CALDS
Registered
NDIS
Provider

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NDIS Core Module Policy and Procedures

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DIVISION 1 – RIGHTS AND RESPONSIBILITIES

Participant Charter of Rights Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2022/05	22/09/23	Added duty of care vs dignity of risk		09/2025 or in response to any legislative triggers

POLICY

The CALDS respects and fully commits to upholding the rights of all people, including those with disabilities. CALDS's Participant Charter sets out its participants' rights. It also sets out participant responsibilities and the responsibilities of CALDS in ensuring the rights of all participants and staff are upheld.

The CALDS respects and understands the fine balancing act of ensuring the duty of care is upheld while also respecting the dignity of risk. The duty of care needs to be always upheld; however, the participants should be given the autonomy needed to make their own decisions. It is CALDS's responsibility to mitigate the risks while allowing the participant to freely make their own choices.

An example of this is a person with a physical disability has always wanted to swim, however they were never presented an opportunity. Now in supported independent living environment they have the ability to learn to swim. Duty of care needs to be considered as they cannot swim and this poses a risk, however an ordinary person would have the chance to swim and therefore CALDS should assist in minimising risks to allow the participant to swim. This could include having a 2:1 ratio of staff to participant, having specialised equipment or instructors to assist with swim. If the funding and willingness are there, risk management should be considered to allow the participant to make their own choice.

Another example is a long-term drug and alcohol user can know the risks associated with smoking and still continue to smoke. Staff are being told by the participants medical practitioner that they need to give up smoking to live a longer life. Choice, duty of care, and dignity of risk should all be considered. This may mean that staff present the participant with resources to decrease their smoking and ensure fire safety precautions are in place but still respect the decision of the participant to continue smoking.

PROCEDURES

In supporting participants' rights, CALDS complies with the *United Nations Universal Declaration of Human Rights*, *United Nations Convention on the Rights of Persons with Disabilities, NDIS Act 2013 (Cth)* and *NDIS Practice Standards (2018) - Rights and Responsibilities*.

CALDS will provide all prospective and existing participants with information about their rights by:

- providing them with CALDS's *Participant Handbook and Charter of Rights.*
- *a verbal orientation to the rights and responsibilities of an NDIS Participant; and*
- *accessing advocates, interpreters, translators (including sensory translation services).*

As outlined in CALDS's *Service Access Policy and Procedure*, staff will discuss participants' rights and responsibilities with them during intake and assessment.
To ensure participants understand their rights, staff will provide information in ways that suit their individual communication needs. This includes using the language, mode of communication and terms that the participant is most likely to understand. For example, a welcome package in a choice of Easy Read or Plain English.

Written and verbal information about participant rights will include the advice that this Policy and Procedure can be provided upon request.

Complaints regarding their participant rights will be addressed in accordance with CALDS's *Complaints and Feedback Management Policy and Procedure*.

Responsibilities of staff in relation to participant rights
Upon commencement, all staff will undergo an Induction, which includes training on participant rights. Staff must understand participants' legal and human rights and incorporate them into their everyday practice.

Staff must think about where participants' rights are relevant to their work and the work-related decisions they make. Where rights are relevant, staff must consider whether or not the decision or action limits a participant's rights in any way.

Staff must be able to demonstrate that any limitation on a participant's rights is reasonable, lawful, necessary, and proportionate in the circumstances.

Staff must identify the culture, diversity, values and beliefs of each participant and sensitively respond to them throughout service delivery.

CALDS's *Continuous Improvement Register* will be used to record identified improvements and monitor the progress of their implementation. Where relevant, this information will be fed into CALDS's service planning and delivery processes.

Relationships and Sexual Intimacy
The Participant: People with a disability have a right to engage in relationships of their choice. People with a disability have a right to:

- Have their relationships treated with respect and confidentiality
- Engage in any form of relationship that is legal and non-exploitative
- Live with partners of their choice, marry or have children
- Receive adequate and ongoing support, education, and resources to create opportunities for socialising and developing social networks.

The Provider: Disability support providers and workers have a responsibility and commitment to:

- Model positive relationships in their day-to-day interactions
- Respect the choices people with a disability make about their relationships
- Create positive and supportive environments where people can feel comfortable to create and enjoy relationships

- Respect all forms of relationships
- Provide, or facilitate access to, education, support and resources for those people who need assistance to develop and maintain relationships.

An Easy Read document on sexuality and your rights can be found in the participant welcome package.

Providing feedback
Refer to Complaints and Feedback Policy and Procedure.

Making a complaint
Refer to Complaints and Feedback Policy and Procedure.

Consent to Share Information Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2023/09	28/9/23	Grammer corrections	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
This policy guides staff to apply participant information sharing in accordance with the NDIS Quality and Safety Standards 2018.

This Policy applies to all staff who engage with a participant their carer or person responsible.

POLICY
Effective information-sharing underpins integrated service support functions and is a vital element in providing quality supports and services. So does a participant right to, choice and control over who their information is shared with.

The CALDS Chief Executive Officer (CEO) has systems and processes to ensure staff will not only gain the consent from a participant prior to the sharing of any information, but that they also inform the participant about the purpose and nature of the information being shared.

It is also important staff are aware and follow processes to ensure participants understand they can withdraw consent, in any area of service, at any time they choose. Please refer to the Consent to Share Form in the participant admission folder.

Procedure
Staff employed by CALDS (employee or contractor) are asked to sign an agreement at the time of onboarding. This agreement asks staff to read and agree to:

- Maintaining the privacy and confidentiality of all participants.
- Informing all participants (upon entry into the service) about their rights to privacy and confidentiality.
- Gaining formal consent from the participant prior to sharing any information with family, representatives, other providers, and government bodies.
- Ensuring children under the age of 18 will need their family / advocate / guardian's consent to share information with other providers and government bodies.
- Never release information to a third party without the participants consent (except in certain circumstances such as where a mandatory reporting obligation, or person's life is in danger.

- Inform a participant they have the right to opt-out of information sharing for internal or external audits.

RELATED DOCUMENTS

- Information Collection Consent Form
- Opt out of Audit form
- Consent to Share Information Form

REFERENCES

- NDIS Practice Standards and Quality Indicators 2018
- Disability Inclusion Act and Regulation 2014
- Privacy Act (1988)
- Health Records and Information Privacy Act 2002 No 71

Cultural Awareness Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	02/09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy and Procedure deals with the way in which the organisation ensures that it provides services in a culturally safe and appropriate manner and that it responds to the particular needs of a diversity of people.

The purpose of this Policy and Procedure is to set a formal standard of expectations for participants, visitors and employees, that reflects that CALDS is a Provider committed to cultural safety.

This policy applies to all participants, their families or advocates, staff of CALDS, stakeholders and others interacting with our participants and staff.

DEFINITIONS

Word	Definition
Cultural diversity	Diversity refers to aspects of people such as beliefs, attitudes, languages, social circumstances, ability, ethnicity, sexual orientation, gender history, health status and age.
CALD	Culturally and linguistically diverse refers to backgrounds which are not Anglo Australian, demonstrated through country of birth (COB), language other than English being spoken at home, and English language proficiency
Culturally secure	Culturally secure ways of working respect the legitimate rights, values and expectations of people.
Diversity sexuality and gender	Diverse sexualities and gender identities include people identifying as gay, lesbian, bisexual, transgender or intersex (GLBTI).
Inclusive language	Inclusive language is free of bias, discrimination and avoids stereotyping and mistaken assumptions about people on the basis of their, sex, marital status, pregnancy or potential pregnancy, sexual orientation, gender history, health status, race, nationality, colour or ethnic origin, age, religious or political conviction, disability, socio-economic status.
Trauma	A deeply distressing or disturbing experience or emotional shock following a stressful event or a physical injury, which may lead to long-term neurosis.

Word	Definition
Trauma informed	Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs.
Care Leaver	Many of those who spent time in institutions or out-of-home care as children were deprived of love and a sense of belonging. Most were denied family support and contact and experienced separation, loss and abandonment. They were often taken from their families without permission.
Gender fluid	Also known as non-binary, is a category of gender identities that are not exclusively masculine or feminine. Some identify outside the gender binary of male or female in their gender expression.

POLICY

CALDS recognises, respects, promotes and celebrates the value of cultural diversity and will adopt and implement inclusive policies and strategies, which advance cultural diversity.

CALDS has a commitment to cultural diversity and a commitment to Australian Indigenous peoples.

Underpinning our commitment to cultural awareness is our commitment to the NDIS participant exercising choice and control of the way their services are delivered.

CALDS will insist on a culture that will recognise and value the multicultural nature of Australian society and give specific acknowledgement and support to the cultures of Australian Indigenous peoples.

CALDS will provide a diverse and flexible delivery of services and provide a work environment which supports, values and encourages cultural diversity; and will support and mentor others assist in the development of understandings through staff training and supervision activity.

CALDS will identify any real or potential barriers for the participant to access our services; and address these to eradicate issues of less than acceptable inclusion practices.

PROCEDURE

- CALDS will ensure that all participants are treated fairly and in a non-discriminatory manner.
- This will include referral and intake processes as well as service delivery. Information provided will be either in home language or using an interpreter.
- If a participant has a barrier of not being able to read or understand information, then a support person will be supplied to assist the participant to understand what is being said or explained.
- Employment policies and procedures will foster the cultural diversity of the staff.
- Training and development programs will be conducted to cultural diversity based on need.
- Input from employees, visitors and participants from diverse background will be sought to make changes to service provision and staff training to ensure that all participants and staff are being treated fairly and without discrimination.

RELATED DOCUMENTS

- Human Resource Management Policy
- Complaint or Feedback Form
- Participant/Staff Handbook
- Participant Service Agreement
- Participant Intake form
- Staff Training Register

REFERENCES

- The Racial Discrimination Act (1975)
- NDIS Practice Standards and Quality Indicators 2018
- The Human Rights and Equal Opportunity Omission Act (1986)
- The Disability Act (1995)
- Fair Work Australia (2009). Fact Sheet: Unlawful Workplace Discrimination
- Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex

Personal Privacy, Dignity and Confidentiality Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	02/09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy is about the way in which the organisation ensures that the information it collects and stores about individuals is managed in accordance with legislated Privacy Principles and the privacy requirements of relevant funding bodies.

This policy applies to all employees, contractors and volunteers at all levels of the organisation.

DEFINITIONS

Word	Definition
Health information	Any information or an opinion about the physical, mental or psychological health or ability (at any time) of an individual.
Personal information	Recorded information (including images) or opinion, whether true or not, about a living individual whose identity can reasonably be ascertained
Sensitive information	Information or an opinion about an individual's racial or ethnic origin, political opinions, membership of a political party, religious beliefs or affiliations, philosophical beliefs, membership of a professional or trade association, membership of a trade union, sexual preference or practices, or criminal record.

POLICY

We commit to privacy and confidentiality of the participant's personal information (including health information). Privacy for participants may relate to physical environment, possessions, physical needs, personal relationships, and personal information.

On admission to the service, staff must obtain consent to collect and hold participant information.
CALDS commits to the following:

- Staff must provide to the participant, or representative, information on records we hold.
- Information provided must include the participant's ability to access their own personal information if they wish.
- Staff must not access participant files unless required to do so as part of their usual duties working with participants.

- Any participant files held manually or electronically have restricted access to appropriate staff.
- Client records are not held in areas or on drives shared with staff or others who are not involved in providing service to the participant.
- All staff, when first employed, must sign a confidentiality agreement.
- All staff commit to privacy and confidentiality for each participant when we:
  - provide care to a participant
  - provide privacy for the participant within their home, room or private areas
  - discuss a participant's care and service requirements
  - store a participant's personal information, whether this relates to medical needs or general information.

PROCEDURE

CALDS must provide adequate and appropriate secure storage for personal information collected by staff (see CALDS's *Records and Information Management Policy and Procedure*). CEO (CEO), or their delegate, are responsible for ensuring CALDS complies with the requirements of the Privacy Principles as outlined in the *Health Records and Information Privacy Act 2002 (NSW)*, and, where applicable, the *Privacy Act 1988 (Cth)* by developing, reviewing, and implementing processes and practices that identify:

- how people can consent to their information being collected.
- what information CALDS collects about individuals, and the source of the information.
- why and how CALDS collects, uses, and discloses the information.
- who will have access to the information?
- risks in relation to the collection, storage, use, disclosure, or disposal of and access to personal and health information collected by CALDS.

CALDS will review its privacy and confidentiality arrangements annually, through a Privacy Audit. The data will be collected via various means e.g.; surveys, onsite visits, and internal audits.

CEO (or their delegate) must immediately notify the NDIS Commission and/or relevant state government agency if they become aware of a breach or possible breach of privacy legislation. All staff will receive formal induction and ongoing training in privacy, confidentiality, and information management.

Staff knowledge and application of confidentiality and privacy principles will be monitored on a day-to-day basis and through annual Performance Reviews. Additional on-the-job and formal training will be provided to staff where required.

Staff are responsible for complying with this policy and procedure andtheir responsibilities in relation to collecting, storing, using, disclosing, and disposing of personal and health information, in accordance with this policy and procedure.

Staff must keep personal information of participants, other staff and other stakeholders confidential, in accordance with the confidentiality provisions in their employment or engagement contract.
When collecting personal information from participants or their supporters, staff must explain

- what information is required.
- the occasions when information may need to be released.
- why information is being collected and how it will be used.
- their right to decline providing information.

- their rights in terms of providing, accessing, updating and using personal information, and giving and withdrawing consent.
- who or where their information may be disclosed; and
- the consequences (if any) if all or part of the information required is not provided.

Prior to collecting information, staff must obtain consent from the participant or their supporter, using the relevant *Consent Form* where required.

Information must be collected sensitively and within lawful limits and only for a specific purpose. Staff must collect only what is necessary to deliver services.

Staff must respect people's choices about being photographed or videoed and ensure images of people are used appropriately. This includes being aware of cultural sensitivities and the need for some images to be treated with special care; participants and their supporters must be provided with CALDS's *Privacy Statement* and informed that a copy of the complete policy is available on request. The *Privacy Statement* is to be prominently displayed and included in CALDS's *Participant Handbook.*

Staff will provide information to participants about their privacy and confidentiality in ways that suit participants' individual communication needs. This includes using the language, mode of communication and terms that the participant is most likely to understand. Methods include providing written information in Easy English, explaining information either face-to-face or over the phone and using interpreters and advocates.

Participant and Supporter Privacy and Confidentiality
Participants and their supporters are responsible for:

- providing accurate information when requested.
- maintaining the privacy of any personal or health information provided to them about others, such as contact details.
- completing all consent and permission forms and returning them to the service in a timely manner.
- being sensitive and respectful to other people who do not want to be photographed or videoed; and
- being sensitive and respectful of the privacy of other people in photographs and videos when using and disposing of them.

CALDS will only request and retain personal or health information that is necessary to:

- assess a potential participant's eligibility for a service.
- provide a safe and responsive service.
- monitor the services provided; and
- fulfil contractual requirements to provide non identifying data and statistical information to a funding body.

Information CALDS collects includes, but is not limited to:

- contact details for participants and their supporters.
- details for emergency contacts and persons authorised to act on behalf participants.
- participants' health status and medical records.
- medication records.
- service delivery intake, assessment, monitoring and review information.
- service delivery records, plans and observations.
- external agency information.
- feedback and complaints.

- incident reports; and
- consent forms.

Access
Participant and supporter information may be accessed by relevant staff with a genuine need to know.

Individuals have the right to:
- request access to personal information CALDS holds about them, without providing a reason for requesting access.
- access this information; and
- make corrections if they consider the information is not accurate, complete or up to date.

There are some exceptions set out in the *Privacy and Personal Information Protection Act 1998 (NSW)*, where access may be denied in part or in total. Examples of some exemptions are where:
- the request is frivolous or vexatious.
- providing access would have an unreasonable impact on the privacy of other individuals.
- providing access would pose a serious threat to the life or health of any person; and
- the service is involved in the detection, investigation or remedying of serious improper conduct and providing access would prejudice that.

If an individual requests access to or the correction of personal information, within a service benchmark of 2 working days (and no more than 45 days after receiving the request), staff will:
- provide access, or reasons for the denial of access.
- correct the personal information, or provide reasons for the refusal to correct the personal information; or
- provide reasons for the delay in responding to the request for access to or correction of personal information.

Information storage
Personal files are kept in a secure filing cabinet in a private room, which is kept locked outside of operational hours. Computerised records are stored safely and secured with a password for access. Personal files are available for viewing upon request.

Information disclosure
Participant personal and health information will only be disclosed:
- for medical treatment or emergency.
- to outside agencies with the participants' or parent or guardians' permission.
- with written consent from person/s with lawful authority; or
- when required by Commonwealth Law, or to fulfil legislative obligations such as mandatory reporting.

If a staff member is in a situation where they believe that they need to disclose information about a participant that they ordinarily would not disclose, they should seek the advice of a CEO (or their delegate) before making the disclosure.

Staff Privacy and Confidentiality
Staff information CALDS collects includes, but is not limited to:

- Employee tax declaration form
- An employee or contractor engagement contract
- Employee/contractor personal details.
- An employee's emergency contact details.
- Police and Working with Children Check records
- Worker Screening Unit outcomes
- An employee's work-related qualifications
- First Aid, CPR and Anaphylaxis certificates.
- Employee medical history.
- Employee professional resume.
- An employee's payroll information; and
- Superannuation details
- Comprehensive Vehicle Insurance
- Vehicle Registration

Access
Staff information may be accessed by the CEO (or their delegate).
Staff have the right to:

- request access to personal information CALDS holds about them, without providing a reason for requesting access.
- access this information; and
- make corrections if they consider the information is not accurate, complete or up to date.

There are some exceptions set out in the *Privacy and Personal Information Protection Act 1998 (NSW)*, where access may be denied in part or in total. Examples of some exemptions are where:

- the request is frivolous or vexatious.
- providing access would have an unreasonable impact on the privacy of others.
- providing access would pose a serious threat to the life or health of any person; and
- the service is involved in the detection, investigation or remedying of serious improper conduct and providing access would prejudice that.

If an individual requests access to or the correction of personal information, within a service benchmark of 2 working days (and no more than 45 days after receiving the request), staff will:

- provide access, or reasons for the denial of access.
- correct the personal information, or provide reasons for the refusal to correct the personal information; or
- provide reasons for the delay in responding to the request for access to or correction of personal information.

Information storage
Staff records are maintained by the CEO (or their delegate) in a locked filing cabinet in their office, which is kept locked outside of operational hours.

Computerised records are stored safely and secured with a password for access.

Information disclosure
Staff personal and health information will only be disclosed:

- for medical treatment or emergency.
- with written consent from the staff member; or

- when required by Commonwealth Law, or to fulfil legislative obligations such as mandatory reporting.

Privacy Audits

CALDS will conduct annual privacy audits as per its *Internal Review Schedule*.

The audit will be based on CALDS *Privacy Audit Form* and review:

- what sort of personal information CALDS collects, uses, stores and discloses.
- how CALDS safeguards and manages personal information, including how it manages privacy queries and complaints; and
- How a personal information that needs to be updated, destroyed or erased is managed.

RELATED DOCUMENTS

- Information and Record Keeping Policy and Procedure
- Continuous Improvement Register
- Privacy and Confidentiality Agreement
- Privacy Audit Form (Schedule of Audits)

REFERENCES

- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)

Inclusion and Access Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	22/11/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This evidence guide is about the way in which the organisation ensures that its services are accessible to all people eligible to access a NDIS service provider.

This policy applies to CALDS staff and management.

POLICY

CALDS is committed to social inclusion and community participation in the delivery and expansion of services to participants who are disadvantaged and work in partnership with the community, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, people with different sexual-orientations and those with disabilities.

CALDS will follow the principles and promotion of inclusion. Staff will be trained to follow these principles and promotion strategies.

Community Participation and Integration

Community participation is a practice that places people at the heart of all activities. This participation is carried out by people and with people, rather than on people or to people. Community participation also known as community engagement or community action.

This participation may include:

- Education
- Shopping
- Work
- Social activities
- Volunteering or joining clubs or groups
- Interacting with others; with similar interests.

CALDS promotes inclusion by:

- Working closely with a network of health and allied health professionals to be able to support the holistic needs of our participants.
- Building effective partnerships with participants and their families and support people to discuss and build on shared priorities and the participant's individual needs and goals.
- Focused efforts on building social inclusion and participation opportunities within the range of services provided.
- Providing information on community events and other relevant networks that meet participant’s needs and identified goals.

- Working within the participant's networks and supports including childcare, kinder, school or home environments, which allows CALDS to assist the participant to foster relationships and participate in familiar surroundings.
- Having a community linkages policy that outlines the ways in which CALDS will work with other communities for the betterment of their participants.
- Operating within the CALDS equity and access policy to ensure all people can access our service.

REFERENCES

- Human Rights and Equal Opportunity Commission Act 1986
- Disability Discrimination Action 1992 (Commonwealth)
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984
- Privacy Act (1988)
- NDIS Practice Standards and Quality Indicators 2018

Diversity Awareness, Values and Beliefs Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is providing clear expectations, policy and processes about:

- How CALDS will provide a supportive workplace that respects and values diversity of customs, cultures and beliefs.
- How CALDS will ensure that its services are delivered in a manner that respects and values the customs, cultures and beliefs of its client's preventing harassment or discrimination of any kind.

This policy applies to all staff, participants, stakeholders and referral agencies.

DEFINITIONS

Word	**Definition**
Diversity	Diversity refers to aspects of people such as beliefs, attitudes, languages, social circumstances, ability, ethnicity, sexual orientation, gender history, health status and age.
Cultural Diversity	Cultural Diversity embraces Indigenous Australian and multicultural perspectives.
CALD	Culturally and linguistically diverse refers to backgrounds which are not Anglo Australian, demonstrated through country of birth (COB), language other than English being spoken at home, and English language proficiency.
Culturally Secure	Culturally Secure ways of working respect the legitimate rights, values and expectations of people.
Disability	A Disability may be defined as an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of those impairments.

Word	Definition
Diverse Sexuality and Gender	Diverse Sexuality and Gender identities include people identifying as gay, lesbian, bisexual, transgender or intersex (GLBTI).
Inclusive Language	Inclusive Language is free of bias, discrimination and avoids stereotyping and mistaken assumptions about people on the basis of their, sex, marital status, pregnancy or potential pregnancy, sexual orientation, gender history, health status, race, nationality, colour or ethnic origin, age, religious or political conviction, disability, socio-economic status.
Trauma	A deeply distressing or disturbing experience or emotional shock following a stressful event or a physical injury, which may lead to long-term neurosis.
Trauma-informed	Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how Trauma affects people's lives and their service needs.
Domestic Violence	Domestic Violence is made up of a variety of abusive and intimating actions against an intimate current or former partner.
Care Leaver	Many of those who spent time in institutions or out-of-home care as children were deprived of love and a sense of belonging. Most were denied family support and contact and experienced separation, loss and abandonment. They were often taken from their families without permission.
Gender Fluid	Also known as non-binary, is a category of gender identities that are not exclusively masculine or feminine. Some identify outside the gender binary of male or female in their gender expression.

