involving the participant have been managed.	Conformity
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.	Conformity
All workers are aware of, trained in, and comply with the required procedures in relation to incident management	Conformity

EVIDENCE:

The NDIS Incident Management Policy and Procedure was written with reference to the NDIS incident related rules:

- It defined key terms and requirements, including NDIS reportable incidents and timeframes.
- The steps for response, reporting, investigation, review for continuous improvement and records were outlined.
- There were prompts for identification of incidents, including signs of abuse or misconduct.
- It talked about notifying other bodies and identified police, but any cross over with reporting incidents to OAIC or WorkSafe was not readily observed.
- Staff training was required.

The HR Policy and Procedure committed to providing induction to compliance requirements including incident management.

The H&S Manual V12 covered 30/8/2022 covered incident management and the H&S Handbook V10 30/8/2022 covered incident reporting.

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including incident reporting.

Staff induction presentation V2 covered training in incident reporting, with NDIS Participant incident Management Staff Training V4 18/2/2022 detailing the requirements and requiring staff sign-off. This was supported by the Employee Handbook V5.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in incident management.

The Register of Staff and RAR Register V3 showed all staff had completed incident training.

Staff interviewed stated incident management was covered at induction and they could detail the process, but had not had to respond to any specific incidents.

The Incident Register showed 11 non-reportable incidents had occurred across programs since 2020, with appropriate responses detailed, e.g., 28/2/2022 inappropriate behaviour and 25/1/2022 broken chair. Supporting Incident Reports were available. All participants and family members interviewed confirmed that they received the Catalyst Information pack on intake and that they were informed of the incident reporting process. None of the files reviewed included any recorded incidents.	
Opportunities for improvement	N/A
Non- conformity	N/A

2.7 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** Conformity
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.	Conformity
Conformity	Conformity
An orientation and induction process is in place that is completed by workers including completion of the mandatory NDIS worker orientation program.	Conformity
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 NDIS Practice Standards and other National Disability Insurance Scheme rules.	Conformity
Timely supervision, support and resources are available to workers relevant to the scope and complexity of supports delivered.	Conformity
The performance of workers is managed, developed and documented, including through providing feedback and development opportunities.	Conformity
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.	Conformity
Plans are in place to identify, source and induct a workforce in the event that workforce disruptions occur in an emergency or disaster.	Conformity
Infection prevention and control training, including refresher training, is undertaken by all workers involved in providing supports to participants.	Conformity
For each worker, the following details are recorded and kept up to date: (a) their contact details; (b) details of their secondary employment (if any).	Conformity

EVIDENCE:

The HR Policy and Procedure was written with reference to the Fair Work Act and NDIS Worker Screening Rules. It committed to:

- a diverse workforce of size and qualifications to meet compliance requirements
- recruitment in line with role requirements (with reference to the Guide to Suitability, noting while NDIS Commission had developed verification guidance there was not a certification equivalent to address covered by the NDIA's Guide)
- position descriptions detailing minimum requirements
- screening through police and WWC checks (international police checks if the applicant had lived overseas for a year in the last ten)
- NDIS Screening for risk assessed roles (with transition requirements detailed)
- checking qualifications and professional registration
- only offering student placements to adults
- providing induction to the organisation and compliance requirements including infection control as well as the NDIS Orientation module
- seeking staff feedback on induction
- providing ongoing training in line with the annual Training and Development Calendar including four professional development workshops
- supervision and annual review
- maintaining staff records.

The Policy was supported by the Employee Handbook and Code of Conduct. The record keeping requirements for risk assessed roles were partly identified. 100 points of ID/ right to work or secondary employment were not specified. Although participant vaccination requirements were documented in other policies, the staff equivalent was not documented in the Policy Manual.

The Volunteer Policy and Procedure complemented the HR Policy. A written application was required, followed by a Volunteer Agreement confirming role and induction to related requirements. Support and supervision were provided. There was one volunteer in a non-RAR with no client contact.

The Staff Code of Conduct V7 26/9/2022 established expectations, building on the NDIS Code of Conduct.

Position descriptions articulated requirements (including RAR), responsibilities, and reporting. These were observed for:

- Coordinator Catalyst Employment Outcomes (CEO) V5 14/7/2022
- CEO Facilitator V6 15/3/2022
- CEO Support and Work Placement Officer V1 11/1/2022
- Chief Executive Officer V2 8/2022
- Quality and Compliance Manager dated 8/2022 V3 8/2022 and V4 27/9/2022 within the one document (noting DropBox was affecting some document footers)
- Student Trainer and Administration Manager V2 26/11/2021
- Support Coordinator NDIS V2 4/2/2021

The H&S Manual V12 covered 30/8/2022 covered infection control.

Other supporting documents included the:

- Disputes and Grievances Policy and Procedure
- Equity, Anti-Discrimination and Workplace Harassment Policy and Procedure.

Staff induction presentation V2 covered mission, vision, values, the team, policies, safety and compliance, risk assessed roles and positions, NDIS screening, NDIS Code of Conduct and NDIS Worker induction.

The Employee Handbook V5 covered service and IR information, including induction, probation, policies and procedures (with prompt to know NDIS, complaints, incident, COVID and emergency procedures), Code of Conduct, social media, and vehicle use. The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in position description, checks, HR information and NDIS Worker Orientation Module; it did not pick up on infection control. The Register of Staff and RAR Register V3 identified RARs and related record-keeping requirements, as well as key training, policies provided and COVID vaccination. RAR Register documented person, role, commencement, qualifications, evidence on file, NDIS clearance (requiring DOB for linking), mandatory training (NDIS Worker Induction not orientation certificate, complaints and incident training), driver's license number, induction, policy access, and COVID vaccination (given as sighted and date, but not always clear what was sighted or whether booster was observed). There was a sub-page that showed RARs, category (key personnel, direct or indirect support – not specified supports), assessor, assessor's role and date. RARs were categorised as key personnel, direct or indirect contact, provision of specified services were implied through the direct support category but not specifically stated. The Quality Officer (commenced week of audit) had not yet been added to the list of roles for risk assessment. RAR Register was updated during audit to provide clearer record of what ID information was sighted to meet Migration Act and NDIS 100 points of ID, as well as COVID vaccination information sighted so booster was more evident. While it was clear who was in a RAR, dual roles or newer were not as clear, and who was providing specified services as per the definition was implied but not stated. Staff interviewed consistently described the application, interview, screening, induction, supervision and training approach, with review for staff who had been with the organisation for more than a year. Staff files covered key areas, with supervision records not always filed; refer staff table earlier in this report for sampling records. Many of the staff files sampled were new staff who had been with the organisation for less than a year; other examples of performance reviews were observed, e.g., ED 2/10/2019 and JB 15/10/2020.

Opportunities for improvement	• Staff files were organised, but did not always follow the allocated folder system. Some relevant information was not always retained or recorded as sighted, e.g., DW Social Work certificate. • Some of the newer staff had not added infection control records to file.
Non- conformity	N/A

2.8 Continuity of Supports Outcome: Each participant has access to timely and appropriate support without interruption.	**Rating** Conformity
Day-to-day operations are managed in an efficient and effective way to avoid disruption and ensure continuity of supports.	Conformity
In the event of worker absence or vacancy, a suitably qualified and/or experienced person performs the role.	Conformity
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.	Conformity

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.	Conformity
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.	Conformity

EVIDENCE:

The Service Delivery Policy and Procedure required structures in place to cover staff leave.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including consultation on needs and preferences.

The Risk Management Policy and Procedure required a Business Continuity Pandemic Plan, covered in the emergency section of this report.

The NDIS Risk Management Plan 2022 covered continuity of support.

The Quote for the Delivery of SLES 2023 V2 noted if COVID restrictions were in place, remote learning would be offered.

Other supporting documents included:

- Delegations Schedule V9 11/8/2022
- IEP V3 11/8/2022
- CEO Service Agreement V9 29/8/2022
- Goal Achievement Plan V4 11/8/2022

Staff interviewed indicated their roles were covered in absence, or for training assistants the trainer may run the group in their absence.

The Pandemic Business Continuity Plan COVID-19 (Coronavirus) V41 section titled Business Continuity Plan was more a statement of safety in line with government directives; it did not detail contingency planning or testing as such, but took a risks and mitigations approach. The strategy for the risk of staff not being available was around infection control, which did not address the element of staff absence.

Session plans and support coordination notes were written to ensure continuity if facilitator/ support coordinator absent.

Participants and family members interviewed confirmed that although services have been running without disruption this year after remote services run during lockdowns.

It was noted that with disruptions and lockdowns, services were able to be run remotely and alternative arrangements did not need to be made.

Opportunities for improvement	N/A
Non- conformity	N/A

2.9 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, and ensures the continuity of supports critical to the health, safety and wellbeing of participants in an emergency or disaster.	**Rating**
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.	Conformity
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.	Conformity
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.	Conformity
The plans explain and guide how the governing body will respond to, and oversee the response to, an emergency or disaster.	Conformity
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.	Conformity
The plans have periodic review points to enable the governing body to respond to the changing nature of an emergency or disaster.	Conformity
The governing body regularly reviews the plans, and consults with participants and their support networks about the reviews of the plans.	Conformity
The governing body communicates the plans to workers, participants and their support networks.	Conformity
Each worker is trained in the implementation of the plans.	Conformity

EVIDENCE:

The Risk Management Policy and Procedure required a Business Continuity Pandemic Plan, and an Emergency Management Plan. These were to cover things such as safe service delivery, fire safety, building security, equipment maintenance, and disaster recovery. It talked about working with people, but communication and consultation were not as clear.

The HR Policy and Procedure committed to providing induction to compliance requirements including emergency management.

The Emergency Management Plan V10 26/9/2022 provided a framework including head office evacuation plan, emergency roles and contacts, what to do in an emergency (with scenarios for fire, medical emergency, external threat, bomb/ chemical threat, personal threat, training, testing (evacuation only) and review.

The Pandemic Business Continuity Plan COVID-19 (Coronavirus) V41 provided information on the pandemic, COVID, prevention measures and critical business activities, COVID contacts, communication plan and incident management. The section titled Business Continuity Plan was more a statement of safety in line with government directives; it did not detail contingency planning or testing as such, but took a risks and mitigations approach. The strategy for the risk of staff not being available was around infection control, which did not address the element of staff absence. WorkSafe reporting was still included, although the requirement for this ceased 14/1/2022.