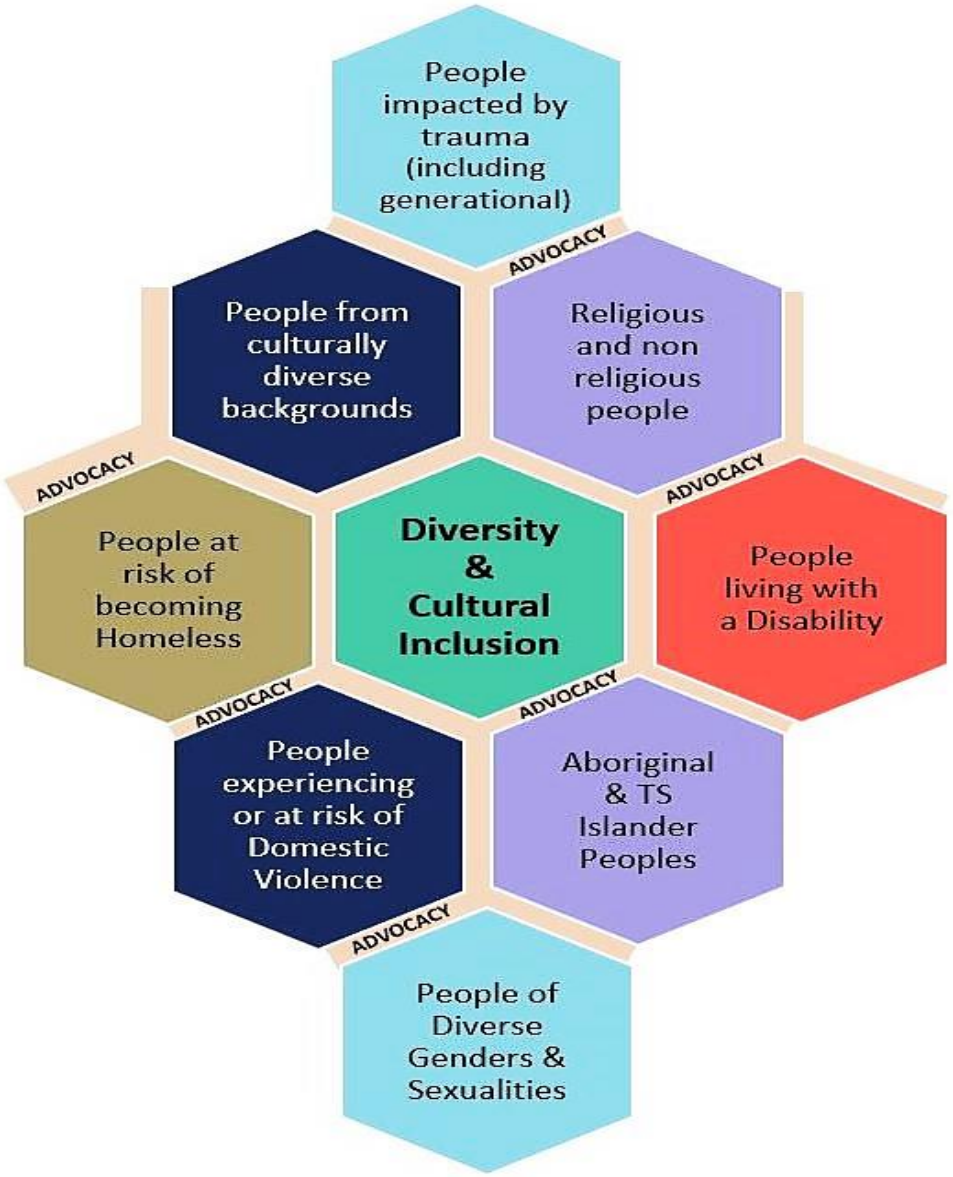
POLICY
This policy will underpin our actions to ensure CALDS is:

- A supportive workplace that respects and values diversity of customs, cultures and beliefs
- Ensures that its services are delivered in a manner that respects and values the customs, cultures and beliefs of its participants and by preventing harassment or discrimination of any kind
- Will welcome participants, visitors and employees, that reflects its ethos, values diversity, expresses a commitment to access and equity, and demonstrates ethical conduct
- We value the choice and control of our participants to receive services that will sit their needs and wishes

Diversity and cultural inclusion refer to creating and maintaining a workplace and culture that is respectful of all people. This applies to:

- Aboriginal and Torres Strait Islander people

- Religious and non-religious people
- People at risk of homelessness or ‘leaving care’
- People of diverse genders and sexualities
- People from non-English speaking backgrounds
- People living with a disability
- People at risk of in the face of domestic violence
- People impacted by trauma
- Australia’s First Peoples (cultural needs)



PROCEDURE

All staff employees and contractors recruited in positions working within service delivery or allied health, will be required to complete a range of mandatory induction processes as well as a number of additional induction or training processes as determined by the CEO or their delegated officer.

One of these modules or processes will be diversity and complexity within the NDIS. The induction to training content will be informed by the characteristics of the participant and staff member.

For example, if a CALDS participant is strongly influenced by their cultural heritage or family ties, and a staff member is sourced and is from the same culture, it is unlikely that staff member will require additional training in cultural diversity. This situation will vary from participant to participant.

Assessment
It is the intake and assessment stage of a participant's journey with CALDS which is of most importance to gather the valuable information about a participant which will help to build a person centred and culturally responsive support plan.

Person centred enabled
Any responses from CALDS in relation to culture, diversity, values, beliefs or other sensitivities will be instigated only on the request of the participant. CALDS staff will not make judgments about the needs or wishes of any participant or their family members.

Where a participant has a community of choice, and social circle established, CALDS will ensure that those connections are maintained and where there is difficulty in supporting a person to maintain those connections 'of choice' the support worker or staff member will alert the CEO (or their delegate) to develop strategies to ensure those connections are not lost.

System supports

Whatever the cultural practices of the participant are CALDS will support staff to support a participant. This may include the use of interpreters, or translators and arrangement for program materials to be available in other languages.

CALDS will ensure feedback and consultation are targeted to capture the demographic of its participants; Australia wide.

RELATED DOCUMENTS

- Human Resource Management Policy
- Complaint or Feedback Form
- Participant/Staff Handbook
- Participant Service Agreement
- Participant Intake form
- Staff Training

REFERENCES

- The Racial Discrimination Act (1975)
- NDIS Practice Standards and Quality Indicators 2018
- The Human Rights and Equal Opportunity Omission Act (1986)
- The Disability Act (1995)

Aboriginal and Torres Strait Islander People Policy and Procedures

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
This Policy deals with the way in which the organisation ensures that it provides services in a culturally safe and appropriate manner and that it responds to the needs of Aboriginal and Torres Strait Islander Peoples.

This policy applies to all staff, volunteers, and stakeholders.

POLICY
CALDS is committed to creating a safe and welcoming environment for all people. In keeping with the NDIS remit of 'choice and control', this policy supports that individual have the right to engage with their Aboriginal and Torres Strait Islander community members and to access appropriate support as required. Staff are to work with Aboriginal and Torres Strait Islander community members and participants in order to fulfil the participants goals and aspirations as per the NDIS Plan.

PROCEDURE
- CALDS will ensure that its' resources are responsive to Aboriginal people's needs. This may include brochures, websites and images used in day-to-day service provision and business management strategy.
- CALDS will display a Statement of Traditional Owners.
- All participants who access the services will be asked if they identify and have an Aboriginal and Torres Strait Islander background.
- Contacting and maintaining networks with local Aboriginal and Torres Strait Islander communities.
- Contacting the participant's family, extended family and community when requested to by the participant.
- Establishing communication processes for maintaining individual's indigenous supports; and being prepared to do this in a manner which demonstrated respect and understanding for the cultural need expressed by the participant.
- Work with other services in a coordinated manner to ensure appropriate services are engaged for the participant.

Care and Support Plans
- Will include actions that promote cultural safety and connectedness and respect for the cultural and spiritual identity of Aboriginal and Torres Strait Islanders.
- The service commits to recognising culturally significant days, events, and collaborations available in the community.

- The CEO (or their delegate) will take responsibility for ensuring events and significant days are disseminated within the service.

Resource
Management and staff of CALDS will refer to evidence based (and Aboriginal approved) resources in their commitment to deliver culturally competent and appropriate service to any Aboriginal or Torres Strait Islander Peoples

Resource: Aboriginal and Torres Strait Islander Engagement Strategy (NDIS)

Underpinning the Principles of
- What is the 'proper way'?
- Importance of cultural competence
- Understanding Country, Culture and Community
- Importance of communication

Governance
- The CEO (or their delegate) will oversee that participant files reflect the culturally appropriate activities and supports as reflected in this Policy and Procedure.
- Annually, participant files will be audited during a 'Surveillance Audit'.
- The CEO (or their delegate) will assign a staff member or external person to conduct random file audits and random participant interviews as resources permit.

Staff and Volunteer Training
CALDS will train all staff and volunteers to ensure staff are aware of strategies for cultural competence in Aboriginal or Torres Strait Islander cultural identity. The aim of this training is to increase access to the service by Aboriginal and Torres Strait Islander people.

RELATED DOCUMENTS
- Support Plans
- Support Management Policy and Procedure
- Inclusion Policy
- Training record

REFERENCES
- Human Rights and Equal Opportunity Commission Act 1986
- Anti-Discrimination Act 1977 (NSW)
- Discrimination Act 1991 (ACT)
- Disability Discrimination Action 1992 (Commonwealth)
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984
- Privacy Act (1988)
- NDIS Practice Standards and Quality Indicators 2018
- NSW disability Inclusion Act and Regulation (2014).

Advocacy Support Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy provides a guide about the way in which the organisation assists service users to access independent services to support them in planning and decision making.

This policy applies to all staff, volunteers and stakeholders.

DEFINITIONS

Word	Definition
Advocacy:	is active support for a cause or position and in this context, it is an expression of support for a person who may find it difficult to speak for him or herself. It may include matters such as achieving social justice, improving a person's well-being, prevention of abusive or discriminatory treatment, stopping unjust and unfair treatment, so that a person's fundamental needs and interests can be met.

POLICY

Disability advocacy is acting, speaking or writing to promote, protect and defend the human rights of people with disability. The NDIS is about choice and control.

The Australian Government, and some state and territory governments, fund independent advocacy to help people with disability who face complex challenges or are unable to advocate for themselves, and do not have family, friends or peers who can support them as informal advocates, to access advocacy support. Refer to CALDS Disability Advocacy Info Sheet.

An independent advocate, in relation to a person with disability, means a person who:

- Is independent of the organisations providing supports or services to the person with disability; and
- Provides independent advocacy for the person with disability, to assist the person with disability to exercise choice and control and to have their voice heard in matters that affect them; and
- Acts at the direction of the person with disability, reflecting the person with disability's expressed wishes, will, preferences and rights; and
- Is free of relevant conflicts of interest

CALDS will also provide all participants with a list of government funded Disability Advocacy

Services.

The types of Advocacies

- **Individual Advocacy**: a one-on-one approach, aiming to prevent or address instances of discrimination or abuse.
- **Systemic Advocacy:** working to influence or secure long-term changes to ensure the collective rights and interests of people with disability.
- **Family Advocacy**: when a parent or family member advocates with and on behalf of a family member with disability.
- **Citizen Advocacy**: matches people with disability with volunteers.
- **Legal Advocacy**: upholds the rights and interests of individual people with disability by addressing the legal aspects of discrimination, abuse and neglect.
- **Self-Advocacy:** supports people with disability to advocate for themselves, or as a group.

PROCEDURE

Supporting advocacy

The CALDS CEO (or their delegate) will be responsible for ensuring:

- All staff receive training in the use of advocates
- Maintenance of printed materials on relevant advocacy services for distribution to service users
- Maintenance of local advocacy resources/contact lists
- Providing service users with information about how to access an advocate
- Information on the use of advocates is included in the Service User Handbook and is explained to each service user at the point of first contact or as soon as practical.

CALDS staff will provide service users with names of local advocacy services available and respect their choice of advocate.

Staff will ensure service users are aware of their right to use an advocate and remind them of this option whenever appropriate, including when a complaint is lodged, or the staff member believes an advocate may be beneficial to the service user.

Appointment of advocates

- Service users wishing to use an advocate should inform CALDS in writing of the name of the person they wish to negotiate on their behalf and the capacity in which the person can act. Service users should complete the Authority to Act as an Advocate form.
- Service users may change their advocate at any time and inform us in writing using the Authority to Act as an Advocate form. If a service user has difficulty completing this form, a staff member will assist them or refer them to an advocacy agency that can assist them in this task.
- Completed authority forms are kept in the service user's record.

Guidelines for advocates
Guidelines for advocates are detailed on the Authority to Act as an Advocate form; this is given to the service user and explained to them if they wish to appoint an advocate.

Working with advocates
Where a service user has identified and nominated an advocate CALDS will:

- Ensure the advocate knows they have been nominated as an advocate and for what purpose.
- Ensure any identified advocate is present at assessment, planning, review or other relevant meetings.
- Communicate and work co-operatively with the advocate; and
- Communicate comprehensively with the advocate in accordance with the service user's wishes and involve them in the care and service planning.

If an authorised representative is acting on behalf of a service user, CALDS staff will require proof of the representing authority. Authorised representatives include:

- Guardians
- Attorneys under enduring powers of attorney
- Agents under the Medical Treatments Act 1988
- Administrators under the Guardianship and Administration Act 1986
- A person otherwise empowered by the service user to act or make decisions in their best interest.

Proof of representative authority will be sighted, and a copy of the documentation placed in the service user's record.

RELATED DOCUMENTS

- Authority to Act as an Advocate
- Advocacy Information Insert.

REFERENCES

- National Disability Insurance Agency
- NDIS Practice Standards and Quality Indicators 2018
- Disability Inclusion Act and Regulation 2014
- Privacy Act (1988)
- Privacy Act 1988 (Cth)
- Australian Human Rights Commission Act 1986 (Cth)

DIVISION 2 – GOVERNANCE AND OPERATIONS

Incidents, Accidents and Emergencies Policy and Procedures

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02		Grammatical corrections		09/2022 or in response to any legislative triggers
2023/3	2/9/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is to ensure that the organisation has procedures in place to protect client's health, safety, and wellbeing in the event of an incident.

These procedures ensure that incidents are acknowledged, responded to, well-managed and learned from.

This Policy applies to all staff, participants, volunteers, contractors, and others who come into contact with us for the purpose of carry out service delivery.

DEFINITIONS

WORD	DEFINITION
Incident	an act, omission, event or circumstance which causes harm, or could cause harm to the client.
Reportable Incident	an incident, of a type (see below list) which must be reported to the NDIS Commission

POLICY

Incident Management is one of the elements in our Integrated Governance Model.
This Policy is a guide to the systems that the organisation has in place to effectively respond to incidents that occur in connection with providing supports.

To comply with the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018. To maintain an incident management system that covers incidents that consist of acts, omissions, events or circumstances that:

- Occur in connection with providing supports or services to a person with disability; and
- Have, or could have, caused harm to the person with disability.

Reportable incidents in the NDIS

All NDIS providers – registered or unregistered – are responsible for the delivery of quality and safe NDIS supports and services.

Registered NDIS providers are required to record and manage all incidents that happen in the delivery of NDIS supports and services in their internal incident management systems and notify the NDIS Commission of reportable incidents.

Registered NDIS providers must notify the NDIS Commission of all reportable incidents (including allegations), even where the provider has recorded and responded within their own incident management system.

For an incident to be reportable a certain act or event needs to have happened (or alleged to have happened) in connection with the provision of supports or services by the registered NDIS provider. This includes:

- The death of a person with disability
- Serious injury of a person with disability
- Abuse or neglect of a person with disability
- Unlawful sexual or physical contact with, or assault of, a person with disability
- Sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity
- Unauthorised use of restrictive practices in relation to a person with disability.

Timeframes for reporting of a reportable incident

	Reportable incident	**Timeframe**
1	death of a person with disability	**24 hours**
2	serious injury of a person with disability	**24 hours**
3	abuse or neglect of a person with disability	**24 hours**
4	unlawful sexual or physical contact with, or assault of, a person with disability	**24 hours**
5	sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	**24 hours**
6	the use of a restrictive practice in relation to a person with disability if the use is not in accordance with a required state or territory authorisation and/or not in accordance with a behaviour support plan.	**Five business days**

For further information including hints and tips, please refer to the **Reportable Incident Guidance on the NDIS Commission website.**

For further guidance, NDIS Commission Videos are available:

Videos:

- Video 1: Reportable Incidents: Overview

- Video 2: Reportable Incidents: Notifying the NDIS Commission
- Video 3: Reportable Incidents: What to expect from the NDIS Commission
- Video 4: Benefits of effective incident management

Staff resources about Incident Management
- Poster: 'Identifying and responding to incidents: 6 step guides for workers'
- Ready reference resource for workers: 'Incident response: Is everyone safe?'
- Detailed Guidance: Expectations of workers providing services in incident management and reporting incidents

Resources for participants:
- Reportable Incidents: Participant fact sheet

NDIS Commission Portal reportable incident resources:
- Reportable Incident Quick Reference Guides
- My Reportable Incidents – Frequently Asked Questions

Unable to report via the NDIS Commission portal

Outside of business hours and if all reasonable steps have been taken, a provider should advise the NDIS Commission of these issues as soon as possible via email to reportableincidents@ndiscommission.gov.au with an email that includes:
- The steps taken to complete the authorised notification form and the presenting issue
- The name of the impacted person
- Describe the immediate response and step taken to ensure the impacted person was safe
- Brief description of the reportable incident
- Whether other authorities, such as the police, were notified.

You will receive an automated response from the NDIS Commission acknowledging receipt. As soon as practical, you will need to progress completion of the 24-hour form. If you continue having difficulties, please refer to the website for detailed guidance or contact the Commission on 1800 035 544.

If the NDIS Commission portal or “My Reportable Incidents” page is unavailable for a period, the NDIS Commission Reportable Incidents team may:

- Provide an authorised form and request the information is submitted via the reportableincidents@ndiscommission.gov.au address; or
- Take the 24-hour notification or further information over the phone.

INCIDENT PROCEDURE

Steps A, B, C, D, E & F

Step A – Information Collection

- Support Worker to report the incident to the Registered Nurse Team Leader
- Support Worker completes an Incident Report that identifies and records details on Shift care relating to the incident - people, place, time and date.

Step B – The Investigation

The Registered Nurse Team Leader will report the incident to the Governance Manager and the Operations manager who will determine from the information provided if this incident is classified as a Reportable Incident by the NDIS Commissioner or a different type of incident.

Reportable Incident must comply with Reportable Incident Process of reporting as per the National Disability Insurance Scheme (Incident Management and Reportable) Rules 2018.

General Incident – accident, non-reportable injury

- Review details of the incident, including:
- People
- Location
- Circumstances
- Outcome – such as injury
- Investigate incident and accidents in accordance with the process listed within the Incident Investigation to determine:
- The immediate reasons for the event.
- The underlying reasons for the event.
- Immediate actions require to fix the reasons for the event.
- Preventive actions required for the future.
- The information gained from incidents will be incorporated into our Continuous Improvement cycle to enable prevention of the incident or accident in the future.
- Each incident's investigation and analysis will vary due to the seriousness of the incident.

Step C – Ensure Participant and Staff are Safe

Registered Nurse Team Leader will ensure that the affected participant is supported and assisted by:

- Informing them that they have access to an advocate, if the participant does not have an advocate, then CEO can help them to access an independent advocate.
- Reviewing their health status to assist and support.
- Reviewing the environment to ensure their safety and to prevent any recurrence.
- Make sure that their well-being is supported and help with the development of their confidence and competence so that they do not lose any functions.
- CEO or their delegate will review the incident with the participant in view of resolving the incident.

Step D – Root Cause Analysis (refer to incident form)

The information gained from an incident is used to amend or implement practices as part of our continuous improvement, including:

- When an investigation by the registered NDIS provider is required to establish the causes of an incident, its effect and any operational issues that may have contributed to the incident occurring, and the nature of that investigation.
- If an incident requires corrective action to be undertaken, then a plan will be developed to adjust practices according to the nature of that action required.

Registered Nurse Team Leader undertakes the analytical process, that includes:

- Determining the cause of the incident.
- Ascertaining if the incident was an operational issue.
- Considering the participant's perspective, including:
- Whether the incident could be prevented.
- How the incident was managed and reviewed.
- Remedial action to prevent future reoccurrence or minimise the impact.
- Reasoning: why this occurred – environmental factors, participant's health.
- Ascertaining if strategies or processes need review and improvement.
- Devising new strategies or procedures.
- Planning for staff training in these new strategies.
- Implementing new strategies.
- Reviewing of new strategies.

All Incident Investigation Forms must be closed out by the Clinical Governance Manager and/or their delegate, plus one other person.

Step E – Determine Corrective Actions

- Registered Nurse/Gov Manager will risk-assess each incident as relevant.
- Incident/Accident/Emergency minimisation and procedures are taught during Orientation and in regularly during various sessions.
- Risks will be identified, and control mechanisms agreed upon with the participant.
- Community Nursing consult with the participant and relevant stakeholders to design specific risk control mechanisms to reduce any risks to the participant and their environment.
- Effectiveness of mechanisms will be reviewed via:
- Participant review processes including Support Plan review.
- Participant's feedback.
- Case Conferencing.
- Internal and External Audits.
- Review of policies and procedures.

Corrective Actions

After the Incident Analysis Procedure has occurred, and corrective action is implemented. Every corrective action must be evaluated to ascertain the effectiveness of the action as per Continuous Improvement Policy – Plan, Do, Check, Act

Step F Informing Participants

- Registered Nurse or the delegate; will inform participants or their advocate about the outcome of the incident in writing or verbally; dependent on the participant and the situation.
- Collaborative practice will be undertaken to ensure that the participant and their advocate are involved in the management and resolution of the incident.

RELATED DOCUMENTS

- Incident report form

- Incident register

REFERENCES

- NDIS Quality and Safety Standards (2018)
- The NDIS Act 2013

Conflict of Interest & Sharp Practices Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This policy is to ensure all staff and participants are aware about Conflicts of Interest unique to NDIS and generally found within a business and human service environment.

All management, staff, and contractors are always required to act in the interests of the organisation, and to notify the organisation when this conflicts with other interests or commitments.

POLICY

CALDS is committed to ensuring that actions and decisions taken at all levels in the organisation are informed, objective and fair.

A conflict of interest may affect the way a person acts, decisions they make and / or the way they vote on group decisions; and in so doing, detracted from the participants right to choose and control around their services.

CALDS will act proactively to manage perceived and actual conflicts of interest through development and maintenance of organisational policies. This will ensure organisational/ethical values do not impede participant's right to choose and control.

Where a worker is working for another agency and is exposed to one of CALDS clients who is also serviced by the other provider, we will ensure that the client is not working with that person in our service also. In that situation a conflict-of-interest form will be completed, a strategy documented, and the conflict of interest will be listed on the conflict-of-interest register with an appropriate review date.

Conflicts of interest must be identified, and action taken to ensure that personal or individual interests do not impact on the organisation's services, activities, or decisions.

This policy requires all employees and management:

- Act impartially and without prejudice
- Declare any potential or actual conflict of interest, and
- Do not accept gifts or benefits that would influence a decision.

This will include situations in which:

- Close personal friends or family members are involved, such as decisions about employment, discipline or dismissal, service allocation or awarding of contracts.
- An individual or their close friends or family members may make a financial gain or gain some other form of advantage.
- An individual is involved with another organisation or offers services that are in a competitive relationship with our organisation and therefore may have access to commercially sensitive information, plans and / or financial information.
- An individual is bound by prior agreements or allegiances to other individuals or agencies that require them to act in the interests of that person or agency or to take a Position on an issue.

PROCEDURE

Registration of known conflicts of interest

A register of conflicts of interest will be kept, and management and staff will be asked to declare:

- Potential or actual conflicts of interest that exist when a person joins the organisation.
- Conflicts of interest that arise during their involvement with the organisation.

The register will be maintained by the CEO (or their delegate). All potential and actual conflicts will be recorded in the register, showing:

- Identification and declaration of conflicts of interest

In addition to an initial declaration of any potential conflicts of interest at the beginning of their involvement with the organisation, all management and staff are required to declare any potential or actual conflicts of interest they are aware of:

- At the beginning of any meeting or decision-making process, informing those present when a conflict becomes apparent.
- Outside of a meeting, speak with the CEO (or their delegate) when a conflict becomes apparent.
- By providing formal notification in writing to the CEO (or their delegate).

Avoid participating in or promoting sharp practices

The Code of Conduct requires all staff and contractors to avoid engaging in, participating in or promoting sharp practices.