The H&S Manual V12 covered 30/8/2022 covered emergency procedures and COVID-19. Annual evacuation exercises were required. The H&S Handbook V10 30/8/2022 covered similar topics, including emergency management. Emergency management was also covered in the Employee Handbook V5.

The Risk Management Plan 2022 V10 considered COVID-related risks.

The External Site WHS Checklist was to be used to check individual site and workplace site safety, including emergency features and information. Records were observed for Frankston 4/2/2022.

Evacuation information was displayed appropriately at Frankston. At head office this was within the WHS manual, rectified during audit.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in risk and safety, but did not specifically identify emergency or COVID requirements.

There were a range of emails to support communication/ training re the COVID plan, emergency management and WHS, e.g.:

- Email to admin staff 28/2/2022 with COVID Plan V39 and RAT information, noting this was to be distributed to trainers given the change to mask requirements
- Email to staff 15/2/2022 with V38
- Email to staff 7/1/2022 with V37 and first update for the year
- Email to staff 27/10/2021 with V36
- Email 25/9/2022 to staff with NDIS Policies and Procedure Manual V17
- Email 21/9/2022 to staff with revised H&S Manual V12 and WHS Handbook V10 welcoming feedback.

Records were stronger in communication rather than consultation with staff, and lighter again for participant communication and consultation regarding emergency planning, including COVID response, however interviews indicated this occurred, and evidence was considered proportional to a SLES and support coordination service.

Staff interviewed were aware of the COVID requirements, and consistently talked to ongoing communication around the requirements.

Sight tours showed sanitiser was available. Site tour at Frankston showed COVID safety information displayed, with room capacity reported to having changed over time in line with restrictions. Head office had a sign in system. Head office had the WHS Manual displayed. First aid kits at head office and Frankston had been recently checked.

Fire systems at Frankston showed regular checks, and the school leaver conducting the tour talked to these and the multiple evacuations. The fire extinguisher at head office was last tested in 2021. Staff noted they had recently been contacted by the testing company, who had realized the oversight and followed up. Generally, no participants attended head office.

Opportunities for improvement	N/A
Non- conformity	N/A

Core Module 3. Provision of Supports

These NDIS Practice Standards set out the responsibilities for NDIS Providers when providing supports to participants.

3.1 Access to supports Outcome: Each participant accesses the most appropriate supports that meet their needs, goals and preferences.	**Rating** Conformity
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.	Conformity
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.	Conformity
Each participant is supported to understand under what circumstances supports can be withdrawn. Access to supports required by the participant will not be withdrawn or denied solely on the basis of a dignity of risk choice that has been made by the participant.	Conformity

EVIDENCE:

The Service Access Policy and Procedure committed to safe, engaging, accessible services:

- Waiting lists and priorities were to be fair, noting there was no waiting list.
- The opening hours and days were detailed.
- Participants were to be provided with an Information Pack covering entry, exit, eligibility, priority, conditions and costs. Information was to be in accessible formats relative to client and demographic needs.
- Where required or requested, participants were to be provided with information and support to access a person of their choice, such as an advocate, to assist them to access the service.
- The service access process was outlined, including steps to remove any barriers to access.
- Reasons for service refusal were articulated, as well as the process for explaining this.
- Management was to review the entry and referral process at meetings, as well as track demand.

The Physical Accessibility Policy and Procedure focused on access more broadly. It required:

- website, signage and participant information to be in a range of formats including easy read, or use of interpreters and advocates as required
- resources to accommodate participant needs
- site accessibility and safety including eating/ drinking facilities, toilets and property storage.

The Participant Charter set out rights including information about services, costs and conditions.

The Assessment Planning and Review Policy and Procedure stated barriers to access would be reviewed.

The Decision-Making and Choice Policy and Procedure stated where the provider was unable to meet the person's needs or goals a relevant referral would be made.

The Exit and Transition Planning Policy and Procedure outlined the steps for where either the participant or the provider were initiating exit. For provider-initiated exit this was to be explained to the participant, with feedback sought for continuous improvement. Reasons for exit were articulated.

The Participant Handbook V12 15/2/2022 provided information on the organisation and services, as well as the Client Charter V7 21/1/2021 that promised fair services, with supports in accessible locations.

The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 detailed service information and written reasons for service withdrawal, with examples given.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in service information, service access including referrals, eligibility, priority, refusal, and reasonable adjustments. The website included service and contact information. All Participants and family members interviewed confirmed that they received the Participant Information Pack on intake and that the information had been explained and made clear. All files reviewed included signed Permission form, Consent to speak with Auditor and Rights and Responsibilities acknowledgement form. The School Leavers files included Employment Support Plans which identified the participants preferences for employment and areas that the participant may need to focus to support employment such as work skills, reading, writing and money handling.	
Opportunities for improvement	N/A
Non- conformity	N/A

3.2 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** Conformity
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.	Conformity
In collaboration with each participant: (a) risk assessments are regularly undertaken, and documented in their support plans; and (b) appropriate strategies are planned and implemented to treat known risks to them. 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.	Conformity
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.	Conformity
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.	Conformity
Where progress is different from expected outcomes and goals, work is done with the participant to change and update the support plan.	Conformity

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.	Conformity
Each participant's support plan is communicated, where appropriate and with their consent, to their support network, other providers and relevant government agencies.	Conformity
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.	Conformity
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.	Conformity

EVIDENCE:

The Assessment Planning and Review Policy and Procedure described a holistic, partnership, strengths-based, capacity building approach to assessment, planning and review with participants and stakeholders. The process was to identify goals, needs, and preferences. This was to be formalised in the service agreement, with requirements for these detailed. It talked about providing the person a copy of the agreement, explaining it, and maintaining a copy; it did not talk about documenting where a person did not get a copy. Barriers to access would be reviewed. Review requirements were articulated, including the annual or as agreed timeframe, with a stronger focus on goals than risk, or emergency planning in the context of the new standards.

The Service Delivery Policy and Procedure committed to supporting person-centred participation, informed decision making and independence. This was to be supported by holistic, collaborative, strengths-based assessment, planning and review.

The Risk Management Policy and Procedure required use of Individual Risk Assessments for participants.

Provider offered services with an employment focus, with the exception of a small support coordination cohort. They were not responsible for health or emergency support as such.

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including participant emergency contacts and response.

Individual Employment Plans (IEPs) were available to document SLES goals, details and responsibility, with participant and CEO sign off.

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including participant medical information and emergency contacts, and employer feedback. It identified if there were any medication, health, disability or allergy matters the employer should be aware of.

The Goal Achievement Plan V4 11/8/2022 was available to document NDIS goals, support coordination work towards this, progress, outcomes and responsibility. It included fields for risks and mitigations, as well as prompts to consider cultural and religious context, or any advocacy required.

There was a Job Vacancy Checklist available to document why the participant was applying for a role and related matching information. It was not versioned.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in risk identification, choice and control, information in easy read or alternative format, support networks, consent, service planning and review. Staff interviewed indicated they worked to each participant's plan, with consideration for any risks, noting most SLES participants had a level of independence relative to job-seekers. Participants and families interviewed confirmed that they were involved in decision making about services and employment goals. The Specialist Support Coordination participant sampled had detailed information in file notes about required services and actions being taken. School Leavers participant files sampled included Employment Support Plans detailing goals and actions being taken and the Session Plans include specific actions and work being completed with individuals to assist them in meeting their employment goals. School Leavers files sampled were all involved in work placements and files included External Site Work Health and Safety Checklists completed to check for site risk such as those associated with fire safety systems, housekeeping, electrical, slips and trips, manual handling, amenities and first aid.	
Opportunities for improvement	N/A
Non- conformity	N/A

3.3 Service Agreements with Participants Outcome: Each participant has a clear understanding of the supports they have chosen and how they will be provided.	**Rating** Conformity
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.	Conformity
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.	Conformity
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.	Conformity
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; 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; and	N/A

e) How behaviours of concern which may put tenancies at risk will be managed, if this is a relevant issue for the participant.	
Service agreements set out the arrangements for providing supports to be put in place in the event of an emergency or disaster.	Conformity

EVIDENCE:

The Assessment Planning and Review Policy and Procedure was to be formalised in the service agreement, with requirements for these detailed. It talked about providing the person a copy of the agreement, explaining it, and maintaining a copy; it did not talk about documenting where a person did not get a copy. Provider always had a signed agreement with one copy retained by the provider, and the other fully signed copy returned to the participant or their representative.

The Model Support Coordination Rules outlined the steps for establishing a service agreement with strengths and goals. It detailed record-keeping requirements, and billing in five-minute blocks.

The Service Agreement CEO easy read V9 28/8/2022 and Service Agreement Support Coordination easy read V8 28/8/2022 detailed rights and responsibilities, and compliance with relevant legislation (e.g., NDIS, Disability, Guardianship and Administration Acts as well as Consumer Law), payment options, changes to the agreement, ending the agreement, what to do if there was a problem, with internal and Commission contacts. The Agreement was to include individual contacts and activity information, with annual review. It included a checklist to indicate people understood this. While the Agreement was saved as easy read and included pictures, it was written at a grade 10.3 level. The Service Agreement was available in full format V10 27/9/2022.

The Quote for the Delivery of SLES 2023 V2 detailed supports that would be provided in the first year. (JB title was Operations Manager, not the current title.)

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including placement details, induction and identification of risk, safety and supervision, placement support officer, freedom from harassment and discrimination, incident reporting, participant emergency contacts and insurance coverage, as well as employer feedback. It was written with reference to Cert I and II, not SLES.

All School Leaver files reviewed included Service Agreements signed within the last twelve months. The organisation noted that the Service Agreements are reviewed and updated annually along with the consent forms.

The Specialist Support Coordination client file reviewed included a Service Agreement signed 2/08/2021 valid from 31/07/2021 to 31/07/2022. It was noted though that the participants NDIS Plan was rolled over and the organisation was in the process of appealing to the NDIS to have the NDIS Plan reviewed and updated. The example of meeting held 1.09.2022 was reviewed, with the LAC the Support Coordinator and NDIS representatives in attendance.