The term ‘sharp practices’ refers to a range of practices involving unfair treatment or taking advantage of people, including over-servicing, high pressure sales and inducements. Some sharp practices may undermine the integrity of NDIS providers, workers and/or the NDIS sector as a whole.

Although not usually unlawful, and therefore not prohibited outright, sharp practices are considered unethical, dishonest and not in the interests of the participant.

The organisation will ensure their workers are aware of their obligations not to participate in sharp practices such as, but not limited to:

- Misleading or deceptive conduct
- Coercive or exploitative conduct

Scenario
As part of her NDIS Plan, Tamina has funding to purchase a new powered wheelchair to replace her old one which is outdated and has a battery malfunction. Tamina visits a wheelchair supplier and talks to a sales representative about her needs. Tamina uses her wheelchair almost exclusively indoors or on paved outdoor services, but the sales representative suggests that she may be interested in a four-wheel drive wheelchair with larger tyres which gives additional traction, stability and comfort on uneven surfaces such as at parks or dirt walking tracks. He notes that for this week only this particular model is 20% off, which makes it only a couple of hundred dollars more expensive than the entry level model that Tamina had been looking at and as such is excellent value-for-money. Tamina is unsure whether she really needs such an elaborate model, and says she'll go away and think about her options. Tamina then receives follow-up phone calls from the sales representative three times over the following week asking if she's made up her mind and reminding her that this special offer ends in only a few days. Tamina feels pressured and talks to her Local Area Coordinator. The Local Area Coordinator encourages Tamina to raise her concerns with the NDIS Commission, who investigate further and find that the incident may constitute unconscionable conduct and refer the matter to the Australian Competition and Consumer Commission (ACCC) for further investigation and action.

RELATED DOCUMENTS

- Conflict of Interest Register
- Risk Register
- Risk Management Policy
- Whistle blower Policy

REFERENCES

- NDIS Code of Conduct
- NDIS Quality and Safety Standards 2018

Risk Management Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy deals with the way in which the organisation identifies, assesses, and manages potential and actual risks.

It is the responsibility of the CEO (or their delegate) to carry out risk management analyses for the organisation and to take appropriate measures.

DEFINITIONS

Word	**Definition**
Risk management	is a systematic process whereby an organisation identifies and assesses risks, develops strategies to mitigate risk, assigns responsibilities, and monitors and reviews progress.
Risk	is the chance of something happening that will impact on objectives, measured in terms of likelihood of occurrence and impact
Likelihood	is the probability or chance of an incident occurring?
Impact	is the actual or potential impact that may result from a risk occurring.
Due Diligence	is an action considered reasonable for people to be expected to take in order to keep themselves or others and their property safe?
Risk assessment	is the process of analysing and evaluating the likelihood and impact of potential risks?
Risk treatment	is identifying and implementing actions to eliminate risks or reduce impacts.
Risk incident	is realisation or occurrence of a risk impact.

POLICY

It is considered good governance for an organisation to have in place a risk management policy that articulates the organisation's commitment to effectively managing risk.

The CALDS CEO recognises:

- the link between effective risk management and the achievement of objectives

- the importance of considering risks in decision making
- the expectation from stakeholders that risks are effectively managed.

For this reason, CALDS has in place a robust governance, risk and compliance management system linked able to support the corporate and service delivery functions of the organisation. The compliance management system monitors risk across the following areas:

- Incident Management
- Complaints and Feedback Management
- Work Health and Safety
- Human Resource Management
- Financial Management
- Information Management
- Governance
- Participant Risk
- Regulatory Compliance Register

The CALDS compliance management system has a dedicated risk management register kept updated by the CEO (or their delegate) and monitored regularly at management and board level.

A key requirement for the CEO (or their delegate) is that the compliance management system registers are viewed weekly at minimum. **This will be strengthened by ensuring the position description reflects this duty as well as the Delegations Matrix.**

PROCEDURE

Risk identification

CALDS identifies risks through formal and informal processes such as: observation of workplace practice, monitoring of regulatory requirements, organisational system reviews, regular audits (e.g., WH&S, policy compliance), analysis of information gathered relating to Incidents, Complaints and Feedback.

Organisational risks are categorised and summarized as follows:

Risk type	**Area compromised**
Strategic	Goal and intended outcomes of CALDS Intellectual property Reputation Organisation and sector positioning Resourcing, growth, and improvement
Compliance	Entity legislation (e.g., incorporations, co-operatives, or others) Contractual obligations Insurance Taxation Employment legislation (refer to the Human Resources Policy) Work health safety legislation (refer to the Work Health Safety Policy)
Financial	Fraud Income, budget and expenditure operations Debt collection Governance and management by Board

Risk type	Area compromised
Operational	Governance Service delivery (e.g., clinical, projects, programs) General equipment, resources and facilities Human resource management Information management Break-in, theft, and fire
Market/Environmental	Natural disasters or major storms Changes in government and/or government policy Major legislation changes
Participant	Risks to participants - including environmental, fire, falls, transport, staff working in participant's home, changes in consistency of performance of activities, interruptions to service delivery and exit plans (transitioning services to another service provider) Suitable and appropriate staff

Organisational risks are categorised and summarized as follows:

Risk type	Area compromised
Strategic	Goal and intended outcomes of the Service Intellectual property Reputation Organisation and sector positioning Resourcing, growth and improvement
Compliance	Entity legislation (e.g., incorporations, co-operatives or others) Contractual obligations Insurance Taxation Employment legislation (refer to the Human Resources Policy) Work health safety legislation (refer to the Work Health Safety Policy)
Financial	Fraud Income, budget and expenditure operations Debt collection Governance and management by Board
Operational	Governance Service delivery (e.g., clinical, projects, programs) General equipment, resources and facilities Human resource management Information management Break-in, theft, and fire
Market/Environmental	Natural disasters or major storms Changes in government and/or government policy Major legislation changes
Participant	Risks to participants - including environmental, fire, falls, transport, staff working in participant's home, changes in consistency of performance of activities, interruptions to service delivery and exit plans (transitioning services to another service provider) Suitable and appropriate staff

Risk assessment
The risk assessment matrix, risk likelihood and rating tables below are applied to all identified risks to determine their level of risk based on two categories: likelihood and impact.
Risk assessment also includes reviewing existing controls, whether specific to that risk or by default.

Risk matrix

Likelihood						
	Almost certain	Low Medium	Medium	Medium organisation High	High	High
	Likely	Low	Low organisation Medium	Medium	Medium organisation High	High
	Possible	Low	Low	Medium	Medium organisation High	High
	Unlikely	Low	Low	Low organisation Medium	Medium	Medium organisation High
	Rare	Low	Low	Low	Medium	Medium organisation High
		Minimal	Minor	Moderate	Significant	Severe
				Impact		

Risk likelihood

Rating	Description	
Almost certain	90% or greater probability	Expected to occur in most circumstances
Likely	50-90% probability	Will probably occur in most circumstances
Possible	20-50% probability	Could occur at some time
Unlikely	10-20% probability	Not expected to occur
Rare	<10% probability	Would occur only in exceptional circumstances

Risk impact

Rating	Description	
Severe	Business objectives and/or continuing viability is threatened	Death or serious injury to a person
Significant	Business objectives are not met	Serious injury or illness requiring medical treatment with permanent consequences
Moderate	Business objectives may be threatened	Injury or illness requiring medical treatment
Minor	Business objectives require monitoring	Minor injuries
Minimal	Business objectives unlikey to be affected	Minor first aid injury

Risk rating
The risk rating assists **[insert organisation name]** in determining if the risk is acceptable or unacceptable. A low rating risk may be expected and acceptable with minimal treatment response, whereas a high rating risk is not acceptable and therefore requires a response to minimise or eliminate risk.

High	Requires immediate action to mitigate the risk
Medium organisation High	Requires short-term action to mitigate the risk
Medium	Requires medium term action to mitigate the risk (work within other priorities)
Low organisation Medium	May require attention
Low	Manage by routine procedure

2.5 Risk treatment
Risk treatment involves identifying and implementing actions to eliminate risks or reduce their impacts. In treating risk the organisation, board and staff members ensure that:

- The cost of implementing risk treatments is balanced with the expected and actual risk reduction outcomes
- If eliminating risk is to discontinue an activity, remove an identified risk item, or avoid new or potential risks
- Risk reduction activity involves implementing reasonable and practical steps to reduce risks and minimise loss, injury or harm. For example, where transport of heavy boxes is unavoidable, a trolley and safe lifting training is provided
- Major risks and their responding treatments are logged in the organisation's Risk Register
- Risks that are substantially mitigated by the existence of a specific organisational policy or listed in the organisation's Compliance Register may not be required to be recorded in the Risk Register
- Risk specific to client service delivery are managed under a clinical risk management framework
- Risks specific to individual projects are identified and responded to through project implementation; these may not be required to be recorded in the Risk Register.

Risk Treatment should adopt the hierarchy for controlling Risks:

- Eliminate the hazard
- Substitute the hazard for something safer
- Isolate the hazard from people
- Use engineering controls
- Use administrative controls
- Use personal protective equipment.

The diagram below depicts the organisation's risk management process.

Reporting and record-keeping

- Risks identified in the organisation's Risk Register and the Compliance Register are reported to the CEO (or their delegate) in the appropriate meetings.
- Related discussion and outcomes are recorded in Board and relevant minutes.
- Risk management discussion and outcomes from staff meetings are recorded in meeting minutes.

RELATED DOCUMENTS

- The compliance management system
- Risk assessments (varied throughout support forms)
- Risk register

REFERENCES

- Work Health and Safety Act (2011)
- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)

Work Health and Safety (Environmental Management)

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2022/06	25/06/2022	Adding NDIS Commission contact details for COVID 19 positive test.	KK	
	05/23	COVID 19 positive reporting update	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This policy aims to provide guidance to **CALDS** in developing and implementing work health and safety (WHS) systems that are compliant with health and safety legislation, and effectively prevent and respond to health and safety risks and incidents.

This policy applies to all CALDS workers, including permanent, contract and casual employees, Board members, contractors, students, volunteers, and visitors.

Definitions

WHS	**Work Health and Safety.**
Workers	The collective term used in this policy to refer to a person who carries out work for **CALDS** including permanent, contract and casual employees, contractors, sub-contractors, employees of a contractor, students, and volunteers.
Workplace	This is a place where work is carried out for a business or undertaking and includes any place where a worker goes, or is likely to be, while working.
Hazard	A situation or thing that has the potential to harm a person.
Risk	Likelihood that a harmful consequence (death, injury or illness) might result when exposed to a hazard.
Incident	Any accident or event that occurs in the course of **CALDS**work.
Work Health and Safety Committee (WHSC)	Committee established by workers, bringing together employees and management to assist in the development and review of health and safety policies and procedures for the workplace.

WHS	Work Health and Safety.
Work Health and Safety Representative (WHSR)	Employee elected or selected to represent the health and safety interests of employees within **CALDS.** The WHSR assists both the FSO and FAO in monitoring and reporting WHS risks and incidents.
Fire Safety Officer (FSO)	Employee elected or selected to supervise day-to-day fire prevention, protection, fire safety functions and implement emergency procedures. The FSO assists the WHSR and FAO in monitoring and reporting WHS risks and incidents.
First Aider	Individuals who are certified to provide First Aid.
First Aid Officer (FAO)	A First Aid Officer, who is an employee, elected or selected to be responsible for administering First Aid, monitoring and maintaining First Aid facilities and policies. The FAO assists both the WHSR and FSO in monitoring and reporting WHS risks and incidents.
Infection	Requires three main elements — a source of the infectious agent, a mode of transmission and a susceptible host.
Infection control	Is preventing the transmission of infectious organisms and managing infections if they occur.
Infectious agents	Are biological agents that cause disease or illness to their hosts.
Contact transmission	Usually involves transmission of an infectious agent, by hand or via contact with blood or body substances. Contact may be either direct or indirect.
Direct contact transmission	Occurs when infectious agents are transferred from one person to another: for example, a client's blood entering a healthcare worker's body through an unprotected cut in the skin.
Indirect contact transmission	Involves the transfer of an infectious agent through a contaminated intermediate object or person; for example, an employee touches an infected body site on one client and does not perform hand hygiene before touching another client.
Standard precautions	Are work practices which require everyone to assume that all blood and body substances are potential sources of infection, independent of perceived risk.

Principles
Safe working premises, equipment and culture are a priority for CALDS.
Workers' orientation, training and consultation relevant to their position and responsibilities is key to WHS.

Outcomes
- Workers are provided with a safe working environment that they have contributed to.
- Workplace incidents and injuries are prevented or minimised.
- CALDS workers understand and comply with their WHS obligations.

Delegations

Board of Directors	Endorse, comply with and ensure compliance with the WHS Policy. Monitor work health and safety risk management strategies, incidents, and injuries.
Business services/ management	Comply with the WHS Policy. Ensure compliance with the WHS Policy. Ensure staff are provided with relevant training in WHS. Lead emergency responses where the delegated WHSR is not available. CEO (or their delegate) Receive and respond to WHS reports from WHSC or WHSR. Operational decision-making relating to WHS management, including expenditure. Refer serious WHS issues to the Board and/or to relevant authorities.
Program Services and allied health	Comply with the WHS Policy.

Risk management of WH&S
This WHS Policy is informed by and complies with relevant legislations including:
The model WHS laws (the model laws), which are comprised of the:

- model WHS Act
- model WHS Regulations
- model Codes of Practice.

As CALDS will operate throughout Australia, WH&S process will also be influenced by the jurisdictional instruments, particularly in respect to Workers Compensation and Return to Work matters.

Where a Health and Safety Representative is required, CALDS will ensure representative(s) have the appropriate training in matters relevant to both National and State legislative instruments.

Work Health Laws by State

State	Legislative instrument for workers compensation and RTW	Tick Applicable
NSW	https://www.safework.nsw.gov.au/	☐
QLD	https://www.worksafe.qld.gov.au/	☐
ACT	https://www.worksafe.act.gov.au/about-worksafe-act	☐
SA	https://www.safework.sa.gov.au/	☐
NT	https://worksafe.nt.gov.au/	☐
WA	https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_650	☐

State	Legislative instrument for workers compensation and RTW	Tick Applicable
VIC	https://www.worksafe.vic.gov.au/occupational-health-and-safety-act-and-	☐
TAS	https://worksafe.tas.gov.au/	☐

COVID-19
As an NDIS provider CALDS must implement *control measures* to minimise the spread of COVID-19 and ensure the health and safety of all employees, contractors and participants. This is a requirement under Work Health and Safety laws.
The latest information and support for NDIS providers and participants on COVID-19 is available from the NDIS website and the NDIS Quality and Safeguards Commission website. If staff are unsure, refer to these resources for information about what to do.

The Australian Government Department of Health has published a range of specific resources on COVID-19 for health and aged care providers and workers, including those providing in-home care. Many of these resources will also be of relevance to NDIS providers.

Website updates at: https://www.ndis.gov.au/coronavirus/latest-advice-ndis

COVID-19 Vaccine Roll Out
- Which vaccine will disability care workers receive?
- When will disability care workers get the vaccine?
- How will the vaccine be rolled out to disability care workers?
- The national rollout of COVID-19 vaccines
- How COVID-19 vaccines work
- Vaccination and my WHS duties
- Workers, customers and vaccinations

Which vaccine will disability workers receive?
Disability care workers will receive the Pfizer/BioNTech vaccine in Phase 1a of the National Rollout Strategy.
For more information about the COVID-19 vaccines, see the Department of Health website.

When will disability care workers get the vaccine?
Disability care workers are a priority population in Phase 1a of the National Rollout Strategy. Phase 1a vaccinations are expected to begin in February 2023.

How will the vaccine be rolled out to disability care workers?
Steps for providing vaccines to residential aged care and disability care workers are provided in the National Rollout Strategy.

Staff requiring more information can speak to the CEO how the COVID-19 vaccines will be distributed go to the Department of Health website.

Where CALDS employee staff directly using a tax file number, the appropriate Workers Compensation cover will be in place within each state.

(Accurate at 25/05/2023)

Working in a shared living environment
All staff working in a Supported Independent Living services will receive training (at induction and then annually) in how to manage the risks associated with delivering services in a shared living environment.

The CEO (or their delegate) has made available a home risk assessment for all staff to implement if working with a participant in their home in a shared living environment.

The CEO (or their delegate) will review risks and incidents on a monthly basis, and refer any issues identified for inclusion in the Continuous Improvement Register.

Remote or isolated work
Remote or isolated work is work undertaken when isolated from the assistance of other people because of the location, time or nature of the work being done.
CALDS must manage the risks associated with remote or isolated work, including ensuring effective communication with staff carrying out remote or isolated work.
Reporting
Incidents or injuries relating to WHS should be reported in accordance with CALDS's Incident Accident and Emergency Policies and Procedures.

COVID-19 POSITIVE REPORTING OBLIGATION
Accurate as at 25/06/2023

Providers are required to notify the NDIS Commission:
- if a support worker or NDIS participant is confirmed to have COVID-19
- if there are changes to the scale of their operations
- any other changes related to COVID-19.

Providers can do this by completing their Notification of event – COVID-19 (registered provider) form on the NDIS Commission's website or phoning 1800 035 544
Providers should refer to the NDIS Practice Standards and Quality Indicators to ensure they are prepared.

RELATED DOCUMENTS
- Incident Form
- Hazard Form
- Position Descriptions
- Compliments, Complaint/Feedback Form
- Individual Risk Assessment
- Participant Risk Assessment
- Participant Home Risk Assessments
- Work Health and Safety Register

REFERENCES
- NDIS (Quality and Safeguards Commission) NSW 2018
- Safe work Australia: National Code of Practice

Financial Management Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2309/2025 or in response to any legislative triggers

POLICY STATEMENT
This procedure guide deals with the way that the organisation plans the use of its financial resources to ensure that it remains in good financial health.

Applies to CALDS board and staff members.

Strategy
The overall goal of the CEO (or their delegate) (Owner) is to ensure that the organisation's processes for financial planning, management and reporting are competent and accountable.

For this reason, CALDS has:
- A financial plan and/or annual budget showing that the organisation can meet its financial obligations
- A business plan with relevant financial forecasting
- An effective financial delegation's process
- Regular financial reporting provided to the CEO (or their delegate) (owner)
- Solvency (sufficient funds to cover liabilities).
- Evidence of meeting financial reporting obligations to external bodies; and
- People with appropriate financial management skills

PROCEDURE
The following practices apply to financial management including recording of the business earning separately and being documented as a legitimate enterprise, with a clear revenue stream and records of deductible business expenses.

As documentation and organisation of information about company transactions will be used to facilitate financial management for tax purposes.

Bank accounts
All bank accounts are maintained.
Separate bank accounts are maintained for business and private purposes.

Credit Cards
Cardholders must only use a CALDS Corporate Credit Card for official CALDS business activities only.

Budget
An annual budget is developed by CALDS, supported by the CEO (or their delegate).

Books of Accounts
CALDS is responsible for maintaining accounts, assisting the financial advisor in the preparation of the annual budget and for preparing monthly, quarterly and annual financial reports.

CALDS is responsible for processing all receipts and payments.

Income
All monies received are receipted and recorded in the electronic finance system. Receipts and a banking statement are printed from the electronic finance system.

Payments
All payments (except petty cash) are made by electronic transfer.

Recurrent payments
Recurrent payments; wherever possible, are made electronically.

Supplier accounts
Wherever possible, accounts are established with suppliers and purchases charged to the accounts. Accounts are paid in full, within the required terms for payment, on receipt of the statement or invoice.

Asset Register
The Asset Register will list the assets owned by CALDS. It will contain details about each fixed asset to track their value and physical location.

The register will show the quantity and value of items such as office equipment, motor vehicles, furniture, computers, communications systems and equipment. (see "Asset Register" form)

Reconciliations and ATO reports
The following reconciliations and ATO reports are completed at the end of each month:

- All bank accounts are reconciled against bank statements.
- The Instalment Activity Statement is completed and forwarded to the ATO.

The following reconciliations and ATO reports are completed at the end of each quarter:

- The Business Activity Statement is completed and forwarded to the ATO.
- Superannuation Guarantee contributions are reconciled, and payments made.

The following reconciliations and ATO reports are completed at the end of each year:

- Books of accounts are balanced and closed off.
- Wages are reconciled, and Payment Summaries completed and forwarded to staff and the ATO.
- Audit reports are prepared.

Audit
Annual Acquittal Statement and audited Financial Report will be forwarded as per contractual requirements to the relevant government bodies. If the business grows to more than $50,000 then Financial Acquittal Statements will be forwarded.
An annual audit is undertaken each year by a qualified external Auditor.

Suspected Financial Abuse

Staff are trained to look for signs of financial abuse signs when spending time with Participants.
Staff are also trained to discuss preventive measures with participants. These measures include:

- Ensure they are aware of their rights to confidentially and privacy.
- Encouraging participants to have networks beyond their family circle.
- Not to relinquish control of their finances if they are still able to manage them themselves.
- Not to make significant financial decisions following a major event (i.e., Loss of a partner).
- Ensure they are aware of their right to refuse people access to their funds.
- Encouraging them to make plans in advance whilst they are still independent.
- Encouraging them to ask for help if they feel overwhelmed, confused or feel they are being taken advantage of.

If any staff member suspects that a participant is being financially abused, then the following steps are to be taken:

- Staff to gather evidence and record in participants case notes.
- Contact the CEO (or their delegate) to discuss evidence gathered.
- The CEO (or their delegate) will gather the details of the abuse and write a report of the situation.
- The CEO (or their delegate) to inform the relevant authorities and obtain support for the participant.

Payments and Pricing (NDIS)

- CALDS must adhere to the NDIA Price Guide or any other Agency pricing arrangements and guidelines as in force from time to time.
- CALDS must declare relevant prices to participants before delivering a service. This includes declaring any notice periods or cancellation terms.
- Participants are not bound to engage the services of CALDS after their prices have been declared.
- CALDS can make a payment request once that support has been delivered or provided.
- No other charges are to be added to the cost of the support, including credit card surcharges, or any additional fees including any ‘gap’ fees, late payment fees or cancellation fees. These requirements apply to all CALDS regardless of whether funding for the support is managed by the participant or managed by a CALDS or managed by the Agency.
- A claim for payment is to be submitted within a reasonable time (and no later than 60 days from the end of the Service Booking) to the participant or to the NDIS
- CALDS will not charge cancellation fees, except when specifically provided in the NDIA Price Guide.
- CALDS and participants (except for those that are self-managing) cannot contract out of the Price Guide. Where there are any inconsistencies between the Service Agreement and the Price Guide, the Price Guide prevails.
- Where required, CALDS will obtain a quote for services and have this approved by the participant.

Debtor Management

Outstanding debts will be reviewed on a weekly basis by the CEO (or their delegate) – Operations, who will decide upon the appropriate action to be taken.

Records of all interactions with debtors will be maintained in CALDS's financial management system.

The CEO (or their delegate) will contact debtors regarding overdue payments 15, 22 and 29 days from the date an invoice is issued.

15 days after Issue of Invoice
If the CEO (or their delegate) is successful in speaking to the participant/carer and in gaining assurance of prompt payment, the CEO (or their delegate) will record the promised date for payment in the financial management system and email the participant a reminder.

If the CEO (or their delegate) is not successful in gaining assurance of prompt payment, they will email the participant/carer stating services might be withdrawn or terminated if payment is not made within 7 days.

22 days after Issue of Invoice:
If the CEO (or their delegate) is successful in speaking to the participant/carer and in gaining assurance of prompt payment, they will record the promised date for payment in the financial management system and email the participant a reminder. If appropriate, a payment plan may be agreed.

If the participant/carer are not contactable, the CEO (or their delegate) will check the participant's file and speak to any of the participant's care staff to check if they are overseas, in hospital, or otherwise unavailable.