Opportunities for improvement	N/A
Non- conformity	N/A

3.4 Responsive Support Provision Outcome: Each participant accesses responsive, timely, competent and appropriate supports to meet their needs, desired outcomes and goals.	**Rating** Conformity
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.	Conformity
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.	Conformity
Reasonable efforts are made to involve the participant in selecting their workers, including the preferred gender of workers providing personal care supports.	Conformity
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.	Conformity

EVIDENCE:

The Assessment Planning and Review Policy and Procedure described a holistic, partnership approach to service provision, based on individual needs and preferences.

The Service Delivery Policy and Procedure committed to supporting person-centred participation, informed decision making and independence.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including consultation on needs and preferences, as well as qualified staff.

Staff interviewed gave examples of individual responsive support, such as finding a screen-writing mentor for a participant who aspired to be a screen-writer, as well as least restrictive options, such as travel training with the outcome of independent travel.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in specific training to individual participant needs (e.g., epilepsy).

Daily support was not provided.

The Specialist Support Coordination participant file included detailed Activity Logs with notes maintained against goals and time taken for each activity. The logs included individuals contacted and actions taken, and the participant interviewed confirmed that he was always consenting to contact being made on his behalf.

The Specialist Support Coordination Participant interviewed confirmed that he was very happy with the service, and he confirmed that his preferences and goals were the focus and that the information being provided by the Specialist Support Coordinator was clear.

The Catalyst Employment Outcomes Session Plans, created for each training session with the School Leaver participants includes detailed information such as the current work placements, goals of each participant and a breakdown of the activities during the day for each participant such as training, completion of activities, work site visits and placements. The examples of the Frankston Plan for session 28 held 12/08/2022 and the Preston Plan for session 34 held 28/09/2022 were reviewed.

The four School Leaver Participant files reviewed included Practical Placement Agreements with their employers and External Site Work Health and Safety Checklist completed prior to the placement to check that the workplaces were appropriate and safe. Records reviewed included agreements and checklists completed

for AP dated 30/03/2022 and 23/03/2022, JG dated 18/03/2022 and 18/03/2022, DI dated 20/07/2022 and 20/07/2022 and T dated 18/03/2022 and 18/03/2022. Staff interviewed talked confidently to responsive, evidence-based service provision. One gave the example of an individual outcome with positive participant response 'This was the best day of my life. I owe you my life. I'm so grateful.	
Opportunities for improvement	N/A
Non- conformity	N/A

3.5 Transitions to or from the provider Outcome: Each participant experiences a planned and coordinated transition to or from the provider.	**Rating** Conformity
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.	Conformity
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.	Conformity
Processes for transitioning to or from the provider (including temporary transitions referred to in subsection (2)) are developed, applied, reviewed and communicated.	Conformity

EVIDENCE:

The Exit and Transition Planning Policy and Procedure outlined the steps for where either the participant or the provider were initiating exit. This included transition planning with consent. The focus was on exit, temporary transition or risk were not as clearly articulated.

Examples of planning for transition to employment were observed including:

- DM IEP 5/6/2022
- CF Transition to Employment Plan 6/7/2022.

It was noted as NDIS audits do not require exited participant sampling SLES participants who had successfully transitioned to audit would not be picked up in participant sampling.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in transition and risk.

The SLES program had a focus on transition, supporting school leavers to transition to employment. Staff interviewed talked to preparing people for transition to employment.

The Specialist Support Coordination participant interviewed confirmed that he was involved in the evaluation of his situation, and he confirmed that his preferences and goals were the focus and that the information being provided by the Specialist Support Coordinator was clear.

Detailed Activity Logs were reviewed in the file with notes maintained against goals and time taken for each activity. The logs included individuals contacted and actions taken and the participant interviewed confirmed that he was always consenting to contact being made on his behalf.

The Support Coordinator interviewed was aware of the participants needs and risks associated with services. She was aware of the current circumstances of the participant and risks relevant to him in association to the services he had and will be engaging with.	
Opportunities for improvement	N/A
Non- conformity	N/A

Core Module 4. Support Provision Environment

These NDIS Practice Standards set out the environment in which supports are provided to participants.

4.1 Safe environment Outcome: Each participant accesses supports in a safe environment that is appropriate to their needs.	**Rating** Conformity
Each participant can easily identify workers who provide supports to them.	Conformity
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.	Conformity
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.	Conformity
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.	Conformity
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).	Conformity
Systems for escalation are established for each participant in urgent health situations.	Conformity
Infection prevention and control standard precautions are implemented throughout all settings in which supports are provided to participants.	Conformity
Routine environmental cleaning is conducted of settings in which supports are provided to participants (other than in their homes), particularly of frequently-touched surfaces.	Conformity
Each worker is trained, and has refresher training, in infection prevention and control standard precautions including hand hygiene practices, respiratory hygiene and cough etiquette.	Conformity
Each worker who provides supports directly to participants is trained, and has refresher training, in the use of PPE.	Conformity
PPE is available to each worker, and each participant, who requires it.	Conformity

EVIDENCE:

The Service Access Policy and Procedure stated the service environment was to be kept clean, hygienic, safe, secure and aesthetically pleasing at all times.

The Physical Accessibility Policy and Procedure required site safety including eating/ drinking facilities and toilets, with an annual accessibility audit.

The Participant Charter set out rights including safe services.

The HR Policy and Procedure committed to providing induction including infection control.

The H&S Manual V12 covered 30/8/2022 covered training (including infection control, and emergency procedures for wardens), consultation, risk management, incident management, emergency procedures, first aid, infection control, COVID-19, PPE, inspection, issue resolution, manual handling, chemicals, vehicles, site safety (office, home and community), robbery and events. The H&S Handbook V10 30/8/2022 covered similar topics, including risk management, incident reporting and emergency management.

The Client Charter V7 21/1/2021 promised supports in safe locations.

The Staff Orientation and Induction Checklist V1 9/6/2022 was available to document training in safe environment and risk.

The Practical Placement Agreement V11 5/8/2022 set out the responsibilities of learners, staff/ contractors and employers, including induction and identification of risk, safety and supervision, as well as if there were any medication, health, disability or allergy matters the employer should be aware of.

The External Site WHS Checklist was to be used to check individual site and workplace site safety, including emergency features and information. Records were observed for Frankston 4/2/2022.

Staff interviewed were conscious of safety and gave examples of COVID safety and infection control precautions. They stated PPE was available.

The file for the Specialist Support Coordination participant reviewed, BM had a Home Assessment completed 27/07/2020. The Specialist Support Coordinator confirmed that she had followed up on actions raised and that there had been no change to the house, but it was noted that the organisations processes dictate that the assessment is to be completed annually.

The four School Leaver Participant files reviewed included External Site Work Health and Safety Checklist completed prior to the placement. The checks include a review of basic safety such as fire safety systems, housekeeping, electrical, slips and trips, manual handling, amenities and first aid. Records included checklists completed for AP dated 23/03/2022, JG dated 18/03/2022, DI dated 20/07/2022 and T dated 18/03/2022 and it was noted that the External Site Work Health and Safety Checklists were completed on or just before the date of the Practical Placement Agreements being signed with the employer.

Head office and Frankston showed current tag and testing. Site tours showed emergency safety systems in place; refer opportunities for improvement in risk and emergency sections of this report.

Site tour of Frankston showed a commercial kitchen with related safety measures in place. The school leaver conducting the tour was aware of the infection control, handwash and cleaning measures on site, as well as in their workplace.

Opportunities for improvement	• The Specialist Support Coordination Participant reviewed had a Home Assessment completed 27/07/2020 which had not been formally reviewed since. • Provider's systems and records for staff driving organisational vehicles were stronger than those for staff driving their own vehicles, given there was sometimes a need to

	drive participants to work placements. (It was noted the provider was not registered for assist travel transport and email 5/10/2022 to HR helpdesk showed follow up on related policy requirements.)
Non- conformity	N/A

4.2 Participant Money and Property Outcome: Participant money and property is secure, and each participant uses their own money and property as they determine.	**Rating** Conformity
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.	Conformity
If required, each participant is supported to access and spend their own money as the participant determines.	Conformity
Participants are not given financial advice or information other than that which would reasonably be required under the participant's plan.	Conformity

EVIDENCE:

Provider did not manage participant money or property, and did not offer financial advice. This was supported by staff interviews, and service information was clear for participants.

The Physical Accessibility Policy and Procedure required site safety including facilities for personal property storage.

Site tour at Frankston discussion indicated the rom was locked if the group went out.

Opportunities for improvement	N/A
Non- conformity	N/A

4.3 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
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
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
All medications are stored safely and securely, can be easily identified and differentiated, and are only accessed by appropriately trained workers.	N/A

EVIDENCE: N/A Provider did not manage medication. This was clearly stated by the Medication Management Policy and Procedure, and was reiterated in staff interviews. Staff noted they had first aid training to respond if required, including if a participant with anaphylaxis had a reaction they could not manage themselves. The Practical Placement Agreement V11 5/8/2022 was available to identify if there were any medication, health, disability or allergy matters the employer should be aware of.	
Opportunities for improvement	N/A
Non- conformity	N/A

4.4 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
Providers identify each participant requiring mealtime management.	N/A
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
With their consent, each participant requiring mealtime management is involved in the assessment and development of their mealtime management plans.	N/A
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
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 proactively managing emerging and chronic health risks related to mealtime difficulties, including how to seek help to manage such risks.	N/A
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
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	N/A

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.	
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
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
EVIDENCE: N/A Provider did not manage or provide mealtime support. This was consistently supported by staff interviews.	
Opportunities for improvement	N/A
Non- conformity	N/A

4.5 Management of Waste Outcome: Each participant, each worker, and any other person in the home is protected from harm as a result of exposure to waste, infectious or hazardous substances generated during the delivery of supports.	**Rating** N/A
Policies, procedures and practices are in place for the safe and appropriate storage, handling and disposal of waste and infectious or hazardous substances (including used PPE), and each policy, procedure and practice complies with current legislation and local health district requirements.	N/A
All incidents involving infectious material, body substances or hazardous substances are reported, recorded, investigated and reviewed.	N/A
An emergency plan is in place to respond to clinical waste or hazardous substance management issues and/or accidents. Where the plan is implemented, its effectiveness is evaluated, and revisions are made if required.	N/A
Each worker involved in the management of waste, or infectious or hazardous substances, is trained in the safe and appropriate handling of the waste or substances, including the use of PPE or any other clothing required when handling the waste or substances.	N/A
EVIDENCE: N/A Provider did not manage waste. Masks were optional under current state restrictions. This was supported by staff interviews, with staff able to describe various means of disposing of PPE in the community if required, as the bin arrangements differed across sites.	