If there is no acceptable reason for non-payment, the CEO (or their delegate) will consider withdrawing/terminating services with immediate effect. If so, they will inform the participant in writing.

If the participant is self-managing their NDIS plan and there are doubts about the participant's capacity to self-manage, the CEO (or their delegate) will contact the NDIA.

The CEO (or their delegate) will email a final demand letter requiring payment within 7 days, stating that unless payment is received in that timeframe, recovery will commence through a debt collection agency without further notice.

29 Days after Issue of Invoice (unless participant/carer known to be overseas, in hospital, etc.)
If a debt is not paid within this timeframe, and an agreed payment plan has not been reached, the CEO (or their delegate) will ensure that services are withdrawn or terminated with immediate effect if this has not already occurred.

The CEO (or their delegate) will inform the participant/carer in writing and decide the further action to be taken (for example, arrangements for debt collection, or a repayment plan).

Finalising Debts
The CEO (or their delegate) may accept a reasonable request for payment by instalments, provided agreement is reached on the terms and the timeframes. Such agreements are to be in writing and confirmed by both parties, with a copy provided to the participant and a copy retained on the participant's file.

In the event of a payment default the full amount of the debt will become due for payment and will be referred to CALDS's debt collector.

Prior to referring a debt to a debt collection agency, the CEO (or their delegate) will determine whether this is a financially worthwhile option for CALDS.

REFERENCES

- Work Health and Safety Act 2011
- Australian Securities Industry Council (financial abuse)
- Provider Registration Guide to Sustainability
- Privacy Act (1988)
- NDIS Practice Standards and Quality Indicators 2018
- Corporations Act 2001

Delegations of Responsibility Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy deals with the way in which the organisation ensures that responsibilities and accountabilities within the organisations business and service areas are allocated across the organisation.

The policy applies to all staff and volunteers of CALDS who have delegated authority to act and sign documents on behalf of CALDS.

POLICY

Delegations are a key element in effective governance and management of CALDS and provide formal authority to staff and volunteers to commit the organisation and/or incur liabilities for the organisation.

CALDS is committed to the highest standards of integrity, fairness, and ethical conduct, including full compliance with all relevant legal requirements, and in turn requires that all managers, employees, volunteers, and contractors acting on its behalf meet those same standards of integrity, fairness, and ethical behaviour, including compliance with all legal requirements.

There is no circumstance under which it is acceptable for CALDS or any of its employees or contractors to knowingly and deliberately not comply with the law or to act unethically in the course of performing or advancing CALDS business.

The CEO (or their delegate) is responsible for the management of the organisation and can delegate any of its functions.

Delegations are decided with the intention to ensure that the appropriate officers have been provided with the level of authority necessary to discharge their responsibilities.

Please refer to the comprehensive delegations of authority register within the Compliance Management System.

Information and Record Keeping Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
The purpose of this policy and procedure is to provide direction to staff on the creation and management of information and records.

This policy and procedure apply to all CALDS staff; aspects of CALDS's business; and business information created and received.

This policy and procedure cover:
- information and records in all formats, including documents, email, voice messages, memoranda, minutes, audio-visual materials and business system data.
- all applications used to create, manage and store information and records, including CALDS's participant and financial management systems, email, websites, social media applications, databases and business information systems; and
- information and records created for CALDS and managed in-house and off-site.

DEFINITIONS

Word	Meaning
Information	knowledge communicated or received. It is the result of processing, gathering, manipulating, and organising data in a way that adds to the knowledge of the receiver.
Information management	a system for creating, producing, collecting, organising, storing, retrieving and disseminating information that may be in any format and available from internal or external sources.
Record	recorded information in any form (including data in a computer system) that is required to be kept as evidence of the activities or operations of the organisation.
Records management	the efficient and systematic control of the creation, receipt, maintenance, use and disposal of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records.

POLICY
CALDS's information and records are a corporate asset, vital both for ongoing operations and also in providing valuable evidence of business decisions, activities and transactions.

CALDS maintains a records management system 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.

Recordkeeping processes underpin CALDS's day-to-day actions and it has an ongoing commitment to continuous improvement in this area. CALDS is committed to establishing and maintaining information and records management practices that meet its business needs, accountability requirements and stakeholder expectations.

What is a record?
In the NDIS context records are "documents, information and data stored by any means and all copies and extracts of the same". As such, electronic or handwritten notes and recordings (audio and visual) are all formal records. A record provides evidence of actions or decisions about a participant and the delivery of services and supports and is used to capture information that is necessary or useful and to be relied on in the future (rather than just as a reference).

Why are good record keeping practices important?

- Keeping reliable records is important to ensure that the information contained within them can be relied upon in the future in supporting participants and delivery services.
- In order to achieve the purposes for which records are created, they need to be made in such a way that ensures they are credible and contain sufficient information to assist. In the NDIS context, records can be created for the following important purposes:
    - Tracking and organising the delivery of supports and services
    - Communication between workers, the support team, the participant and their representative for the purposes of continuity of care
    - For use in support planning and assessments and to support future plan reviews
    - To feed into administration (invoicing, claims, rosters etc.)
    - For use in legal proceedings and complaints to ensure facts are available to respond accurately and provide evidence
    - To ensure compliance with the legal obligations of a provider under the NDIS Rules
- If records are created and they do not assist with the purposes above, they can cause poor outcomes for participants, limit the ability of a provider to meet the participant's needs and answer complaints or claims and impact a provider's compliance.

PROCEDURES
All information, in paper copy, electronic or any other format, created by CALDS staff in the course of their employment, or that is accessed by staff on CALDS's equipment, is the property of CALDS.

All documents and electronic records that contain private and confidential information about participants, staff, or CALDS as an organisation, will be retained in locked cabinets with access restricted to the CEO (or their delegate).

No information or any form of media (such as USB drives) relating to CALDS work may be taken from the premises without the prior permission of the CEO (or their delegate).

Staff have access to participant information held in files on a 'need to know' basis. Access to information should be provided to authorised staff for legitimate business purposes only.

Information is to be treated in the strictest of confidence and is not to be divulged unless for legitimate and legally permissible purposes.

Use of records by staff is monitored and file audits are undertaken to ensure files are complete, up-to-date, and procedures are being followed (see CALDS's *Internal Audit Schedule).*

Sharing Corporate Information within CALDS
Information and records are a corporate resource to which all staff may have access, except where the nature of the information requires restriction. Access restrictions should not be imposed unnecessarily but should protect:

- individual staff and participant privacy; and
- sensitive material such as security classified or material with dissemination limiting markings, for example 'Commercial in Confidence'.

Storage and Security
Electronic records are stored securely with back up and disaster recovery systems in place. The greatest level of care is taken for participant-related records.

CALDS's electronic data, including email data, is securely stored and backed up on both a cloud drive and a hard drive. Back up occurs weekly.

CALDS uses Microsoft Office, Shift Care and hard copy for the capture and storage of specific information and records.

All CALDS computers have password protection. Corporate records must not be maintained in email folders, shared folders, personal drives or external storage media as these lack the necessary functionality to protect business information and records over time. Records created when using social media applications or mobile devices may need to be captured into CALDS's electronic system.

Where it is necessary to remove participant records from CALDS's premises, they should be moved securely in a non-transparent container (for example, a locked briefcase).

Hard copy files are kept in locked filing cabinets in secure, lockable areas with access limited only to authorised staff. Hard copy filing cabinets are regularly maintained and cleaned, with pest management programs in place, and kept free from water, dampness and mould. They should be stored away from direct sunlight, heat and risk of fire.

Staff are expected to lock unattended computers and maintain a 'clean desk' policy.

Regular physical access and digital access internal audits will be undertaken in accordance with CALDS's *Internal Audit Schedule*.

Once information can be destroyed it is placed in a secure bag to be collected by a secure destruction company for shredding.

CALDS keys are not marked as, or in any other way be identifiable as, CALDS keys. All keys will have an inscribed number and be documented to have been provided to a particular staff member in a *Key Register*, which will be maintained by the CEO (or their delegate) - Corporate.

Keys for items such as CALDS's secure filing cabinets are stored in a lockable box and are available to authorised staff when they need to access files from the secure cabinet. Access to these keys is through CALDS's CEO (or their delegate) - Corporate.

In compliance with state and Commonwealth legislation, staff must maintain the physical privacy of personal information and organisational records. The use and storage of consent and release forms support the collection and release of specific information.

Information Handling Operational Guideline - Recording, disclosing and using information

The NDIS Act contains a number of specific authorisations that allow NDIA staff and other persons in lawful possession of protected Agency information (for example, contractors, local area co-ordinators or providers of supports) to record, disclose to any person or otherwise use protected Agency information to people outside the NDIA (section 60(2)).

When determining whether a participant has consented to the disclosure of protected Agency information about them, it is important to remember that the consent can be in writing (such as an email) or provided orally (such as over the telephone or in a face-to-face meeting).

Where consent is given orally, NDIA staff must make a written record of that consent.

Exemptions

If the urgent disclosure of protected Agency information is necessary to prevent or lessen a serious threat to an individual's life, health or safety, CALDS will carefully consider the matter and proceed with the urgency required by the circumstances.

A serious threat to life, health or safety could arise when a person is subject to, or at risk of, harm, abuse, neglect or exploitation. Such threats could be physical or emotional, such that the person has suffered or is likely to suffer physical or psychological injury that jeopardises or is detrimental to their wellbeing.

The NDIS Act allows for the recording, disclosure or use of protected Agency information when a person to whom the information relates requests or consents to the disclosure (express consent) or can be taken to have requested or consented to the disclosure (implied consent) (section 60(2)(d)(iii)).

Freedom of Information

CALDS will provide participants and government agencies access to records in accordance with any applicable legislation, including Freedom of Information legislation. NDIS participants are funded via a Commonwealth government agency.

What is FOI?

The Freedom of Information Act 1982 (FOI Act):

- gives everyone the right to access copies of documents (except exempt documents) held by the Australian Government and its agencies
- requires Government agencies to make FOI decisions and provide access to any documents released online in a FOI disclosure log
- requires Government agencies to publish a broad range of information under the Information Publication Scheme (IPS).

This policy and procedure will be reviewed at least every two years by the CEO (or their delegate). Reviews will incorporate staff, participant, and other stakeholder feedback. CALDS's feedback collection mechanisms, such as staff and participant satisfaction surveys, will assess the accessibility and non-bias approach within CALDS to access personal information under the FOI process.

CALDS's *Continuous Improvement Register* will be used to record identified improvements and monitor the progress of their implementation. Where relevant, this information will be fed into CALDS's service planning and delivery processes.

Destruction of Records
When information is no longer needed for the purpose for which it was obtained, CALDS must take reasonable steps to destroy or permanently de-identify it.

CALDS will retain and dispose of information in accordance with the National Archives of Australia Records 2017/00015859 and will observe any further obligations within each state of Australia, where CALDS is delivering NDIS services to participants.

As a registered NDIS provider, CALDS must keep records relating to service delivery for 7 years from the date they were created.

Disposal and archiving of	Retention Period
Aboriginal & Torres Strait Islander (Health Record)	Destroy 1 year after client is confirmed deceased or 7 years after last recorded contact, whichever is sooner
Human Resources Documentation	7 years
Business Information	7 years
Internal Audits	2 years
Participant Records	7 years
Complaint or Incident Records	7 years
Contracts / Leases	7 years
Corrective Actions	2 years
Financial	7 years
Management Review	2 years

Note: Where a person under 18 is involved (participant or employee), the record must be kept in line with the above retention period from the date that the young person will turn 18.

Example: A participant is 16 years old at the time an incident occurs in the year 2020.

- The person will turn 18 on the 30/12/2022
- You file the documentation.
- The documentation can't be disposed of until 30/12/2029, which is 7 years from the time that young person turns 18.

RELATED DOCUMENTS

- Personal Privacy, Dignity and Confidentiality Policy and Procedure
- Key Register
- Internal Review and External Audit Schedule

REFERENCES

- Freedom of Information Act 1982
- National Archives of Australia Records 2017/00015859
- Sections 4, 9, 26, 36, 50, 53-57, 60-68, 186-187 and 197(2) of the National Disability Insurance Scheme Act 2013 (NDIS Act).
- National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013 (Protection and Disclosure of Information Rules).
- Sections 6 and 52(1) of the Privacy Act 1988 (Privacy Act)
- Archives Act 1983 (Archives Act)

- Australian Privacy Principles

Sample Template:

Data Breach Response Plan

Actions in the first 24 hours after discovering a data breach are crucial to the CALDS success of its response. This Data Breach Response Plan sets out responsibilities of CALDS staff in the event CALDS experiences a data breach (or suspects one has occurred).

A data breach occurs when personal information is lost or subjected to unauthorised access, disclosure or other misuse.

This plan is intended to enable CALDS to contain, assess and respond to data breaches quickly and transparently, to help reduce potential serious harm to affected people and to comply with the Notifiable Data Breaches (NDB) Scheme.

Immediate Action – All Staff

- ☐ Immediately notify the manager of the actual or suspected data breach.
- ☐ Record and advise the manager of the:
  - time and date the breach or suspected breach was discovered.
  - type of information involved.
  - cause of the breach.
  - extent of the breach.
  - context of the affected information; and
  - context of the breach.

Case Manager

- ☐ Assess and determine whether a data breach has or may have occurred. The assessment should consider the:
  - type or types of personal information involved in the data breach.
  - circumstances of the data breach, including its cause and extent; and
  - nature of the harm to affected people and if this harm can be removed through remedial action.
- ☐ Determine whether the data breach is likely to cause serious harm to any of the people that the information relates to (and is therefore Notifiable under the NDB Scheme). In the context of a data breach, serious harm may include serious physical, psychological, emotional, financial, or reputational harm.
- ☐ Record the data breach in CALDS *Incident Register*.

Note: If CALDS acts quickly to remediate a data breach and as a result it is not likely to result in serious harm, it is not considered a Notifiable Data Breach.

Minor Breach

- ☐ Within 24 hours, notify CALDS Data Breach Response Team, including:
  - a description of the data breach.
  - action taken by the manager or CALDS staff member/s to address the breach or suspected breach.
  - the outcome/s of that action.
  - confirmation that the incident has been recorded in CALDS *Incident Register*; and
  - sign off from the manager that no further action is required.

Notifiable (Serious) Breach

- ☐ Immediately notify CALDS Data Breach Response Team, including:

- a description of the data breach.
- action taken by the manager or CALDS staff member/s to address the breach or suspected breach.
- the outcome/s of that action.
- confirmation that the incident has been recorded in CALDS Incident Register.
- advice that the breach is considered Notifiable; and
- a request for further action to be undertaken by the Data breach Response Team.

Note: it is not necessary that all members of the Data Breach Response Team be included in all data breach responses. However, where a Team member is affected or involved in a breach, or where a Team member can assist in mitigating the harm caused by a breach, a primary or secondary contact must be involved in the response.

CALDS Data Breach Response Team

CALDS Data Breach Response Team includes [these are examples and should align with your business' organisational structure and support services]:

[Governing Body]

[Kiran Kundnani 0452 224 119] (primary contact)
[Mohini Prasad 0499 356 684] (secondary contact)

Legal

[Kiran Kundnani 0452 224 119] (primary contact)
[Mohini Prasad 0499 356 684] (secondary contact)

IT

[Kiran Kundnani 0452 224 119] (primary contact)
[Rosheena Prasad 0447 305 201] (secondary contact)

Communications

[Kiran Kundnani 0452 224 119] (primary contact)
[Rosheena Prasad 0447 305 201] (secondary contact)

Compliance

[Kiran Kundnani 0452 224 119] (primary contact)
[Mohini Prasad 0499 356 684] (secondary contact)

ShiftCare

[Kiran Kundnani 0452 224 119] (primary contact)
[Rosheena Prasad 0447 305 201] (secondary contact)

Quality Management Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2023/03	03/23	Dysphagia management, Mealtime and Emergency/disaster management added	KK	03/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is to explain the general procedures relating to Quality Management System

The following guidelines are to be adhered to by all managers, supervisors and employees.

POLICY

Quality management principles are a set of fundamental beliefs, norms, rules and values used as a basis for quality management. They are foundations to guide performance improvement. Quality Policy –a statement of our company's commitment to quality and an enunciation of our quality objectives. This is issued by our CEO/Managing Director and is to be reviewed annually.

ISO 9001: 2015 Quality Management Principles

Principle 1: Customer focus: The primary focus of quality management is to meet customer requirements and strive to exceed customer expectations.

Principle 2: Leadership: Leaders at all levels establish unity of purpose and direction and create conditions where people are engaged in achieving the organisation's quality objectives.

Principle 3: Engagement of people: Competent, empowered and engaged people at all levels throughout the organisation are essential to enhance its capability to create and deliver value.

Principle 4: Process approach: Consistent and predictable results are achieved more effectively and efficiently when activities are understood and managed as interrelated processes that function as a coherent system.

Principle 5: Improvement: Successful organisations have an ongoing focus on improvement.

Principle 6: Evidence-based decision-making: Decisions based on the analysis and evaluation of data and information are more likely to produce desired results.

Principle 7: Relationship management: For sustained success, an organisation manages its relationships with interested parties, such as suppliers.

General Requirements
The CEO will drive the governance and accountability and delegate responsibilities as appropriate to ensure consistency in meeting their customer's needs and expectations and to continually improve the system's effectiveness in delivering a high level of customer service.

NDIS Quality and Safeguarding Framework guides the CALDS model for quality management.

The NDIS Practice Standards CALDS are assessed against are:

The Core Module, consisting of 22 individual practice standards in 4 divisions:

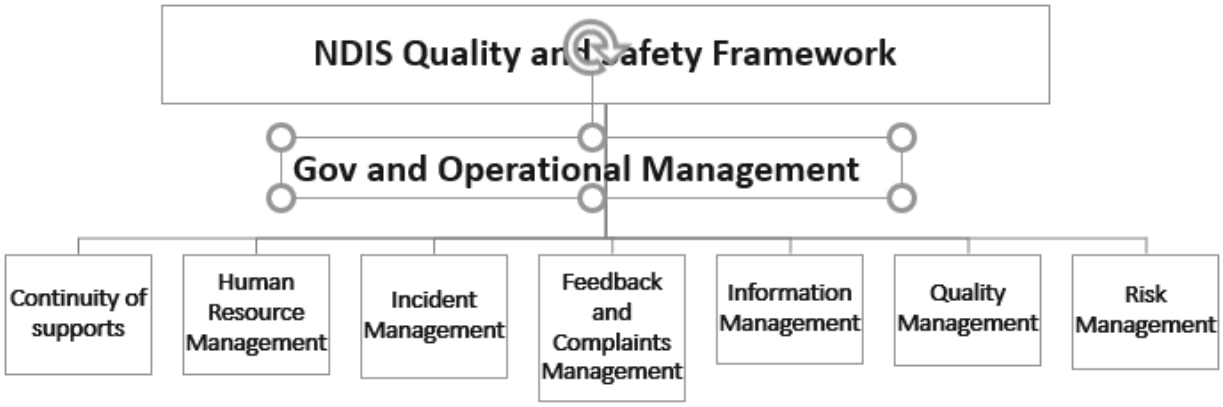
1. Participant Rights
2. Governance
   Emergency and disaster management
3. Provision of Supports
4. Support Provision Environment
   Mealtime management

Module 4.4 Waste Management
Module 4.3 Specialised Support Coordination

In Module 1: High Intensity Daily Personal Activities

- **Severe dysphagia management**

Figure 1 CALDS Quality Framework



RELATED DOCUMENTS

- Risk Management Policy and Procedure
- Internal Quality Audits
- Position descriptions
- Compliance Management System
- Complaints and Feedback Policy and Procedure

- Incident Reporting Policy and Procedure
- Continuous Improvement Policy and Procedure

REFERENCES

- Work Health and Safety Act (2011)
- Privacy Act (1988)
- NDIS (Quality and Safeguards) Commission (2018)
- NDIS Practice Standards and Quality Indicators 2018
- Tools and resources used
- Results of consumer feedback
- National Disability Insurance Scheme Act (2013)

Integrated Governance Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is to draw attention to conceptual association between governance as a broad term and how this overarching function must link and connect with all sub-standards within the NDIS Quality and Safety Standards Division 2 indicators.

This policy applies to all board, management or CALDS staff included in the process of implementation, monitoring or evaluation of any NDIS Provider governance processes. Inclusive of employed, contractor, independent contractor staff.

POLICY

The CALDS governance systems are in place to keep the organisation accountable to regulatory and legislative frameworks as well as the Australian Institute of Company Directors (AICDs) Good Governance Principles.

It is the responsibility of the CEO (as outlined in their position description) who in turn will delegate functions and responsibility to others (as accommodated for in relevant positions descriptions).

A business must integrate the systems, principles and processes to create 'overlap', alignment and a bird's eye view of what is going on across all areas of the organisation. By facilitating 'a birds' eye view', using a Compliance Management System (Excel based currently) the CALDS CEO (or their delegate) will be well positioned to view, monitor, measure and evaluate the success or need for improvement in all areas of service and corporate function.

CALDS considers the Division 2 Governance sub-standards as elements of its integrated governance model. These include:

- Incident Management.
- Complaints Management.
- Work Health and Safety.
- Human Resource Management.
- Financial Management.
- Information Management; and

The role of the CALDS leadership/management

The Leadership/management within each of the areas of governance within CALDS must be responsible to:

- Build and maintain strong linkages and relationships with other governance areas

within the organisation.
- Ensure there are formal and informal lines of communication at all times.
- Contribute to quality improvement and innovation in their area of accountability while encouraging and monitoring the same with their direct and indirect reports.
- Keep all workforce or human resource materials and documents up to date and representative of the work and functions an individual is responsible for.

The organisational structure of the CALDS

Related documents
- Human Resources Policy and Procedure
- Board and Governance Support Documents
- CALDS Compliance Management System
- All CALDS position descriptions.

REFERENCES:

- Spiering & van Amerongen (2014)
- A Clinical Governance Framework for Medicare Locals (2010)
- Northern Melbourne Medicare Local Integrated Governance Framework
- The challenges of an integrated governance process in healthcare (Article in Clinical Governance an International Journal · June 2011
- NADA Governance Toolkit
- The NDIS Act 2013
- The NDIS Quality and Safety Standards 2018
- The Code of Conduct and individual staff(s) professional bodies.

Open Disclosure Policy and Procedure*

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The Purpose of this Policy and Procedure is to support the organisation to communicate openly with participants, and their person(s) responsible when an adverse event occurs.