The H&S Manual V12 covered 30/8/2022 covered risk management, incident management, emergency procedures, first aid, infection control, PPE, and chemicals. The H&S Handbook V10 30/8/2022 covered similar topics, including risk management, incident reporting and emergency management.	
Opportunities for improvement	N/A
Non- conformity	N/A

MODULE 4. SPECIALIST SUPPORT CO-ORDINATION

1 Specialised Support Co-ordination Outcome: Each participant receiving specialised support coordination receives tailored support to implement, monitor and review their support plans and reduce the risk and complexity of their situation.	**Rating** Conformity
Demonstrated knowledge and understanding of the risk factors experienced by each participant with high-risk and/or complex needs.	Conformity
Participants are involved in the evaluation of their situation and the identification of the supports required to prevent or respond to a crisis, incident or breakdown of support arrangements, and the promotion of safety for the participant and others.	Conformity
Consultation is undertaken with the participant and, with the participant's consent, the participant's support network and mainstream services (as appropriate) in planning and coordinating supports to implement the participant's plan, and any plan review.	Conformity
In consideration of each participant's individual needs, preferences and circumstances, suitable NDIS providers and mainstream service providers that have the appropriate skills and experience to deliver the required support are identified.	Conformity
There is proactive engagement to ensure that all providers implementing the participant's plan understand and respond to the risk and/or complexity of the participant's situation, and collaborate with other relevant providers, where required.	Conformity
All monitoring and reporting obligations associated with the participant's plan are managed effectively.	Conformity

EVIDENCE:

The Model Support Coordination Rules provided a framework written in for participants:

- Support Coordinators were to assist people to connect with services and track budget, building skills and capacity to self-manage.
- It outlined the steps for establishing a service agreement with strengths and goals; risks were not as clearly articulated.
- Crisis resolution and complex coordination would be provided if needed and funded.
- The end of plan report writing process was described.

It was not a difficult read as such, but included some long sentences (first sentence in COI was 48 words long) and words not overly common, such as undue.

The Assessment Planning and Review Policy and Procedure described a holistic, partnership, strengths-based, capacity building approach to assessment, planning and review with participants and stakeholders.

The Goal Achievement Plan V4 11/8/2022 was available to document NDIS goals, support coordination work towards this, progress, outcomes and responsibility. It included fields for risks and mitigations.

Other supporting documents included:

- Support Coordination Welcome Pack Contents V1 26/9/2022
- Personal Information Release Permission Form V4 20/1/2022
- Feedback to Auditors Consent Form V3 21/1/2021
- My Rights and Responsibilities with Catalyst V3 21/1/2021
- Support Coordination for Participants V1 26/9/2022
- Service Agreement Easy Read Support Coordination V8 27/9/2022
- Service Agreement Template Support Coordination V10 27/9/2022
- NDIS Progress Report e.g., DM and TD (not dated).

Staff file showed a qualification in social work and experience in disability.

The participant interviewed confirmed that he was involved in the evaluation of his situation, that he chose the supports and services that he was being supported to identify and engage with. The participant confirmed that he felt that he had full control over the supports and noted that he and his sister get notified of the use of funds for Specialist Support Coordination

The Support Coordinator interviewed was aware of the participants needs and risks associated with services. She was aware of the current circumstances of the participant and risks relevant to him in association to the services he had and will be engaging with.

The client file reviewed included detailed notes about progress being made toward goals, all contacts with the participant and supports and time for each activity.

Opportunities for improvement	N/A
Non- conformity	N/A

2 Management of a Participant's NDIS Supports Outcome: Each participant exercises meaningful choice and control over their supports and maximises the value for money they receive from their supports.	**Rating** Conformity
Supports and services are arranged using the participant's NDIS amounts as directed by the participant and for the purposes intended by the participant.	Conformity
Each participant has been provided with information about their support options using the language, mode of communication and terms that the participant is most likely to understand.	Conformity
As appropriate, each participant is supported to build their capacity to coordinate, self-direct and manage their supports and to understand how to participate in Agency planning processes such as establishing agreements with service providers and managing budget flexibility.	Conformity

Supports funded under a participant's plan are used effectively and efficiently and are complemented by community and mainstream services to achieve the objectives of the participant's plan.	Conformity

EVIDENCE:

The Model Support Coordination Rules stated Support Coordinators were to assist people to understand funding, how to use funds, connect with services and track budget, building skills and capacity to self-manage.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including having information in an appropriate format, cultural and religious development, privacy and confidentiality, independence and autonomy, life free from abuse, neglect, discrimination and exploitation, consultation on needs, preferences and decisions, making complaints and access to advocates. It was written with reference to UN Conventions, the Disability Act, Charter of Human Rights and NDIS Standards. This was supported by the Participant Charter, Participant Handbook, Information and Welcome Packs, and the Service Agreement.