DEFINITIONS

Word	Definition
Open Disclosure	An open discussion or series of discussions with a participant and/or their person responsible about a participant safety incident which could have resulted or did result in harm to that participant while they were receiving health care.
Adverse event	is any event or circumstance which resulted in unintended and/or unnecessary psychological or physical harm to a patient during an episode of health care
Harm	is impairment of structure or function of the body and/or any harmful effect arising from an incident including disease, injury, suffering, disability, and death. Harm may be physical, social, or psychological.
Near miss	is an incident that did not cause harm but had the potential to do so
No-harm incident	means an incident where the patient was exposed, but where no harm resulted

POLICY

What is Open Disclosure?
Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care with the patient, their family, carers and other support persons. The essential elements of open disclosure are outlined in the national **Australian Open Disclosure Framework.**

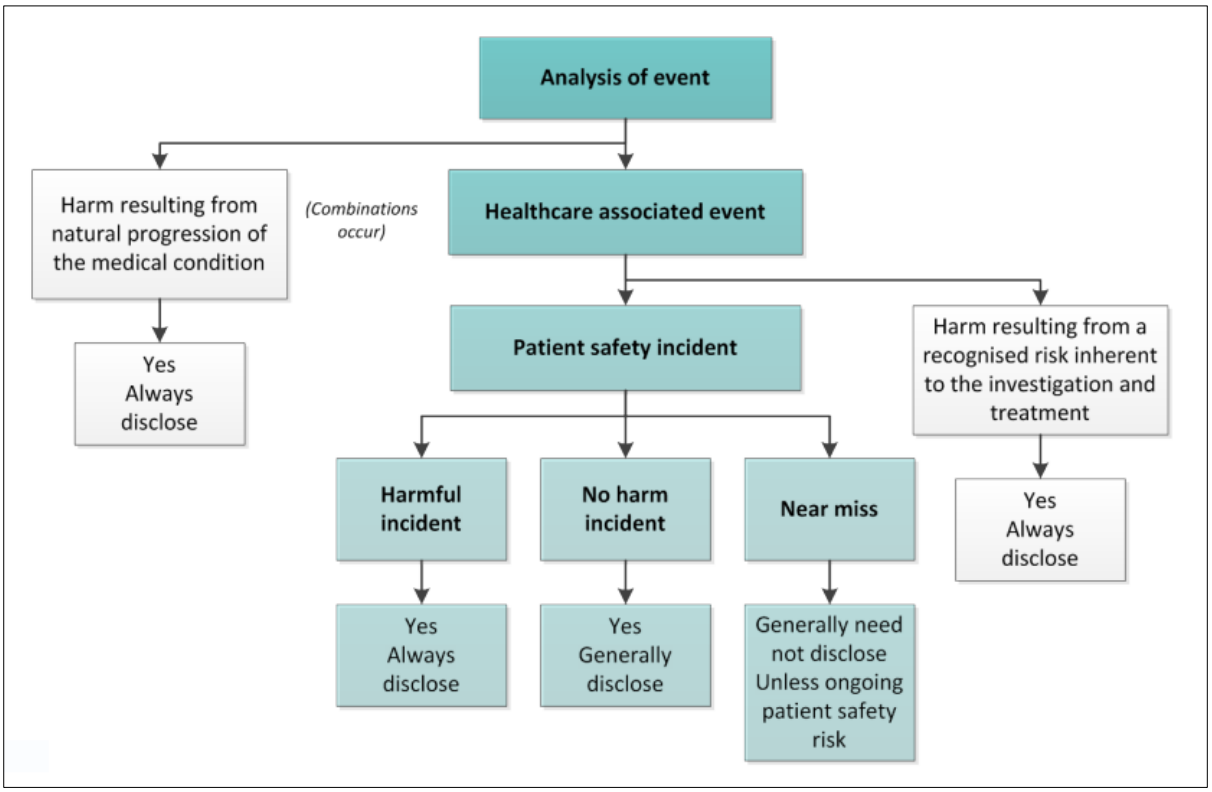
When do we use Open Disclosure?
Whenever a harmful incident occurs, the participant and/or their person responsible must be informed. This includes harm from an outcome of an illness or its treatment that did not meet

the participant's or the clinician's expectations; or harm resulting from a recognised risk inherent to the investigation and treatment.

No-harm incident
When a no harm incident has been identified, generally the participant and/or their person responsible would be informed. Even though no harm is immediately apparent, an ongoing participant safety risk may be present and the participant and/or their person responsible may be aware that some sort of mistake or incident has occurred.

Near-miss incident disclosure

- Where there is a near-miss incident, the disclosure is discretionary and based on whether it is felt the participant would benefit from knowing. For example, if there is an ongoing safety risk to the participant.
- Advice may be required from the Senior Leadership Team to assist with the determination of risk.
- The timeliness of informing participants must always be considered. Near miss incidents must be entered into the incident management system.
- Open disclosure is also recommended when the participant has been harmed as a result of the natural progression of their medical condition, or from a risk inherent to the investigation and treatment of their medical condition.



Legal liability & precautions
Open disclosure does not, of itself, create legal liability, and acknowledgment of an adverse event is not the same as an admission of liability. However, it is important that workers use the language of apology, concern, and regret without apportioning blame or admitting liability.

Workers of CALDS will take care not to:

- State or agree that they are liable for harm caused to a client.
- State or agree that another worker is liable for harm cause to the client.
- State or agree that CALDS is liable for the harm caused to a client.

Examples of language that may be useful includes:
"I am very sorry this has happened."
"I am sorry that this hasn't turned out as expected."

CALDS is committed to creating a positive culture of trusted and productive communication between participants, support persons and the workforce, in which open disclosure is standard practice. This policy forms part of our broader organisational incident management system.

The purpose of this policy is to:
- Enable CALDS to communicate openly with participants, and their support person(s) when an adverse event occurs.
- Ensure that communication with, and support for all affected participants and staff, occurs in a supportive and timely manner.
- Provide a framework for open disclosure that establishes a standardised approach to open disclosure across CALDS [include following if your organisation assesses against NSQHS Standards] and adheres to the principles of the Australian Open Disclosure Framework.

PROCEDURE

Scope of policy
This policy applies to all communications with participants and their support persons following harm from an adverse event, no-harm incidents, or near misses across all areas of CALDS.

While the policy focuses on adverse events, the harm suffered by a client does not have to be serious or permanent for open disclosure principles to apply.

Open disclosure: key elements
Open disclosure consists of five key elements, which are:
1. An apology.
2. A factual explanation of what happened.
3. An opportunity for the client to share their experience.
4. A discussion of the potential consequences; and
5. An explanation of the steps being taken to manage the incident and to prevent recurrence.

In addition to these core elements, open disclosure includes:
- Acknowledging to the client and their support persons(s) when things have gone wrong.
- Listening and responding appropriately when the client, or their support person(s) express their concerns or feelings.
- The opportunity for the client and/or their support person(s) to ask questions.
- Providing support to participants and/or their support persons(s), as well as workers, to cope with the consequences of an incident.

Open disclosure may involve one discussion, or a series of interactions. The duration of the process will depend on the severity and nature of the incident, the needs of the client and/or

their support person(s), how the investigation into the incident progresses, and whether the client has any ongoing care needs as a result of the incident.

Open disclosure: when to disclose
When a harmful incident occurs, CALDS must inform the client and/or their support person(s). This may include harm from an outcome of an illness or its treatment that did not meet the client or staff member's expectations, or harm resulting from a risk inherent to treatment.

When a **no-harm incident** has been identified, CALDS will generally inform the client and/or their support person(s). Even though no harm may be immediately apparent, there may be a chance of an ongoing client safety risk, or their support person(s) may be aware that some kind of mistake or incident has occurred.

For a **near miss incident,** disclosure is discretionary, and is based on whether CALDS feels the client would benefit from knowing. This could include situations where there is an ongoing safety risk to the client. Not all near miss incidents require open disclosure, for example, if disclosure may result in distress to participants or their support person(s).

Near miss incidents must be recorded in the incident management system.

Promoting a culture of open disclosure
CALDS commits to the following key actions and will ensure that all workers are trained and supported to implement these actions. Implementation of these actions will contribute to successful open disclosure:

- Establishing good rapport and relationships with participants, as well as their support persons, from the outset of their care.
- Ensuring that informed consent is obtained, and that the client has reasonable expectations prior to receiving the care, treatment or procedure.
- Accurately communicating the potential risks involved in the procedure or in health care generally.
- Acknowledging an unexpected event as close to the occurrence of the event as possible, even if further investigation is needed.
- Refraining from speculating on the causes of an incident, making unrealistic promises, or attributing blame.
- Remaining respectful to the client, their support persons, and other workers at all times.
- Communicating compassion and remorse when talking with participants; and
- Listening actively to participants during disclosure of discussions and being conscious of body language.

Open disclosure: process
CALDS will follow the below process when implementing open disclosure.

Step 1: Detecting and assessing incidents	• Immediate steps taken to prevent further harm • Initiate response • Escalate
Step 2: Signalling the need for open disclosure	• Acknowledege the adverse event to the client and/or support person(s) • Signal the need for open disclosure
Step 3: Preparing for open disclosure	• Investigation • Gather all necessary information
Step 4: Engaging in open disclosure	• Meet with the client and their support person(s) • Clearly explain the incident • Offer practical and emotional support
Step 5: Providing follow-up	• Provide feedback to the client and their support persons • Agree on future care
Step 6: Completing the process	• Reach an agreement • Provide the client with final written and verbal communication
Step 7: Maintaining documentation	• Maintain a record of open disclosure • File relevant documents in the client record

Procedures for review of this policy
This policy will be reviewed and updated if necessary [annually/biannually], by the CEO (or their delegate) and any changes made will be approved by the Management Team.

REFERENCES

Open Disclosure: The Australian Commission on Safety and Quality

Continuous Improvement Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	Added delegate for reporting QMS	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy and Procedure deals with the way in which the organisation continually reviews and improves on its own performance.

All staff, contractors and subcontractors are responsible for continuous improvement as their respective Position Descriptions will reflect.

Glossary Continuous Quality Improvement Terms

Word	Meaning
Accreditation:	A formal recognition that explicit standards have been achieved by a particular organisation. An accreditation system needs to have a set of standards, a review program that assesses the extent to which the standards have been achieved, and criteria which guide the awarding of accreditation.
Quality	The standard of something as measured against other things of a similar kind; the degree of excellence of something.
Quality Audit	Quality audit is the process of systematic examination of a quality system carried out by an internal or external quality auditor or an audit team. A distinguishing attribute and/or the degree of 'excellence'.
Quality management:	Is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. Quality management focuses on long-term goals through the implementation of short-term initiatives.
Continuous quality improvement	Continuous Quality Improvement (CQI) is a method of leadership and management used to assess and improve quality which: • Defines quality in terms of participant perceptions of service. • Analyses systems – not people or things. • Promotes partnerships with internal and external suppliers and stakeholders. • Uses accurate data to analyse processes and to measure improvement. • Involves staff in systems analysis and improvement. • Sets up effective, collaborative meetings and communication processes.

Word	Meaning
	• Trains managers in leading the improvement process. • Engages staff in the improvement process. • Achieves improvement through incremental steps. • Links evaluation to planning
Quality control (QC)	A component of 'a Continuous Quality Improvement' process. Quality control can be defined as "part of *quality management* **focused on fulfilling *quality requirements*."**
Quality assurance (QA)	A component of 'a Continuous Quality Improvement' process. Quality assurance can be defined as "part of *quality management* **focused on providing confidence that *quality requirements* will be fulfilled."**
Quality action plan	A document prepared by an organisation to record areas requiring improvement. • What needs improvement? • Why it needs improvement? • Who will do this? • When this will be implemented? • How it will be monitored for success?
Self-assessment:	An internal assessment in consultation with service users, staff and other stakeholders as applicable, to determine whether the service provider's performance and delivery meet the Service Excellence Standards. The self-assessment provides an opportunity to identify your organisation's strengths and to prioritise areas for system improvement.
Desk top audit	An audit conducted off-site by a reviewer of all documents for example, policies and procedures, registers and forms. Reviewers or Assessors often do this prior to arriving on site for an 'assessment' to get a feel for what the 'processes' are supposed to look like.

POLICY

CALDS actively pursues and demonstrates continuous improvement in all aspects of governance and operations with the aim of improving services to service users. This ensures CALDS continues to change and adapt to the needs of its service users, funders and the wider community.

Systems and resources are provided that support the ongoing planning, monitoring of quality initiatives on an organisational level as well as at a program level. Systems are put into place that encourage participation in a variety of ways, implementing ongoing monitoring of standards, initiating quality improvement measures and coordinating the services' evaluations, audits and accreditation reviews.

Continuous quality improvement (CQI) is an agenda item for Board meetings and staff meetings.

Quality improvement activities are to be based on the quality cycle. A structured Quality Improvement Plan is maintained and outlines the specific tasks to be undertaken by staff during a quality cycle.

PROCEDURE

Participation and feedback

CALDS routinely collects information on its services to identify progress, achievements and

areas of improvement. This information is collected through a variety of mechanisms including strategies e.g., stakeholder and staff surveys, have your say focus groups, interviews, literature reviews, audits, trend analysis of incidents, complaints, hazard reports, observations and policy/record/system reviews.

Information from surveys, stakeholder interactions and staff/volunteer-initiated changes shall be reviewed by the CEO (or their delegate) and appropriate corrective or preventive actions shall be taken if adverse trends are determined.

Wherever practical, findings will also be shared with relevant staff and their input sought regarding improvement solutions.

Initiating additions or changes
Staff are encouraged to initiate changes or additions to the quality management systems at any time by sending an email to the CEO.

The email should outline:
- A description of the issue/s identified, and
- List of suggestions/ideas to resolve/improve the issue/s.

On receipt of the email the CEO (or their delegate) will:
- Clarify the issue, talking with staff and/or stakeholders to better understand the issue.
- Identify solutions to the issues, considering the needs of the organisation, staff, service users and stakeholders that may be affected. Actions may range from procedure documentation or policy development to system redesign or creation to be taken, if any.
- Where improvements are significant, the process is recorded on the quality improvement plan (see the following page).
- Nominate the person responsible for carrying out the solution and the timeframe for implementation and review.
- Provide feedback to all involved on the actions taken.
- Evaluate whether the solution was effective.
- File a copy of the initial email and action taken when closed out in the closed section of the Quality Improvement Folder.

Accreditation and validation reviews
CALDS is required to undergo a quality accreditation review against the NDIS Quality and Safety Standards 2018, as determined by the NDIS Commission**.**

Accreditation is a tool to measure performance and outcomes and identify opportunities for improvement against an agreed set of Standards. The improvements identified through the review process are summarised in the Accreditation Report and included in the Quality Improvement Plan

Research
CALDS will access and share information that adds value and quality to the services being provided. This can include reports from government or other services on evidence based and informed practice models and the latest trends in care and casework.

From time-to-time **CALDS** may implement research projects to document its own best practice approaches. This information is distributed across the organisation and to stakeholders to encourage the promotion and implementation of quality initiatives.

Quality cycle
CALDS employs a quality cycle approach to continuous quality improvement that is systematic, and future directed. The quality cycle involves steps to continually evaluate and improve services and the results for stakeholders. This is commonly known as Plan-Do-Check-Act cycle. The quality improvement cycle does not stop and is never finished based on an assumption that there will always be opportunities for improvement, with better results seen as each cycle is completed.

Quality improvement plan
CALDS will develop and work within a three-year quality improvement plan, outlining the specific tasks to be undertaken by staff during the quality cycle and the steps to meet accreditation requirements. CALDS goals and outcomes as outlined in the Strategic Plan should be considered in all stages of the quality cycle.

The **CEO (or their delegate)** will support and monitor the implementation of the Quality Improvement Plan.

RELATED DOCUMENTS

- Compliments, Complaints and Feedback Forms
- Incident Investigation Form
- Feedback Analysis Annual Review
- Complaints Register
- Continuous Improvement Register
- Hazard Report
- Orientation Process
- Policies and Procedures Reviews
- Document Control Register
- Corporate Governance.

REFERENCES

- Work Health and Safety Act (2011)
- Disability Inclusion Act and Regulation 2014
- Privacy Act (1988)
- NDIS Practice Standards and Quality Indicators 2018

Complaints and Feedback Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy is about the way in which the organisation encourages and collects feedback from services users or other stakeholders and manages complaints about its services or activities.

This policy applies to all staff, participants, stakeholders and the community.

POLICY

Complaints and Feedback is one of the elements in our Integrated Governance Model.

It is the policy of CALDS to create an environment where complaints and concerns, compliments, and suggestions (feedback) are welcomed and viewed as an opportunity for acknowledgement and improvement.As a participant exercises choice and control, and is encouraged to do so, we will ensure that individuals always feel they have the right to make comments and complaints and are encouraged to exercise their right.

The culture we create is one of “blame free” and resolution focused culture, respecting an individual’s right to privacy and confidentiality.

Please also refer to Whistle-blower Policy for details on protecting those who make complaints about breaches of Code of Conduct.

It is acknowledged that such comments and complaints are vital to review internal performance and processes and to seek continuous improvement of services as we seek to achieve our care commitment. participants, families, and / or other stakeholders may submit compliment, complaint and / or feedback form about CALDS supports or services, staff, and / or contractors.

It is our policy to follow the principles of procedural fairness and natural justice and comply with the requirements under the National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018.

DEFINITIONS

Word	Definition

Compliment	an expression of praise, encouragement or gratitude about an individual staff member, a team or a service.
Complainant	a person who makes a complaint, or has a complaint made on their behalf.
Complaint	an expression of dissatisfaction made to or about an organisation, related to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected.[1]
Procedural Fairness	a principal that requires a fair and proper procedure be used when making a decision.

PROCEDURE

Information for clients and stakeholders

CALDS complaints and feedback procedure will be documented for clients and stakeholders in our Complaints Brochure and in Easy Read format for our participants. These are made available and are part of the Welcome Pack on admission.

On admission, all clients will be informed of their rights and responsibilities with regards to complaints and appeals at the earliest possible stage of their involvement with the organisation.
The orientation and Welcome Package material will contain information on the following:

- how to make a complaint or lodge an appeal, including an anonymous complaint
- contact person for lodging a complaint or appeal
- how the organisation will deal with the complaint or appeal, the steps involved and the timelines
- the rights of the complainant to an advocate, support person or interpreter
- how the person will be informed about the outcome of their complaint or appeal
- how to make a complaint to an external body including contact details

Training procedures

- Staff will be trained on the complaint's management procedures during their induction, and as part of ongoing refresher training.
- CALDS will utilise Induction Modules to ensure staff have been orientated to the Complaints and Feedback process.
- From time to time, as resources allow, Managers and relevant staff, will undergo training for complaints management and resolution to support clients throughout the complaint process and appropriately respond to complaints in an empathetic manner.
- This will include open communication strategies such as acknowledging the grievance without being defensive and making apologies while accepting responsibility for what occurred.

Complaint Handling

- When a complaint is received it will be forwarded or handed to the CEO (or their delegate)
- The complaint will be registered in the Complaints and Feedback Register
- A letter acknowledging the complaint was received will be sent to the person making the complaint
- The CEO (or their delegate) will keep the person making the complaint, in the loop on all matters.

[1] AS/NZS10002:2014 Guidelines for Complaint Management in Organisations

- If required, the CEO (or their delegate) will organise an investigation into the Complaint.
- The Complaint will be managed efficiently, compassionately and within the time frame specified.
- Prior to a formal response being given to the person making the complaint, the CEO (or their delegate) will meet with the person and explain the outcome.
- A formal acknowledgement will at that time, be given to the person making the complaint.
- If the person making the complaint is not satisfied with the outcome information will be provided on the 'next steps' that can be taken in relation to the matter.

If the person making the complaint is happy with the outcome, the matter will be finalised.

CALDS will ask for feedback from the person who made the complaint, at approximately 1 month after the matter has closed. This is to ascertain their satisfaction at the way in which the complaint was handled.

Appealing the Outcome of the Complaint an appeal
Clients or their advocates may lodge an appeal if they disagree with a decision made by the organisation, or by a staff member. An appeal should be made in writing on the internet, via email, using the Dropbox or in person.

Procedure for appeals management
Any staff member may be a recipient of a complaint, and is responsible for:

Receiving the complaint:
Listening to the complainant, acknowledging the concern raised, and explaining the next steps to the complainant.
Depending on the type and severity of the complaint, either discussing with the complainant an agreed upon resolution (for smaller matters) or referring the complaint on to CEO (or their delegate) for further investigation and action.

The CEO (or their delegate) will be responsible for:
Processing the appeal which includes:
- registering the appeal in the Complaints Register as an appeal
- informing the complainant that their complaint has been received and providing them with information about the process and time frame
- At this point the CEO (or their delegate) will ask the person making the Complaint what their desired outcome would be.

If the CEO (or their delegate) feels this outcome cannot be met, the person making the complaint will be given External complaint mechanisms.

External Complaints Body

NDIS Commission
Ph: 1800 035 544 (free call from landlines) or TTY 133 677.
Help with Interpreter Services
Interpreters can be arranged by calling 131 450 Translating and Interpreters Service
National Relay Service and ask for 1800 035 544.
https://www.ndis.gov.au/understanding/language-interpreting-services
Auslan Services Australia Telephone **1300 AUSLAN**
Completing a complaint contact form.

https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=PRD00-OCF

Record Keeping
Copies of all correspondence will be kept in in a secure location and any sensitive correspondence must be password protected.

The complaints register and files will be confidential, and access is restricted to the CEO (or their delegate) or their delegate.

Evaluation and Learning
A statistical summary of complaints and appeals will be created using the Complaints and Feedback Register. This will be reviewed each month. Learnings will inform improvements and staff development topics.

RELATED DOCUMENTS

- Compliments, Complaint / Feedback Form
- Participant information about making a Complaint
- Complaints Register
- Quality Improvement Plan (Register)
- Service Agreement
- Code of Ethics and Conduct Policy / Form
- Continuous Improvement Policy
- Incidents, Accidents and Emergencies Policy
- Risk Management Policy

REFERENCES

- Work Health and Safety Act (2011)
- NDIS Practice Standards and Quality Indicators 2018
- NDIS (Complaints Management and Resolution) Rules 2018
- Privacy Act (1988)

Human Resource Management Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/01	30/11/2021	Retention and contingency.	GI	30/11/2022 26/9/23
2023/02	04/23	Added buddy shift checklist sign off	KK	04/2025 or in response to any legislative triggers

PURPOSE AND SCOPE

This policy and procedure set out recruitment and selection, staff management and exit procedures and demonstrates CALDS commitment to effective, transparent and fair human resources practices.

This policy and procedure apply to the staff, students, management, and volunteers.

POLICY

Human Resource Management Policy is integrated into the CALDS Workforce Framework.

CALDS is committed to building and promoting a diverse and talented workforce that has the support and capacity to deliver high quality services to its participants. CALDS will employ enough support staff, taking into consideration qualifications and experience to meet legislative, policy and service standards.

Each participant's support needs will be met by staff who are competent in their role, hold relevant qualifications and have relevant expertise and experience to provide person-centred support.

PROCEDURES

Position Requirements

Minimum qualification and experience requirements will be included in recruitment documentation and Position Descriptions.

Support Workers must have experience working in the community services sector. A Certificate III or IV in Individual Support or equivalent is preferred, but not required.

In addition to the above requirements, all staff must have, the additional training to match the needs of the participant. For example, if a participant requires assistance with medication, only a support worker who has been inducted to 'medication management' should be assisting this person with their medication.

All staff who are working with a participant are required to have a First Aid Certificate which includes a CPR component. Nurses are required to demonstrate the renewals of their CPR and/ First Aid Certificates also.

Where a participant has anaphylaxis or asthma; evidence of training is required and should

be noted in the Training Register with evidence of completion stored safely in the staff file.

The Register - Staff Matrix which forms part of the Compliance Register, outlines necessary requirements, and provides a source of monitoring.

Position Descriptions
The CEO (or their delegate) will develop and update Position Descriptions for all positions within the business. Positions Descriptions must set out:

- the minimum qualifications
- experience, skills, and knowledge required
- as well as the responsibilities, scope, and limitations of each position.

Recruitment and Selection
CALDS's CEO (or their delegate) is responsible for recruiting staff and will:

- develop selection criteria for each position.
- advertise positions, respond to enquiries, and email application forms if requested.
- contact applicants and arrange interviews (including interview panels).
- speak with nominated referees and seek opinion about the applicant's qualities, skills and capacity to fulfil the role.
- support selected applicants through the appointment process, including mandatory checks and contract negotiations; and
- notify unsuccessful applicants in writing or verbally, offering feedback on application.

Selection will be based on merit and have respect to CALDS's *Disputes and Grievances* and *The NDIS Code of Conduct Policies and Procedures*.

Staff will be paid as per the Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] unless otherwise negotiated with the CEO or their delegate.

Unsuccessful applicants have the right to appeal recruitment decisions. Appeals should be directed in writing to the CEO (or their delegate) and a final decision will be made by CALDS's CEO (or their delegate). Applicants who successfully appeal will be provided the opportunity for a second interview. Applicants who are not successful in their appeal will be provided advice in writing to this effect.

Acceptable Worker Screen Checks
When an individual applies in any role under the National Disability Insurance Scheme, they must undertake a risk assessment check for the NDIS to make informed decisions whether a person poses unacceptable risks to people with disability.

The check is quite distinct from the National Police Checks (NPC) and is handled by the government screening units of the NDIS.

This newly improved NDIS Worker screening check is valid for up to 5 years from the point of issue.

Refer to the Acceptable Worker Screening Handbook in the Human Resource file.

Who needs a NDIS worker screening Check?
All workers seeking to work in roles that involve care for people with a disability (irrespective of the degree) must approach the NDIS for a worker screening check. These NDIS checks are recognised nation-wide and will enable screened workers to deliver support services in other states and territory in Australia. The NDIS workers screening check is the priority

document for those involved in NDIS related work.

Risk assessed roles
Any staff member engaged in a risk assessed role, requires an NDIS Check. This is mandatory.

A 'risk assessed role' includes:

- key personnel (such as management and operational positions)
- a role for which the normal duties include the direct delivery of specified supports or specified services to a person with disability
- a role for which the normal duties are likely to require 'more than incidental contact' with people with disability. This includes:
  - physically touching a person with disability; or
  - building a rapport with a person with disability as an integral and ordinary part of the performance of those duties; or
  - having contact with multiple people with disability either as part of the direct delivery of a specialist disability support or service; or in a specialist disability accommodation setting.

'**Contact**' includes any form of face-to-face or physical contact, and communication, whether oral, written, or electronic.

A NDIS Check is not mandatory for:

- individuals with only 'incidental contact' with a NDIS participant
- individuals working for a self-managed participant or an unregistered provider.

Are acceptable checks transferrable or national?
Acceptable checks are not transferable or portable through the different states in Australia. Until a worker gets their NDIS worker screening clearance, they must have an "acceptable check" in any State/Territory where they seek to provide support and services to people with disabilities.

Can I confirm the clearance status of my worker?
The NDIS has a worker screening database which will hold the register of workers who have applied for an NDIS worker screening check. Also, registered NDIS providers will be able to access the commission portal of the NDIS to view the clearance status of workers in the database.

The option is equally available to self-managed participants and unregistered providers. However, they will need to complete an application form to request access to the NDIS worker screening database. These forms are available in all state and territory NDIS worker screening units.

NDIS Worker Screening Database

State	Worker Screening Database	Check if applicable
NDIS Check Queensland (QLD)	Anyone in Queensland (QLD) seeking to work in roles subsumed in the NDIS, they must obtain the NDIS worker screening check. It is issued by the agency present in your state and is mandatory. No acceptable checks are valid after the transition period except on special conditions. Workers based in QLD can get their NDIS worker screening check from the following link: https://www.ndiscommission.gov.au/providers/application-form	☐

Additional Requirements for NDIS Workers - State and Territory

State	Where to obtain the additional requirement	Check if applies
Queensland	In Queensland, it is an offence for registered NDIS providers to engage a person: • without a clearance • subject to a suspension, interim bar or exclusion. + Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships Working with Children Blue Card Services Free call: 1800 113 611 Ph: (07) 3211 6999	☐

Disclosures
CALDS must also provide an opportunity for prospective employees and volunteers to disclose any criminal record or disciplinary actions as part of the recruitment process.

The CEO (or their delegate) will be responsible for ensuring criminal record, working with children or worker screening check is acceptable before employment is offered.

Employment contracts will stipulate that all staff are obligated to:
- advise the CEO (or their delegate) if they are charged with a criminal offence which is punishable by imprisonment or, if found guilty, could reasonably affect their ability to meet the inherent requirements of their job; and
- disclose formal disciplinary action taken against them by any current or former employer, including findings of improper or unprofessional conduct by a Court or Tribunal and investigations the staff member has been the subject of.

Student Placements
Secondary school students on a formal work experience program do not need a check to work with people with disability in the NDIS. However, they must be directly supervised by someone

who does have a check.

A police check is required for tertiary students aged 18 years and older. These checks must be administered by the relevant course coordinator in the educational institute, or the student can obtain a police check through the New South Wales Police website.

For international students or students who have resided in an overseas country for 12 months or more in the last ten years, as they are only here for a short period, the usual requirement for obtaining an international police check (see below) is waived. However, they must complete a Statutory Declaration declaring that they do not have any charges laid against them by police concerning any offence committed in Australia or in another country in the past, any offence of which they have been found guilty, committed in Australia or in another country in the past.

International Police Checks
Prospective staff must be informed at the beginning of recruitment processes that if they have resided continuously in an overseas country for 12 months or more in the last ten years, they should contact the relevant overseas police force to obtain a criminal or police record check. If they were a minor when they were overseas, they do not require international police check.

Some countries will not release information regarding an individual for personal or third-party purposes. In these extenuating cases, where an international police records check cannot be obtained, a statutory declaration and character reference checks must be conducted with at least two individuals who personally knew the individual while they were residing in the other country. This should be undertaken as a very last resort if the international police check is actually unavailable and cannot be obtained.

The applicant must be informed that referees will be asked whether they have knowledge or information concerning the applicant, which would adversely affect the applicant from performing the job, including any relevant criminal offences. The credentials of persons acting as referees must be verified and can include previous employers, government officials and family members.

In the case of asylum seekers and refugees who may be unable to provide character references to accompany a statutory declaration, the statutory declaration will suffice with proof of status. However, eligibility to work should be confirmed as part of the recruitment process using the Department of Immigration & Border Protection's Visa Entitlement Verification Online (VEVO) checking system at http://www.border.gov.au/VEVO.

Results of the Police Record Check
Information released as part of a police record check is restricted according to the relevant legislation or release policies operating in the specific police jurisdiction. Where the police record check reveals no disclosable court outcomes, outstanding charges or other matters, their appointment may be confirmed.

An applicant should not automatically be precluded from a job or placement on the basis of having a police record. The CEO (or their delegate) should give consideration to the following criteria:

- the relevance of the criminal offence, in relation to the job or placement.
- the nature of the offence and the relationship of the offence to the particular job or placement for which the applicant is being considered.
- the length of time since the offence took place.

- whether the person was convicted or found guilty and placed on a bond.
- whether there is evidence of an extended police record.
- the number of offences committed which may establish a pattern of behaviour which renders the applicant unsuitable.
- whether the offence was committed as an adult or a juvenile.
- the severity of punishment imposed.
- whether the offence is still a crime, that is, has the offence now been decriminalised.
- whether there are other factors that may be relevant for consideration; and
- the person's general character since the offence was committed.

Where the CEO (or their delegate) makes the decision not to take on an applicant, volunteer, or student with a disclosable record, they must:

- inform the unsuccessful applicant of the decision and its rationale.
- provide an opportunity for the unsuccessful applicant to discuss the results; and
- inform the unsuccessful applicant of the opportunity for the decision to be reviewed.

Working with Children Check

The CEO (or their delegate) will:

- ensure staff or volunteers issued with a Negative Notice do not undertake child-related work; and
- periodically go to the NSW Office of the Children's Guardian website and check the status of all staff and volunteers with WWC Check cards using the Verify function.

Staff and volunteers must:

- inform CALDS within seven days if they have been issued with an Interim Negative Notice or Negative Notice, or if they have a relevant change in circumstances: and
- not engage in child-related work if they have been issued with a Negative Notice.

More information about the New South Wales Working with Children Check, including information about whether people are eligible and how to apply, is available from the New South Wales Office of the Children's Guardian at https://www.kidsguardian.nsw.gov.au/.

Storage of Documentation and Confidentiality

Information obtained as part of the safety screening process must be treated with the highest level of confidentiality and privacy in accordance with the relevant legislation and standards. See CALDS's *Privacy and Confidentiality* and *Information and Record Keeping Policies and Procedures*.

Other Checks

In addition to the Mandatory Checks, the CEO (or their delegate) must also confirm the identity (through photo identification), qualifications (through sighting a copy) and referees of all prospective staff prior to their appointment.

If qualifications are a mandatory requirement of the role, original qualifications must be copied, certified as being a true copy of the original and returned to the applicant.

If there are doubts about the qualification, the CEO (or their delegate) should undertake an online check to verify that the qualification was awarded to the applicant.

If an online check is not possible, the applicant should provide a letter from the registrar of the relevant institution confirming that the qualification was in fact awarded to the applicant.

If there are any concerns about the authenticity of the qualification as presented, the issuing institution must be contacted directly to verify that the qualification was completed and issued

to the relevant applicant on the date specified.

Vehicle Check
Staff using their privately owned vehicles to complete their work are required to provide their employer with:

- A copy of their vehicle registration
- A copy of their driver's licence
- A copy of their comprehensive car insurance.

If a staff member will provide transport at any time, to a participant, additionally the staff member must complete Vehicle Check every month (refer Human Resources/Employee Management/Vehicle. The CEO (or their delegate) will check that the inspection results match the vehicle presentation.

Training and Development
Records of induction, training, and organisational and professional development provided to all staff will be kept on each staff record as well as in CALDS's *Training and Development Register*.

Induction
All new staff must be provided an orientation and induction incorporating their job description, staff Code of Conduct, an organisation chart highlighting their direct supervisor and other relevant information to orientate them to the organisation.

Prior to engaging with participants, all staff must undergo a comprehensive Induction. This will include (but is not limited to) the provision of information and training in:

- the mandatory **NDIS Worker Orientation Program** covering human rights, respect, risk, and the roles and responsibilities of NDIS workers. The NDIS Commission will advise NDIS providers when the e-learning module is available to them.
- the areas listed in CALDS's *Induction Checklist*; and
- all relevant policies and procedures.

Where possible, cultural awareness training will be delivered by local Aboriginal and Torres Strait Islander and CALD groups to ensure it is tailored to the organisation's service areas. All staff will be asked to provide feedback on the Induction process to contribute to CALDS's continuous improvement. Ongoing training will be provided in these areas where required.

All staff, volunteers and student who will be interfacing with a participant or the family/carer of a participant must be issued with verifiable identification. A participant must be able to verify a CALDS staff member is who they report to be.

Ongoing Training and Development
CALDS is committed to ensuring all staff have the necessary skills and knowledge to competently undertake their duties. CALDS will identify, plan, facilitate, record and evaluate the effectiveness of training and development for staff to ensure they meet the needs of each participant.

The following mandatory training will be provided to all relevant staff each year (as relevant to the position they hold):

Infection Control + use of PPE	Expires after 12 months

Complaint Handling	No expiry
Incident Management	No expiry
Basic Food Handling (if dealing with food)	Expires after 12 months
Contingency Planning for Emergencies, Disaster and Infection prevention	Expires after 12 months
Fire Safety Awareness	Expires after 12 months
Mandatory Reporting	No expiry
First Aid and CPR	As per provider
Manual Handling	Expires after 12 months
Work Health and Safety	No Expiry
Participant Risk Webinar.	No Expiry

In addition to mandatory training, all CEO (or their delegate) and staff will have the opportunity to participate in training and development activities each year. Training and development methods available include on-the-job training, internal or external courses, support for undertaking research or project work, attendance at conferences or seminars, and networking, coaching and mentoring programs.

Training on specific issues or areas will be provided where a need is identified, for instance, NDIS information and preparedness training; disability and mental health; cultural awareness; LGBTI awareness; use of interpreters and translators; and referral and support networks.

Annual staff Performance Reviews will encourage staff to take an active role in their ongoing development by identifying their training and development needs in consultation with the CEO (or their delegate).

The CEO (or their delegate) is responsible for overseeing staff training and development needs. They will track training undertaken and future needs in **CALDS's *Staff Training and Development Register*** and plan and publicise upcoming training and development opportunities.

All training delivered to staff will be evaluated for effectiveness using **CALDS's *Training Evaluation Form***. Feedback obtained from evaluations will be used to inform future training provided to staff and improvements identified will be tracked in **CALDS's *Continuous Improvement Register*.**

Where the CEO (or their delegate) decides, in consultation with the CEO (or their delegate) - Corporate, that it is necessary for a staff member to acquire a particular skill or qualification in

order to carry out their duties, CALDS will consider being fully responsible for all costs incurred in the staff member meeting that requirement. Where CALDS's capacity and resources allow, staff will be supported to pursue further education or training that will contribute to their professional development, but which may not be a requirement directly relevant to their current position.

CALDS will provide equity of access to professional development opportunities for all staff, taking into account the organisation's needs and the needs and skills of staff. Where a staff member wishes to pursue further education or professional development that is not a requirement for their current position or directly relevant to CALDS's needs, CALDS will not directly contribute to the cost of the staff member's training.

At the CEO (or their delegate)'s discretion, and considering any impact on service delivery or other staff, the staff member may be:

- permitted to take annual leave or unpaid leave that would assist them to participate in the activity; and
- granted up to two days' study leave as necessary to attend examinations.

Staff Retention and Contingency

To improve the employee safety, experience and the organisations' ability to maintain continuity of service for the service user, CALDS will:

1. Ensure an adequate contingency is in place in respect of staff being unable to come to work due to illness, or the impact of an emergency or disaster (inclusive of any infectious outbreaks) please refer to the Business Continuity Plan.
2. Staff will be offered clinical or practice supervision relative to the role they carry out within CALDS.
3. Performance appraisals will be carried out every 12 months.
4. All efforts will be made to assist a staff member learn and grow in their role.
    - Where advancement is possible the organisation will support staff to do so.

Performance Reviews

All staff will undergo annual Performance Reviews with the CEO (or their delegate and it is an expectation for staff to attend at least 80% of any clinical or practice supervisions provided.

Performance Reviews will be conducted for all staff on a yearly basis. These will assess staff capability to perform their role and their understanding and application of CALDS's policies and procedures and provide an opportunity to set future professional goals.

The CEO (or their delegate) will notify their staff in writing, two weeks in advance, of the date and time of their performance review. Staff must complete a *Staff Training Needs Analysis* before the date of the review and take this with them to the interview.

Before the interview, the CEO (or their delegate) will review the performance of their staff over the past year and make preparatory notes. Either party can request that a support person be present during the interview.

Performance Reviews will seek to:

- clarify any issues relevant to the staff member's job description and performance.
- identify the staff member's strengths.
- identify areas where the staff member needs to improve.
- discuss the ***Staff Training Needs Analysis*** completed by the staff member and

any training that will help the staff member improve their skills.

- make changes to the staff member's *Staff Training Needs Analysis*, where necessary. Both parties must sign this document as agreement on the staff member's training needs.
- identify and confirm the actions to be taken to maintain, enhance or improve performance; and
- set future professional goals.

The CEO (or their delegate) will complete a ***Staff Performance Review Feedback Form***. This will be signed by them and the staff member.

Where strategies for performance improvement are required, a *Staff Performance Improvement Plan* must be completed and signed by the staff member and the CEO (or their delegate).

After the Performance Review, a *Staff Training Plan* should be completed and signed by both the staff member and the CEO (or their delegate).

A copy of the completed Staff Training Plan will be placed on the staff member's file and a copy given to them.

If a staff member believes that they have been directly or indirectly discriminated against in the performance review, they should take action in accordance with CALDS's *Disputes and Grievances Policy and Procedure*.

A copy of all documentation relating to staff Performance Reviews must be retained on their staff record.

Workers Compensation Claims
This section must be read in conjunction with CALDS's *Return to Work Policy and Procedure.*

Staff members who have been injured or become ill and wish to make a Workers Compensation claim must do the following:

1. If they have not already done so, record their injury or illness in writing as soon as possible, using CALDS's *Incident Register*, within 30 days of becoming aware of the injury. This can be done by the affected staff member or someone on their behalf. If the affected staff member is unable to record their injury or illness in the *Incident Register,* they will need to notify the CEO (or their delegate) of their injury or illness in writing within 30 days of becoming aware of it. If the injury was a result of a motor vehicle accident, it must also be reported to the police.
2. Be assessed by a doctor, who will determine the kind of treatment required, including the frequency and duration of treatment. The doctor will also issue a *Certificate of Capacity*, which is required to make a claim.
3. Complete a *Worker's Injury Claim Form*, available from SafeWork NSW, and submit it to the CEO (or their delegate).

The CEO (or their delegate) will submit the completed *Worker's Injury Claim Form* to SafeWork NSW within 10 calendar days of receiving it.

Staff making a Workers Compensation claim may be required to attend an independent medical examination, conducted to help SafeWork NSW make decisions about the person's possible compensation entitlements, treatment, recovery, rehabilitation and return to safe work. Staff making a Workers Compensation claim may also be asked to provide a statement

to the relevant a SafeWork NSW Investigator.

SafeWork NSW will notify staff making a Workers Compensation claim of the outcome within 28 days from the date they received the claim.

CALDS will make every reasonable effort to support its staff in any claim for Workers Compensation, including adhering to this Policy and Procedure, providing staff with return-to-work information and assisting staff with planning their return to work.

Termination of Employment
Staff are required to give CALDS the relevant notice as stated in the relevant industrial Award or instrument in the event they choose to end their employment with the organisation. This notice must be provided in writing.

CALDS has the discretion to pay the staff member their notice period in lieu of having them attend work for the notice periodicals will ensure all salary and entitlements are paid to the staff member within 14 days of the end of their employment with the organisation.

Performance Management
Staff who are not performing satisfactorily, engage in misconduct or do not comply with CALDS's Code of Conduct, Policies and Procedures or their Employment Contract may face disciplinary action. CALDS management staff are responsible for identifying problems as soon as they arise and taking action. They must maintain records of all performance-related discussions and counselling sessions, and these must be kept on staff records.

In all processes the principles of natural justice must be followed. This means the staff member must have an opportunity to state their point of view before action is taken and that the decision maker must not be biased. If a staff member engages in serious misconduct so that it is unreasonable for CALDS to continue their employment, they may be dismissed instantly. Examples of such misconduct include theft, assault and fraud. Such action must be supported by a high level of evidence.

Other misconduct that may result in disciplinary action includes:
- not complying with CALDS's Code of Conduct; and
- preventing other staff from carrying out their duties.

If misconduct occurs, the CEO (or their delegate) must complete a *Staff Performance Management Template* detailing relevant incidents and behaviours. If the CEO (or their delegate) identify unsatisfactory performance of a staff member, they must advise the staff member.

Training may be required to improve the standard of the staff member's performance. An opportunity must be provided for the staff member to improve their performance within a reasonable timeframe. If the staff member's performance does not improve to the required standard after assistance and training has been provided within the specified time, the CEO (or their delegate) must complete a *Misconduct or Non-Performance Report* outlining specific performance problems.

The CEO (or their delegate) will meet with the staff member and inform them that a report will be written, and they will be provided with a copy.

The following process will then be followed:
1. Discussion/Counselling – between the CEO (or their delegate) and the staff

member. The problem will be explained, and the staff member asked to respond. The staff member is entitled to have a support person present. If misconduct or non-performance is proved, the CEO (or their delegate) will advise the staff member of the corrective action they need to take. The CEO (or their delegate) will record details of the disciplinary session in the *Misconduct or Non-Performance Report*. All parties present must sign the report.

2. First warning - if the incident of misconduct is repeated or performance does not improve, the CEO (or their delegate) will issue a first written warning. If the case is considered severe enough, the first warning can be regarded as the final warning.
3. Final warning - if the problem persists, the CEO (or their delegate) will issue a final written warning to the staff member. If the issue is not resolved, the CEO (or their delegate) may proceed to dismiss the staff member.

The CEO (or their delegate) will maintain formal records (*Misconduct or Non-Performance Reports*) of each counselling/disciplinary session and keep them confidential. All records must be sighted and signed by the relevant staff member as true. Such records will provide important evidence if the matter proceeds to the Fair Work Commission.

Dismissal

CALDS must comply with all State and Federal legislation and the staff member's Employment Contract in relation to disciplinary action and employment termination. CALDS must ensure:

- dismissal is not for an unfair reason.
- the staff member knows the reason for dismissal and has an opportunity to respond in relation to that reason; and
- it gives the staff member appropriate notice or compensation in lieu of notice.

Staff may be dismissed on the basis of:

- their conduct, capacity, or performance.
- operational requirements, e.g., the position is no longer required; or
- other reasons sufficient to justify termination.

Exit Interviews

The CEO (or their delegate) will ensure all staff leaving CALDS have the opportunity to complete an Exit Interview. Exit interviews are voluntary and allow departing staff to offer feedback and suggestions that CALDS may use to improve its workplace practices and environment.

Staff will be provided with an Exit Interview Questionnaire to complete their Exit Interview.

Process for Filling a Vacant Position

1. Review the Position
2. Clarify the need for and the role of the position and develop or review the position description.
3. Develop essential and desirable selection criteria e.g., the Recruitment and Selection Form.
4. Determine how each of the selection criteria are assessed, e.g., written application and/or interview.

Advertise the Position

Positions are advertised internally and externally.

Interview Applicants

The interview will be conducted by the CEO (or their delegate), with an appropriate Interview Form. All applicants are asked the same questions. The questions explore the applicant's relevant skills and experience to perform the duties.
When all interviews have been completed the preferred applicant is selected.
Recruitment decisions and reasons for decisions are documented.
Pre- Employment/Reference Checks are conducted.

The successful applicant will be notified, and feedback provided to unsuccessful applicants.
An offer of employment is made to the successful applicant conditional on the following pre-employment checks:

- Reference checks e.g., Telephone Reference Check Form, (if the position is a Risk Assessed Role)
- Criminal record check and working with Children Check
- Registration Check (as applicable to role)
- Insurances (as applicable to role)
- Licenses (as applicable to role)
- Mandatory Worker Screening
- NDIS Worker Orientation Program
- An 'Offer of Employment' is sent to the applicant for signing; prior to commencing employment

Procedure for New Staff
The CEO (or their delegate) will complete an Orientation procedure with the new employee.

An Orientation Form will be completed by the new employee and signed off by the CEO (or their delegate).

The Orientation Form will include a checklist indicating which policy and procedure documents are most relevant to each role. The checklist will set out clear expectation on times for which it is expected that the policy will be read and signed off.

All forms and documents signed by the employee are filed in the employee file with copies provided to the employee as appropriate.

Supervision of New Staff
New staff are supervised and orientated to their position.
Senior staff are mentored by the CEO (or their delegate).
The duration of support is dependent on the new staff person's skills and experience but at least two support worker shifts are supervised by another support worker once general orientation is complete. Buddy shift checklist to be signed off by the staff supervising and RN.

Position Descriptions
All staff have a position description which specifies their roles and responsibilities.
Position descriptions are reviewed and updated.

Each staff member is provided with a copy of their position description prior to commencing employment and whenever their position description is changed.

Code of Conduct and Privacy and Confidentiality
All staff are required to comply with the Code of Conduct, which encapsulates the respectful, safe and professional delivery of support to our participants, representatives, the community and any other stakeholders.

Staff are required to sign a ‘Code of Conduct’ and a ‘Privacy and Confidentiality Agreement’ on commencement. Disciplinary action will be taken if staff do not abide by it.

Record keeping
A staff personnel file is maintained for each employee. It includes:

- Application for Employment
- Criminal Record Check and Working with Children check
- Professional registrations
- Signed Offer of Employment
- Copy of driving license, car registration/insurance (wherever applicable)
- Signed Code of Conduct
- Signed Privacy and Confidentiality Agreement
- Training offered
- Training provided
- Attendance at mandatory training
- Evaluation of training events
- Mandatory Worker Screening
- (Refer to Help at Home Induction Checklist)
- Employees are entitled to see their file at any suitable time arranged with the CEO (or their delegate).

CALDS must not allow a person to become a staff member unless satisfied that regulatory checks are current and in place.

This is assured as the organisation does not enter a staff member to the system until the mandatory training has been completed.