The Service Delivery Policy and Procedure committed to supporting person-centred participation, and collaborative services.

The Physical Accessibility Policy and Procedure required website, signage and participant information to be in a range of formats including easy read.

The Decision-Making and Choice Policy and Procedure stated surveys would assess participant and stakeholder understanding of rights and support to exercise them.

Other supporting documents included:

- Support Coordination Welcome Pack Contents V1 26/9/2022
- Invoicing Weeks ending 10 and 17/6/2022, 22 and 29/7/2022, and 5 and 12/8/2022.

The participant interviewed confirmed that he was very happy with the services of the Specialist Support Coordinator. He confirmed that his preferences and goals were the focus and that the information being provided by the Specialist Support Coordinator was clear.

Detailed Activity Logs were reviewed in the file with notes maintained against goals and time taken for each activity. The logs included individuals contacted and actions taken and the participant interviewed confirmed that he was always consenting to contact being made on his behalf.

The participant and his sister interviewed were able to monitor his funds and plan via the NDIS portal and they confirmed that they were kept updated with use of the Specialist Support Coordination funds with this monitored carefully when running low at the end of the plan.

Opportunities for improvement	N/A
Non- conformity	N/A

3 Conflict of Interest Outcome: Each participant receives transparent, factual advice about their support options which promotes choice and control.	**Rating** Conformity
Conflict of interest policies are provided or explained to each participant using the language, mode of communication and terms that the participant is most likely to understand.	Conformity

Each participant is supported to understand the distinction between the provision of specialised support coordination and other reasonable and necessary supports funded under a participant's plan using the language, mode of communication and terms that the participant is most likely to understand.	Conformity
If the provider has an interest in any support option available to the participant, the participant is aware of this interest. The participant understands that any choice they made about providers of other supports will not impact on the provision of the specialised support coordination.	Conformity
Referrals to and from other providers are documented for each participant.	Conformity

EVIDENCE:

The Model Support Coordination Rules described the support coordinator role. It included a section on COI.

The Governance Policy and Procedure stated potential/ actual Conflict of Interest (COI) would be managed in line with the model rules for Support Coordination.

The NDIS Participants Rights and Responsibilities Policy and Procedure committed to upholding rights including having information in an appropriate format, as did the Physical Accessibility Policy and Procedure.

The Decision-Making and Choice Policy and Procedure provided a framework for informed choice, with advocacy support if required.

Guarding Against Potential or Real Conflict of Interest V4 19/7/2022 was provided as part of the welcome pack, and stated Catalyst workers would give people three relevant service options, and not refer to the organisation as a matter of course.

Other supporting documents included the Support Coordination Information for Participants V1 26/9/2022.

The participant interviewed confirmed that they are given choice of services being engaged with based on criteria such as location. The participant confirmed that he had choice over the providers being engaged and did not feel that choice would impact on the relationship with the Specialist Support Coordinator.

The organisation is providing only Specialist Support Coordination services to the participant sampled.

File notes maintained included details about service providers contacted, research into providers and referrals to the participant.

Opportunities for improvement	The Service Agreement did not provide information on conflict of interest.
Non- conformity	N/A

RATING SCALE

Auditors are required to assess a service provider's performance against each of the NDIS Practice Standards using the following rating scale.

Rating	Attainment Level	Interpretation
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 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 processes 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 certification*.

Opportunities for Improvement consist of a documented statement, which may identify areas for improvement that can be used by the provider to improve their systems and processes.

Protocol for notifiable issues/critical risk is as follows:
If during an audit SAI Global must:
(a) in the event that a critical risk relating to criminal acts or child protection concerns is identified:
  i. immediately notify the SAI Global Technical Manager, the Commission and any relevant authorities (such as the police) of the risk; and
  ii. cease the audit until the Commission notifies the approved qualified auditor that it may recommence;
(b) in the event that a critical risk not covered by (b) is identified:
  i. immediately notify the SAI Global Technical Manager of the risk; and
  ii. document the critical risk, and mitigations taken to date and then seek sign off by the SAI Global prior to submitting to the Commission using the Commission's system within 24 hours; and
(c) Ensure the NDIS provider receives a written copy of the audit findings at the closing meeting.

Note: The Commission will acknowledge receipt and make recommendations about next steps

Email is: aqaenquiries@ndiscommission.gov.au

Timeframes for closure of non-conformities - Additional Information

If non-conformities are not closed within the required timeframes then the following actions will be taken by SAI Global:

- **For organisations not yet certified** – submit to the NDIS Commission that certification is not recommended. Re-application and re-audit will be required.
- **For certified organisations** – submit notification to the NDIS Commission that the certification is to be suspended until the outstanding issues are resolved (90 day timeframe).

Special conditions regarding the timeframes for closure of non-conformities and/or timing of future audits may also be set by SAI Global or the NDIS Quality & Safeguards Commission.