Staff Supervision and Support

- Supervision and support are important for ensuring that staff are supported in their work and that their work is carried out effectively. Additionally, supervision sessions provide an opportunity to follow-up on staff development issues noted in staff development reviews.
- CALDS is to supervise performance issues both at CALDS offices, in the community and at participant's homes.
- Upon employment, all staff are provided with CALDS contact details.
- The CEO (or their delegate) are available for staff to contact over phone and to arrange a meeting where staff require time to discuss concerns.
- Staff’s annual competency assessment, education and training, and performance appraisal also provide other avenues to support and supervise staff.
- All staff can attend meetings/care conferences, to ensure that they are aware of changes to support for participants and have an opportunity to provide input and feedback.

Performance Development Reviews

- CALDS is committed to supporting staff to improve their efficiency and effectiveness. Staff are expected to perform their duties to the best of their ability and to show a high level of personal commitment to provide a quality and professional service always.
- Performance development reviews are conducted annually in consultation with individual staff.
- Performance development reviews are based on position descriptions and agreed work plans.

The aims of the review are:

- To allow free and confidential discussions about work between the employee and the person conducting the review.
- To discuss the employee's job performance in the context of their position description.
- To discuss any work problems and search for solutions.
- To discuss means of improving work performance including identification of training and development needs or changes to work practice.

Staff Education and Training

CALDS provides appropriate training and development opportunities for all employees. This includes:

- The identification of training needs through ongoing staff input, management input and annual performance development reviews.
- The provision of training to meet identified needs.
- Opportunities for all staff to attend training.
- Ongoing evaluation of training to ensure it meets staff needs and improves the operations and services.
- Complete "Training Needs Analysis".

Staff Development Opportunities

- The training needs of staff are discussed with each staff member on recruitment, at the annual staff performance reviews and at supervision sessions.
- CALDS utilises the following mechanisms to support staff development:
    - Staff attendance for up to three (3) days per year at workshops, seminars and conferences.
    - Flexibility of working hours to participate in an accredited course of study at a recognised educational institution.
    - Purchasing resources such as videos and research literature.

PROCEDURE

Staff Performance Dispute Procedure

The following is the procedure to deal with a staff performance dispute not involving misconduct. Misconduct is an action by staff that results in instant dismissal (see definition below).

Verbal Warning

The employee is told as soon as possible of any complaint concerning the performance of their work and is provided with an opportunity to discuss the complaint.

The CEO (or their delegate), in consultation with the employee, outlines how the employee must improve their performance. Any assistance needed by the employee to improve their performance is identified and provided; wherever possible.

A date to review the employee’s performance is set, while considering providing adequate time for the person to resolve the issue and risk to the organisation.

First Written Warning

If the employee's performance is still unsatisfactory at the time of the review, there is further discussion with the employee. This will include the employee, a representative of their choice (optional) and the CEO (or their delegate).

The complaint against the employee and plans for improvement are put in writing and a copy given to the employee, clearly stating that a lack of improvement by a given date will result in a final written warning.

Final Written Warning
If, at the date set, the employee's performance has not improved, there is further discussion with the employee. This includes the employee, a representative of their choice and the CEO (or their delegate).

The complaint against the employee and plans for improvement are recorded in writing and a copy is given to the employee clearly stating that a lack of improvement by a given date will result in termination.

Termination of Employment
If the problem persists after the date set in the final written warning, the employee's employment may be terminated.
The termination must be approved by the CEO (or their delegate).
If the termination is not approved, an alternative process for managing the performance issue is developed.

Detailed notes of performance dispute management are recorded and kept in the individual employee's personnel file.

Disputes and Grievance Procedure
If an employee has a grievance related to their employment or concerning another staff person, it is suggested that the employee approach the person with whom they have a grievance with and attempt to resolve the situation. If this is not possible, the employee or contractor should approach their line manager or the CEO (or their delegate) for discussion and advice on the issue. The discussion is confidential. The employee may also put the issue in writing to a senior staff member and request that the issue be raised.

A decision on the issue and discussion with the employee, will occur within seven business days.

If the employee considers that the discussion has not addressed their concerns adequately, they may seek external advice. This may be with their union representative or another independent body.

Misconduct
Misconduct includes very serious breaches of our policies and procedures or unacceptable behaviour that warrants the dismissal of an employee. Examples of misconduct include:

- Theft of property or funds from our organisation.
- Wilful damage of property belonging to our organisation.
- Intoxication through alcohol or other substances during working hours.
- Verbal or physical harassment or discrimination of any other employee or participant.
- The disclosure of confidential information regarding the organisation to any other party without prior permission.
- The disclosure of participant information other than information that is necessary to assist participants and to ensure their safety.
- Carrying on a private business from our premises or using the organisation's resources for private business without the permission.
- Falsification of any records belonging to the organisation.

- Failure to comply with the Code of Conduct.

Seek Advice
The CEO (or their delegate) must be informed immediately following receipt of an allegation of misconduct.
If necessary, the CEO (or their delegate) will obtain external professional advice.
Staff should consider seeking advice from their union and / or another independent body.

Suspension of Duties
The employee is told as soon as possible of any allegation of misconduct. The employee may be suspended with full pay pending an investigation of the allegation.

A letter outlining the time, date and alleged misconduct is given to them.

Personnel Leave
Application for Leave
Any employee taking leave must complete an "Application for Leave" Form. If the application form is not completed, payment will not be made for leave taken.

The application must be completed and approved before annual leave, long service leave, or if unpaid leave is taken.

Sick Leave
A doctor's certificate is required for sick leave of more than two consecutive days.
When sick leave is required, this should be communicated to the CEO (or their delegate) as soon as possible and at a minimum of at least two hours prior to the usual start time of the employee.

An Application for Leave must be completed immediately after an employee returns to work after sick leave.

The Continuity of Support Policy and Procedure will be implemented to support participants.

Personal/Carer's Leave and Compassionate Leave
Personal/Carer's Leave and Compassionate Leave is defined in the relevant award. (This only applies if staff are under an award.) To qualify for personal leave, an employee's reason for leave must meet the definition of Personal/Carer's Leave and Compassionate Leave within the Award.

An Application for Leave must be completed immediately after an employee returns to work.
When leave is required, this should be communicated to the CEO (or their delegate) as soon as possible and at a minimum of at least two hours prior to the usual start time of the employee.

Recording Annual Leave
Annual leave taken and owing to staff is tracked on the human resource system which also houses personnel Timesheets/Leave/Holidays/Superannuation).

Timesheets
- Each staff member is required to maintain up-to-date Timesheets.
- This may be different for each person given the status of their engagement.

Workers' Compensation

When an employee suffers an injury or suffers from a disease and work is a substantial contributing factor to that illness or injury, CALDS ensures that financial benefits and other assistance are provided as required by the relevant State legislation and regulations.

Employee Exit Procedure
When an employee leaves CALDS the following procedure applies:

- An exit interview is conducted by the CEO (or their delegate), and this will provide useful feedback to the staff member and the organisation.
- The exit interview is to be documented.
- Completed documentation is relevant for review and consideration of improvements.

RELATED DOCUMENTS

- Application for Employment
- Application Interview Form
- Recruitment and Selection Form
- Telephone Reference Check Form
- Staff Employment checklist
- Staff Orientation Form
- New Employee Details
- Personnel File Contents Checklist
- Application for Leave
- Termination of Employment
- Code of Conduct
- Privacy and Confidentiality Agreement
- Compliments, Complaints/Feedback Form
- Training Needs Analysis

REFERENCES

- NDIS Practice Standards and Quality Indicators 2018
- NDIS (Code of Conduct) Rules 2018
- Work Health and Safety Act 2011
- Workers Compensation Regulation
- Fair Work Act 2009
- Anti-Discrimination Act 1977
- Privacy Act 1988
- Workplace Gender Equality Act 2012

Grievance Management Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

Policy Scope and Purpose
CALDS is committed to preventing and effectively responding to staff grievances in the workplace and provide appropriate procedures in managing concerns, grievances and disputes by staff, Board members, volunteers and students.

This policy applies to:
- Grievances between workers
- Grievances about the behaviour of a staff member, student or Board member not directly impacting on the complainant (e.g., witnessing inappropriate behaviour)
- Grievances about a specific policy or decision by the organisation.

This policy does not provide detailed guidance on:
- Grievances between Board members – refer to the organisation's Governance Policy
- Feedback and complaints from clients and stakeholders – refer to the organisation's Communication Policy.

Disciplinary or performance management
- A concern or grievance raised by staff, Board members, students or volunteers is considered separate and independent from disciplinary processes undertaken to manage performance or conduct matters. However, a grievance may give rise to a disciplinary process.

- If a concern or grievance is raised during disciplinary or performance management processes, the matter is to be addressed as per this policy and related procedure, and the disciplinary or performance management process continues independently.

Concern resolution
In the first instance, a concern should be resolved informally. Where this is not possible, or where the complainant seeks a formal outcome, the concern is considered a grievance and the matter proceeds to the formal grievance management process.

Examples of concerns include reports of another staff member's behaviour, or an organisation practice that reflects negatively on the organisation, staff members, Board Members, students, volunteers or clients.

Formal grievance resolution
Complainants are to make formal notification of a grievance by completing the organisation Grievance Notice Form and lodging it with their direct supervisor, next-in-line supervisor, or the CEO (or their delegate).

An appropriate person to manage the grievance is identified, depending on the nature of the grievance.

The person who has received formal notification of a grievance shall acknowledge receipt of the grievance in writing within 48 hours.

The person managing the grievance, the complainant and the respondent (if there is one) manage the grievance process.

This may include:

- The person managing the grievance shall interview the complainant to clarify allegations and details, ascertain desired outcome(s), and advise of the process to be followed.
- The person managing the grievance shall assess the allegations in the context of CALDS policies and relevant legislation, identify whether there is a legitimate complaint, and whether the Human Resources Policy and its Grievance Management Section established an appropriate course of action under which the situation should be addressed.
- Any respondent/s will be informed of the grievance allegations as soon as possible and provided with opportunity to respond in writing and/or in person to the allegations within 10 working days.
- The person managing the grievance may interview other parties only if relevant to the grievance allegation and that a conflict of interest or bias does not exist.
- The person managing the grievance may propose a resolution, allowing both the complainant and the respondent (if any) opportunity to comment and agree to.

After action has been taken to resolve the grievance, if no further response is received from either the complainant or the respondent (if any) is satisfied with the resolution, the grievance is considered closed. The Grievance Process Form is closed off, the original filed with the Grievance Register, and copies placed in the personnel files of both the complainant and the respondent.

Where a grievance remains unresolved, the person managing the grievance may seek a more senior staff member or the Board's President to contribute to the resolution process. Additionally, external mediation may be arranged by the organisation in an attempt to resolve the dispute.

The complainant and/or the respondent may request to have Union representation or an advocate as part of the external mediation procedure.

The complainant and/or the respondent and/or the organisation may seek assistance from a relevant industrial tribunal.

Withdrawing a grievance

The grievance complainant may withdraw their grievance at any time through written notification, providing an explanation as to why the grievance is being withdrawn to all those involved.

A record of the withdrawal shall be kept with the original Grievance Form (with the Grievance Register) and copies kept in the files of both the complainant and respondent.

Ill-founded grievances

The person managing the grievance may determine that the grievance is ill-founded and propose terminating further grievance management procedures.

Final determination to terminate further grievance management procedures is made by the person managing the grievance and their direct supervisor and/or the CEO (or their delegate).

Complainants related to ill-founded grievances have the right to request review of grievance management termination.

Documentation
All grievances are to be lodged using the organisation Grievance Notice Form. Details are to include:

- Grievance allegations
- Respondent's response if any
- Resolution actions previously undertaken
- Proposed resolution actions

Details of how the grievance has been managed are recorded using the organisation Grievance Management Form. Details are to include:

- Names of those involved in the grievance
- Proposed and actual actions undertaken
- Outcomes and further recommendations
- Closure details
- Sign-off by all parties

Details relating to grievances are considered confidential outside those directly involved in the grievance management process.

Copies of Grievance Management Forms and other documentation related to the grievance are retained in the complainant's and respondent's respective personnel files and attached to the organisation's Grievance Register.

A register of grievances and related original documentation are retained in the secure Human Resource filing cabinet by the identified staff member responsible for human resource systems.

Grievances remain on the grievance register for a period of not less than 2 years. For more information on effective dispute resolution refer to Fair Work's Website/dispute resolution

Related Documents

- Grievance Register
- Grievance Management Form
- Grievance Management Notice

References

- Fair Work Act 2009 (Cth)
- Human Rights and Equal Opportunity Commission Act 1986 (Cth)
- Industrial Relations Act 1996 (NSW)

Continuity of Support Policy& Procedure

Record of policy development		
Version	Date approved	Date for review
2021/02		09/2022 or in response to any legislative triggers
2022/03		Added no response plan
	09/23	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is to provide guidance to staff and management on 'maintaining the quality of a Participants Care and Support over time'.

This policy applies to the staff managing and working with participants.

POLICY

To ensure participants have timely and appropriate support with minimal to no interruption, CALDS Scope's staff (CEO (or their delegate) will:

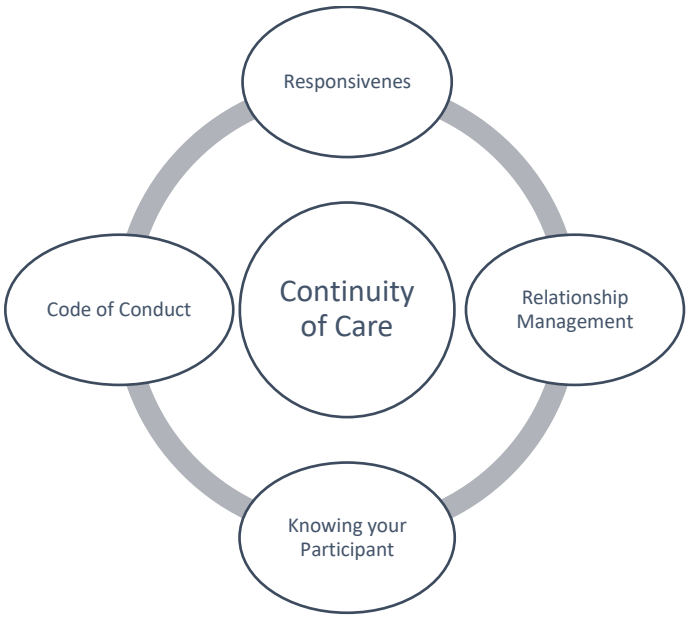
- Arrange schedules to ensure that participants know who is attending to their needs and supports.
- Pair participants with workers who hold appropriate skills and knowledge.
- Be responsive to participant's requests such as workers who speak the same language, are from the same culture, or meet specific criteria are matched, wherever possible.
- Place a support worker with participant taking account of their respective locations to increase the staff retention and reduce staff fatigue.
- Ensure that services and supports are linked to the participants Care Plan/Support Plan – and ultimately their NDIS Plan.
- Contact participants if there are any changes or potential changes in their care personnel.

CALDS will ask its' workforce to care with:

- Documenting all participant's requirements.
- Listing all appointments and tasks related to needs of the participant.
- Accessing, reading and complying with participant's plan.
- Informing the CEO (or their delegate) of any absences in advance.

These concepts are reflected within the Human Resource Policy and Procedure and underpinned by the Code of Conduct.

The Continuity of Care Framework



PROCEDURE

Disruptions and changes

Where disruption or changes cannot be avoided, CALDS will inform participants in advance and match the care or support worker with tact.

Where there is adequate notice the CEO (or their delegate) will contact the participant to:

- Seek agreement to the change
- Ask if they have a worker preference
- Explain alternative arrangements to the participant

CALDS aims to minimise the ‘surprise’ element and keep a transparent relationship between management, care and support staff and the participant.

In case of an emergency, when worker cannot attend work due to circumstances out of their control (such as illness, family emergency) then CALDS will attempt to place a worker who is known to the participant but if this is not possible, they will send the best match to the participant.

CALDS will contact the participant and inform them of the situation and give details of the replacement worker to the participant.

Absence or Vacancy

When a worker is absent, or a vacancy becomes available then CALDS 's the CEO (or their delegate) will:

- Contact a staff member with relevant qualifications to locate a suitable replacement.
- Where possible, provide a staff member who has worked with the participant previously and is aware of the participant’s needs and other responsibilities.
- Where possible, advise the participants of replacement staff and gather feedback on replacement staff member.
- Replacement staff are sensitive to participant's needs and ensure that care is consistent with the participant's expressed preferences.
- Staff who are unable to work, they are required to contact the CEO (or their

delegate),
- If there is an intended absence (such as vacation or appointment) then the staff member should inform the CEO (or their delegate) at the earliest opportunity to allow time to prepare the participant.

No Response Plan
When a person does not answer their down when an appointment has been organised a No Response Form needs to be initiated and a record must be kept.

Service Agreement
- CALDS ensures arrangements are in place to make sure that 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.
- Contingency plans are drawn-up and adhered to, to ensure the continuity of care to all participants throughout their time with us.
- No appointments are ever double booked. When travelling to participants, it is important that adequate travel time is factored in to ensure correct arrival time.

The overall governance of the Rosters and Scheduling is the responsibility of the CEO (or their delegate).

RELATED DOCUMENTS
- Support Management Policy and Procedure
- Support Plans
- Human Resources Policy and Procedure
- Business Continuity Plan
- Person Centred Emergency Preparedness Plan

REFERENCES
- NDIS Practice Standards and Quality Indicators 2018)
- National Disability Insurance Scheme Act (2013)
- Discrimination Act

DIVISION 3 – PROVISION OF SUPPORTS

Access to Services Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy is to guide the organisation in the way in it ensures that its services are accessible to all people within its target group (people funded for NDIS services).

This policy applies to any participant or potential participant and the staff interfacing with those participants.

POLICY

CALDS's service delivery environment is safe and engaging, physically accessible and responsive to its participants' support and communication needs.

CALDS's screening and eligibility, priority of access and waitlist management is undertaken in a fair, equitable and transparent manner, and in line with CALDS's *Participant Charter*. Access to services is based on relative need, service capacity, the best interests of people using the service and potential impact on existing service users.

PROCEDURES

The CEO (or their delegate) is responsible for ensuring staff are familiar with the requirements of this policy and have sufficient skills, knowledge and ability to meet the requirements.

The CEO (or their delegate) review the effectiveness of the entry and referral processes at monthly CEO (or their delegate)' meetings.

Participant feedback and complaints will be addressed in accordance with CALDS's *Complaints and Feedback Management Policy and Procedure*.

In accordance with CALDS's *Personal Privacy, Dignity and Confidentiality Policy and Procedure*, respect for and protection of participants' privacy and confidentiality will be reinforced on an ongoing basis, verbally and in literature promoting the services offered by the organisation.

Where required, participants will be provided with information and support to access a person of their choice, such as an advocate, to assist them to access the service.

To ensure participants understand how to access CALDS, staff will provide information in ways that suit participants' individual communication needs. This includes using the language, mode of communication and terms that the participant is most likely to understand. Methods include

providing written information in Easy English, explaining information either face-to-face or over the phone and using interpreters and advocates.

Service Environment
CALDS ensures its service environment is kept clean, hygienic, safe, secure and aesthetically pleasing at all times, through implementing the following:

- CALDS's *Work Health and Safety Policies and Procedures*, including fire safety and emergency; safety and security; maintenance and management of equipment, furniture, lighting and ventilation; electrical safety; vehicle safety; physical accessibility; chemical use and storage; infection control; and food storage and preparation; and
- CALDS's *Risk Management*; *Incident Management*; *Feedback, Compliments and Complaints*; and *Continuous Improvement* policies and procedures.

CALDS's physical accessibility is ensured through a willingness to make reasonable adjustments to the support delivery environment.

All workspaces will be assessed to ensure they are fit for purpose and suitable for each participant's health, privacy, dignity, quality of life and independence.

CALDS takes a continuous improvement approach to its physical accessibility and encourages participants to use its *Complaints and Feedback Management Policy and Procedure* to assist it to respond to accessibility needs where required.

CALDS opening hours are:

- [example] Monday – Friday 9am - 5pm
- [example] Service Bookings 7 days a week 8am -9pm.

Demand
The CEO (or their delegate) will track demand, as well as participant and accessibility need, by monitoring:

- ***Demographic data***: relating to the local community and its needs from Local, State and Federal Government Sources, including ABS data and specific NDIS market data published by the NDIA.
- ***Unmet need:*** demographic data (as above), CALDS's enquiry and waitlist data and feedback from staff, including those involved in local service networks; and
- ***Opportunities for innovation and improvement:*** through monthly review of CALDS's *Complaints Register* and *Continuous Improvement Register* and annual staff and participant satisfaction surveys.

Information for participants, including CALDS's signage and participant information, will be provided in a variety of formats such as different languages, Easy English, face-to-face or phone explanation by staff, and the use of interpreters and advocates. Specific formats provided will be responsive to demand data (as above) and individual participant needs.

CALDS will provide suitable participant resources to accommodate the local population. These will take into account cultural backgrounds, disabilities, age and developmental stage where appropriate.

Service Access
CEO (or their delegate) will deal with all enquiries from prospective participants or their supporters about accessing services. If CEO (or their delegate) does not take the initial enquiry personally, they will contact the person seeking services or their supporter within 1 working day.

In their first contact with the person or their supporter, CEO (or their delegate) will assess whether the person requires any support to move through the intake process. They will also:

- advise the person of their right to involve a support person in their dealings with CALDS.
- provide information and assist the person to access a support person of their choice, such as an advocate, to help them to interact with the service.
- where physical access issues are identified, consider whether CALDS is accessible for the person, and if not, how it could be made accessible; and
- where a language or cultural barrier is identified, engage an interpreter or an appropriate external agency to support the person. See CALDS's *Service Delivery and Participation Policy and Procedure*.

CEO (or their delegate) will book an Intake Interview with the person within 5 working days of their initial contact with them or sooner if the person's needs are considered urgent.
CEO (or their delegate) will conduct all Intake Interviews. They will provide the person with information about:

- entry and exit procedures.
- eligibility and priority of access requirements.
- conditions that may apply to service provision; and
- fees.

CEO (or their delegate) will undertake a non-discriminatory assessment of eligibility based on:

- the best interests of the participant.
- service guidelines; and
- identified participant needs and risks.

To be eligible to receive CALDS's services, a person must meet the following eligibility criteria. The person must:

- have one or more identified intellectual, cognitive, neurological, sensory or physical impairments that are, or are likely to be, permanent.
- have one or more identified impairments that are attributable to a psychiatric condition and are, or are likely to be, permanent; or
- be a child who has developmental delay.

Consideration must also be given to the person's Priority of Access by examining:

- the person's relative need compared to others who receive or want to receive CALDS's services.
- any special additional needs of the person, and where relevant, their family, carer or other supporters.
- the extent to which CALDS can contribute to those needs being met.
- the resources available within CALDS to meet the person's needs.
- other services the person receives and how CALDS's services will complement those and contribute to improved outcomes for the person; and
- the best interests of the person.

Where relevant, the interview will take into account information already provided about the person in their NDIS Plan. The CEO (or their delegate) will provide the participant with:

- A welcome package with information about rights and responsibilities, including an Advocacy Information Sheet
- Information about fees and pricing is discussed in the Financial Management Policy and Procedure.

Accessibility of information
Where required, the CEO (or their delegate) will provide this information in an alternative format such as a different language, Easy English, detailed verbal explanation or the use of interpreters and advocates.

CEO (or their delegate) will contact the person or their supporter within 1 working day of the Intake Interview to advise them of the outcome.

Where the participant is offered services and accepts, see CALDS's *Assessment, Planning and Review Policy and Procedure*.

Non-acceptance
Where a person is offered services but chooses not to accept the offer, CALDS will respect this choice.

CEO (or their delegate) will encourage the person to contact CALDS should they change their mind, noting that they may need to be placed on CALDS's waitlist if the service has no capacity to provide services at the time they do recontact.

Service Refusal
Where services cannot be provided, the person will be provided with a clear reason based on CALDS's eligibility criteria, Priority of Access requirements or waiting list processes.

CALDS may refuse to offer a person service where:

- they do not meet CALDS's eligibility requirements.
- other potential participants are assessed as a higher priority based on CALDS's Priority of Access Considerations.
- CALDS does not have the capacity to cater to additional participants; or
- CALDS does not have the resources to cater to the specific needs of the person.

A person who meets CALDS eligibility requirements and cannot be offered a service due to lack of capacity, can elect to be placed on CALDS's Waiting List. The person will be advised of the possible waiting time before services might become available.

In either case, the person will be assisted with referrals and support to access alternative services, as per CALDS's *Providing Information, Advice and Referrals Policy and Procedure.*

CALDS will never refuse service to a participant solely due to a choice or decision made by the participant in relation to dignity of risk.

Waiting List Processes
CEO (or their delegate) will contact people on the Waiting List at least every three months to:

- advise them of their current status.
- check whether they want to remain on the list.
- provide referrals to other service providers if required; and
- advise the estimated wait time remaining.

To keep Waiting List size and wait times to a minimum, at the CEO (or their delegate) – Operations' discretion, additional services will be offered where justified by demand and CALDS resources allow.

Appeals
Any person refused services has the right to appeal and should do so in writing to CALDS's

CEO (or their delegate) and a final decision will be made by the CEO (or their delegate).

If required, staff will provide support for a person to make an appeal, by either transcribing their feedback for CEO (or their delegate) review or referring the person to interpreter or advocacy services.

Those not successful in their appeal will be provided written advice to this effect.

If a person is unhappy with outcome of their appeal, they will be directed to CALDS's complaints process. As per CALDS's *Complaints and Feedback Management Policy and Procedure*, information on CALDS's complaints process can be provided in a variety of formats if required including support to access interpreters or advocates if necessary.

Alternative Supports
CALDS will work collaboratively with all people refused services and (with consent) their supporters, to identify what alternative services and referrals could best meet their needs.

With the participant's consent, relevant information will be provided by CALDS to new service providers to support the participant's seamless transition. Where required, CALDS staff will also meet with staff of alternative providers to facilitate a smooth transition for the participant.

Continuous Improvement
CALDS will maintain a record of people who have been refused a service, summarising reasons for their being found ineligible or, if found eligible, reasons for being placed on CALDS's Waiting List.

Access, service refusal and referral information will be tracked in CALDS's participant records to inform CALDS's continuous improvement.

RELATED DOCUMENTS
- Participant Charter
- Fee Schedule
- Complaints and Feedback Management Policy and Procedure
- Personal Privacy, Dignity and Confidentiality Policy and Procedure
- Work Health and Safety Policies and Procedures
- Providing Information, Advice and Referrals Policy and Procedure

REFERENCES
- NDIS Practice Standards and Quality Indicators 2018

Support Planning Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	09/23	NA	KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

To provide management and program design, individual planning, coordination, and Support Management.

To ensure staff are always trained and act professionally when developing plans that empower Participant to achieve their needs, goals, and aspirations.

To keep participants informed on their plan whilst undertaking a holistic approach that incorporates strengths-based and person-centred plans.

All staff involved with participant support management, development of plans or administrative functions relating to plans.

POLICY

It is CALDS policy that all case-managed services are developed and delivered in collaboration with participants or their advocates. All participants, family members, representatives or advocates must be included in any decision-making processes, choice of strategies or activities and approval for all aspects of their support plan. Support Management will include delivery, monitoring, review and reassessment in a timely manner.

Support Planning will be utilised to:

- Empower participants.
- Promote independence.
- Allow them to express their choices, aspirations and preferences.
- Participate in their community and engage in mainstream activities of their choosing.
- Communicate status against goals and outcomes; and
- Enable them to make arrangements that meet their care needs.

This will ensure that a holistic approach linked to the participant's strengths, needs, goals and aspirations are incorporated within their plan. CALDS will utilise this policy to ensure the organisation maintains a contemporary approach to support management services.

PROCEDURE

NDIS support planning is carried out using the following process:

Step 1:
Completion of a Baseline Assessment Tool (BHA) or Comprehensive Assessment tool (CAT) to inform a person centred discover session.

During the discovery session, certain questions will facilitate the discovery of any risks across the following domains in the order as listed below:

1. PERSONAL DETAILS
2. COMMUNICATION NEEDS
3. PEOPLE INVOLVED IN THE DEVELOPMENT OF THE PLAN
4. PARTICIPANT'S STORY
5. ASSESSMENTS PREVIOUSLY CONDUCTED OR ASSESSMENTS REQUIRED TO BE CONDUCTED
6. MOBILITY AND TRANSPORT
7. PHYSICAL ENVIRONMENT
8. LIVING SKILLS
9. INTERESTS, LEISURE, COMMUNITY GROUPS, NETWORKS AND PARTICIPANT INVOLVEMENT
10. FAMILY RELATIONSHIPS AND CONTACTS
11. CULTURAL & SPIRITUAL IDENTITY
12. HEALTH AND MEDICAL
13. DAILY LIVING DEPENDENCY/SELF SUFFICIENCY (Make an assessment as to the degree to which a participant is reliant on our services to meet their daily living needs)
14. ENSURE PERSON CENTRED EMERGENCY PREPAREDNESS PLAN (PCEPP) IS COMPLETED OR SCHEDULED TO BE UNDERTAKEN
15. The Participant Support Plan

Step 2

During the course of completing the assessment Tool, there may be a number of risks identified.

The tool will direct the assessor as to which risk assessment tool to be engaged as a follow up for specific risks. For example, the types of risks that may have been identified using the CAT are:

- Living alone
- Dysphagia (suspected, mild, moderate, or severe)
- Communication issues
- Mobility issues
- Cognitive capacity issues
- Mental health safety issues
- Behaviours of concern
- Complex health issues (multiple diagnosis)

Step 3

After completing any risk assessment(s), risk ratings and risk mitigation strategies, the Participant Support Plan can be completed. It is important to have collected sufficient information to ensure the support plan you develop reflects the NDIS goals, the persons aspirations and views on how those goals can be achieved and all of the person-centred information that describes 'who this person really is. That is the essence of person centeredness.

Step 4

Once risk plans are completed, the participant support plan gets developed and any referrals resulting from risk identified have been noted or actioned, the assessor must list the risks in the Participant Risk Register taking care to ensure the review date is not omitted. The most important piece of information in the participant risk register is the date of review as without

this information a review is not likely to take place.

Step 5
Ensure all risk assessments have been addressed

Step 6 – The We's of Support Plans
It is important to remember that support planning (as with case management) does not end when a person's plan has been developed. Support planning is an ongoing and interactive process between this organisation and the participant, and their chosen carer or family members.

We Screen for eligibility to our service
We assess to find out who this person is and what they need
We collaborate to develop a plan that aligns to the NDIS plan goals and to the participant wishes
We implement the plan (if we are providing the person with support coordination)
We ensure client and support worker are a good match
We monitor the progress of this plan and how the person is enjoying their service
We formally review the progress we are making and check in to see if goals are being met
We adjust our approach if goals are not being realised
We continue to repeat the monitor and review stages unless this person leaves our care.

Step 7 – The pitfalls to watch out for
We must be mindful to not be duplicating a service that the participant is receiving from someone else
We speak up if we think there might be better ways of achieving good results for a person
We report to the manager when we see something dangerous or that we don't think feels right
We remember to see the participant as a whole person and not just for the service we are providing
We don't avoid responsibility; progress notes must be completed carefully and in a timely manner
We write in the participants plan or case notes, as though we know the participant is going to read those notes; what would you like someone to say about you?
We make sure that a support plan review takes place at least annually unless required sooner
We ensure that the support plan is always available to the participant should they wish to read it
We make sure that if the participant is confused by the support plan, we can provide it to them in a way they can understand and in language they will find comforting
We only share a participant plan if the participant has given their consent. Don't forget the consent form in the client's file.
We keep our eyes open to see that support plans are inclusive of general health care, dental care, vaccinations and general wellbeing arrangements. What would you want for your parent, brother or sister?
We check the Person-Centred Emergency Preparedness Plan is both present and current (not more than 1 year old).
We don't support people in the NDIS without reading their plan first. Would you feel comfortable if someone was caring for your mother and had never read their file?

Supporting Autonomy and Dignity of Risk in Decision Making

- CALDS is committed to meeting each of its participant's, personal, and civic rights through the facilitation of their active participation in life choices within our service and the broader community.
- We are committed to a participant to exercise choice and independence.
- It is our practice that participants should be able to participate in social engagement and activities of living of their choice even when these chosen activities are deemed to involve a degree of risk of injury or misadventure.
- The staff and organisation respects participant's decision to participate in risk taking activities except when their decisions are unlawful or unreasonably impinge on the rights of others.
- We will work proactively with participant's and their representatives to create contexts in which participant's experience meaningful choices.

Monitoring the effectiveness of a support plan
How do we know if a plan is working well?

- Sometimes we can see by looking at and speaking to the client
- Sometimes we might speak to family, friends or other service providers who also support the client
- Sometimes, we might call a case conference as we really don't know how the person is going.
- Sometimes, we might call a case conference because we can't seem to get the participant to engage.
- Sometimes, a small or large change to our approach is required see the participant succeed in their goals.
- Sometimes, case review and supervision groups are good places to discuss hurdles we experience with participants and find solutions to keep the progress positive.
- Sometimes, if things are not going as they should, we ask for help. Whether that be from an allied health professional or a person who has more experience than us; or simply just to hear another perspective.
- Sometimes we need to remember, this is another person's life we are dealing with, and they deserve the best chance at making their goals come true.

Reassessment of Support Requirements

Support planning reviews, as discussed above, are required at least annually
It is a requirement by the CEO of CALDS, that a support plan (this is not to be confused with an NDIS Plan) is reviewed at the following occasions:

- When a new service agreement is entered into.
- When a person has a change of circumstances.
- When changes in care or life situation will impact on how care should be delivered.
- At the request of a service user.
- Where risks are impacting a person's quality of life and service delivery.
- Other times, please discuss with your manager.

RELATED DOCUMENTS

- Support plan
- Care Review Form
- Case conference template
- Client prioritisation matrix
- PCEPP
- Comprehensive Assessment Tool
- Living alone risk assessment
- Participant risk assessment and management tool

- Risk registers

REFERENCES

- Work Health and Safety Act 2011
- NDIS Practice Standards and Quality Indicators 2018
- NSW Disability Inclusion Act and Regulation 2014
- Privacy Act (1988)
- Camilleri, R., Gursansky, D. and Kennedy, R. (2021). *PRACTICE OF CASE MANAGEMENT*

Service Agreements with Participants

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	11/23	NA	KK	11/2025 or in response to any legislative triggers

PURPOSE AND SCOPE
This Policy is about ensuring that each participant as a written service agreement that is simple, flexible and reflects their needs, goals and wishes.

It is the responsibility of the CEO (or their delegate) to undertake the development of Service Agreement with the participant to ensure it is designed specifically for the participant.

POLICY
A participant's service agreement must be reviewed whenever a participant's services vary in registration group as the schedule of supports within the service agreement should reflect the actual services being delivered.

The service agreement is also to be reviewed when a participant is provided with a new NDIS Funding Plan.

The CALDS CEO (or their delegate), in alignment with the NDIS Quality and Safety Standards 2018, requires that the following areas be addressed with in a service agreement.

Service agreements are made through a collaborative process with the client, their support network (with the client's consent), and the organisation and includes details such as:

- Services to be provided.
- How, when and where they will be provided.
- Start and end dates.
- Cost and payment method/procedures.
- Process and timeframes for review.
- How any changes will be made to the plan.
- How feedback and complaints can be raised.
- Processes for dispute resolution.
- Responsibilities and obligations of the provider and the participant (including the notice periods for cancellation of a service booking); and
- Notice periods and process for ending the service
- Arrangement's for supports in the event of a major disruption to service delivery capability or restrictions on activity as may be experienced in a COVID-19 outbreak or broader geographic lockdown event.

Clients are supported to understand the process for making a service agreement, and their rights and responsibilities.

CALDS Service agreements include the minimum required information while retaining as

much flexibility as possible for the client should they wish to make changes to their service without the need to make a new service agreement.

Signing a Service Agreement
It is CALDS's preference that a Service Agreement be signed by a participant or their representative, however there is no legal requirement under the NDIS Act 2013 making this a mandatory requirement. If the participant is unable to sign the agreement, the staff member involved must make a file note as evidence of agreement to service.

Access to Information
A participant or their nominated person is to be provided access to their service agreement or any part of their support plan, at any time they require the access (during office hours or by arrangement with 24/7 staff).

Cancellation Information
Cancellation handled in accordance with the NDIA Price Guide, which directs that a provider will not charge a cancellation fee, except when specifically provided in the NDIA Price Guide. In these instances, when less than 24 hours' notice is given a full fee will be charged.

The participant handbook states the situations where a cancellation will be imposed and where a cancellation fee may not be imposed. For example:

The organisation requires at least one full business days' notice when there is a need to cancel a rostered and approved support, service, or shift.

The following circumstances do not apply to one full business days' notice:

- Where a participant requires urgent medical or hospital treatment andis able to provide medical evidence of such.

When, within a 12-month period, over four instances of cancellations or no shows in a occurs, the organisation may seek to review the support plan in consultation with the NDIA.

No fee is payable if the organisation cancels the agreed support shift.

RELATED DOCUMENTS

- Service Agreement
- Easy Read Service Agreement

REFERENCES

- Work Health and Safety Act (2011)
- NDIS Practice Standards and Quality Indicators 2018Support Management Policy and Procedure

Assessment Policy & Procedures

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2019/07				09/2022 or in response to any legislative triggers
2020/01	11/23	NA	KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy and procedure is to set out the approach CALDS will take to assessment, planning and review in respect to participant Support Plans, once a person has been offered and accepted CALDS's services.

This policy and procedure apply to all staff conducting Assessment, Review, Transition or Exit.

DEFINITIONS

Word	Definition
Planning	a process to enable people with a disability to explore their needs, goals and aspirations and the ways they can be supported to achieve these. Planning will have a different focus for each person.
Service agreement	a written agreement between a provider and participant on the supports to be provided and the conditions surrounding those supports.
Support plan	a document developed by a participant and provider in response to a request for supports, prior to the commencement of supports.
Support network	family, friends, carers and other people who have a supportive relationship with a participant.

POLICY

CALDS ensures participants have choice and control in the way they access supports that promote, uphold and respect their legal and human rights and are 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.

Where participants are transferring from other services, the transition is collaboratively planned, and the process is documented, communicated and effectively managed.

The Assessment Principles

- Participant support plans will be reflective of the information collected in assessment
- The assessor understands and applies the principles of flexibility, validity and relevance to the assessment process
- Abilities and barriers are assessed
- Communication issues will be addressed prior to the Assessment Meeting

PROCEDURE

Staff involved in assessment, planning and review activities will be trained in implementing:

- active engagement and early intervention strategies, including with families.
- strength-based planning, assessment and review.
- holistic and collaborative approaches to service delivery; and
- capacity building of families and carers.

Process to follow:

- All documentation relating to assessment, planning and review will be maintained on participant files.
- For all assessments, planning and review activities, staff will discuss participants' legal and human rights, as well as their responsibilities, with them.
- Staff will always confirm participants' understanding verbally, using an interpreter or advocate where required.
- Staff will advise the person of their right to involve a support person in their dealings with CALDS.
- Where required, participants will be provided with information and support to access a person of their choice, such as an advocate, to assist them to access the service.
- Staff will provide information to participants in ways that suit participants' individual communication needs. This includes using the language, mode of communication and terms that the participant is most likely to understand. Methods include providing written information in Easy English and/or explaining information either face-to-face or over the phone and using interpreters and advocates.
- In accordance with CALDS's Personal Privacy, Dignity and Confidentiality Policy and Procedure, respect for and protection of participants' privacy and confidentiality will be reinforced on an ongoing basis, verbally and in literature promoting the services offered by the organisation.
- Where physical access issues are identified, staff will consider whether CALDS is accessible for the person, and if not, how it could be made accessible. Reasonable adjustments to the support delivery environment will be made and monitored to ensure it is fit for purpose and each that each participant's health, privacy, dignity, quality of life and independence is supported.
- Where a language or cultural barrier is identified, staff will engage an interpreter or an appropriate external agency to support the person.
- If necessary and with the participant's consent, other parties such as service providers who deliver existing or complementary services will be included in assessment, planning and review activities.
- Staff will consider the participant's wishes in regard to accepting or rejecting particular support options.
- Should a person request assistance with Support Planning that is beyond the scope of this policy and procedure, the person should be directed to a relevant support coordinator.
- Referral and support to connect the person to the relevant agency or service provider will be provided within a service benchmark of 5 working days.

Post Assessment

Following their Intake Interview, where a participant is offered services and accepts, staff will work with the participant and their supporter/s to assess their needs, develop and agree upon a Service Agreement. Staff will meet with the participant and their supporter/s within 5 working days of their acceptance, or sooner if able, for an Assessment and Planning Interview.

As per CALDS's *Managing Participant Risk Guide,* a risk assessment for each participant's Support Plan must be completed and documented using a *Participant Risk Assessment*. This must also include appropriate strategies to treat risks, and how these will be planned and implemented.
Where relevant, the interview will take into account information already provided about the person in their NDIS Plan.

Living Alone Risk Assessment

Risk of Living Alone
An additional condition has been imposed under section 73G of the NDIS Act for providers of assistance with daily personal activities to participants who live alone
This condition applies to a NDIS provider but only if the provider is registered to provide personal support.
The risk is triggered by a combination of factors occurring simultaneously. Such as, a person receiving personal care activity, while at the same time a situation giving rise to:

1. A participant living alone
2. A participant preferring to only have 'one' and 'the same' support worker attend to their needs.
3. A participant with (1 and 2) and having very few informal supports of any kind.

The above circumstances can lead to a situation where a participant's deterioration could go un-noticed. This new process is in place to manage that risk.

Procedure:
It is required that CALDS:

- Ensure each client receiving personal care is risk assessed at intake, at review and at any other time where a change to the person's situation occurs.
- Ensure that a face-to-face communication or face-face contact occurs, if the Living Alone Risk Assessment result directs that a Risk Management Plan /Strategy be put in place.

The process for managing the identification, assessment and management of a participant is:
New Client

1. New Client: use the updated Initial Assessment and follow on with the Comprehensive Support Plan.
2. If risk is triggered (within Initial Assessment or Comprehensive Support Plan) for Living Alone use the Living Alone Risk Assessment Screening Tool to identify the level of risk.
3. If the client fits the risk threshold (on Screening Tool), proceed to a Participant Risk Management Action Plan.

As per compliance management process:

- this register must be monitored weekly: and
- staff progress notes reviewed daily.

Existing Client

1. Existing Client: use the Living Alone Risk Assessment Screening Tool to identify the level of risk for every client receiving personal care or high intensity personal activities.

2. If risk is triggered (within Initial Assessment or Comprehensive Support Plan) for Living Alone use the Living Alone Risk Assessment Screening Tool to identify the level of risk.
3. If the client fits the risk threshold (on Screening Tool), proceed to a Participant Risk Management Action Plan.
4. Place client details into the Participant Risk Management Register.

As per compliance management process:

- this register must be monitored weekly: and
- staff progress notes reviewed daily.

The Risk Management Action Plan/Strategy

Must contain:

- a procedure that will be used to review of implementation of the agreement, which must include someone other than the support worker checking directly with the participant, and with appropriate frequency, the participant's level of satisfaction with the type, quality and frequency of personal support being provided.
- a procedure that will be used to review of implementation of the agreement, which must include someone other than the support worker checking directly with the participant, and with appropriate frequency, the participant's level of satisfaction with the type, quality and frequency of personal support being provided.
- the means by which the provider will supervise and monitor the performance of the support worker to ensure the performance is consistent with the agreement and the participant's safety and well-being, which must include (as far as practicable) visits by a supervisor to the participant's home, at a specified and appropriate frequency, to undertake in-person supervision of the support worker.
- the means by which the provider will communicate with the participant, which must include (as far as practicable) face-to-face communication with the participant in the participant's home at an appropriate frequency.
- the means by which the provider will engage with other providers who may be involved in providing supports or services to the participant in the participant's home or in supporting the participant to access community-based activities.

Supervision of the worker must also be included in the risk management action plan.

This requires:

- A documented support worker supervision plan
- A process where the supervisor of the support worker is checking the frequency and content of the progress notes written by the support worker in relation to the person at risk.
- A clinical risk reporting mechanism via morning catch ups or formal staff meetings, using a standing agenda item/
- Regular updates to the Participant Risk Register.

Participant Reviews

Staff, with the relevant stakeholders, will review the provision of supports for each participant at least annually with the participant and their supporter/s. Flexibility will be provided in regard to the timing of review assessments, based on participants' needs and wishes, risks and functionality.

Reviews will include:

- the participant's needs (including health, wellbeing and safety needs), goals and longer-term aspirations.
- the participant's progress towards addressing their needs and achieving their

goals.
- recognition and celebration of the participant's progress.
- the participant's and their supporters' age, ability, gender, sexual identity, culture, diversity, values, beliefs, religion or spirituality.
- the participant's support network and how they can be supported to engage with this.
- any barriers to community participation and strategies that could be put in place to help participants overcome them; and
- whether there needs to be a change to the supports provided, ensuring new supports are based on the least intrusive approach and provided in accordance with contemporary, evidence-informed practices.

During Review:
The effectiveness of risk management strategies will also be reviewed with each participant to ensure risks are being adequately addressed, and that changes are being made when required.

Where possible, support provided to participants by CALDS should:
- support them to develop, maintain and strengthen independence, problem solving, social and self-care skills appropriate to their age, developmental stage and culture.
- respect their right to practice their culture, values and beliefs.
- help them take control of and responsibility for their choices and enhance their autonomy, independence and community participation; and
- take into account information in the participant's NDIS Plan (if applicable).

Where a participant's progress is different from expected outcomes and goals, the Support Plan must be updated and reflected in the participant's Service Agreement.

If the participant wishes to change their service delivery outside of the annual review cycle, they can request a review with the CEO (or their delegate) at any time.

RELATED DOCUMENTS
- Participant Assessments
- Continuous Improvement Register
- Restrictive Practice Register (if in use)
- Support Plan
- Participant Risk Tools

REFERENCES
- Work Health and Safety Act 2011
- NDIS Practice Standards and Quality Indicators 2018
- Disability Inclusion Act and Regulations 2014
- Privacy Act (1988)
- Equal Opportunity Act 2010
- NDIS Quality and safeguard Commission (2018)

Collaboration Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2019/07				09/2022 or in response to any legislative triggers
2020/01	11/23	NA	KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

- CALDS Collaboration Policy has been developed to give clear understanding about the importance of collaborating with participants, families, communities and other providers.
- Our Collaboration Policy is to support all relevant parties to have input into the service to ensure supports are relevant, appropriate and in line with the participants Service Agreement.

This policy applies to all staff, students and volunteers of CALDS.

POLICY

CALDS has a collaborative approach to service delivery. Staff are required to:

- First and foremost, remember participants maintain choice and control
- Locating key worker with family and other providers
- Working with other providers in the supply of supports or services
- Transition and exiting the service
- Capacity building
- Support planning
- Developing Service Agreements

Employees are required to work cooperatively with other agencies in the delivery of service. This may include initial contact, sharing ideas and input from participants and families, following through on ideas of provider, and actively listening to discussions.

We will collaborate with all relevant parties to provide participants with the opportunity to access a service network that meets the full range of their needs. The CEO (or their delegate) will contact and establish the relevant service provider and maintain collaborative relationships and protocols and participate in networks with relevant agencies.

Information, knowledge and skills are communicated and shared between the family, the provider, and other collaborating providers. CALDS will collaborate with the participant and their family to ensure that the participant maintains the functionality.

PROCEDURE

Key Worker

- Participants and families may require assistance to locate the right person for the participant.
- Discuss requirements with participant, family and /or advocate.

- Gain written consent to be able to share information with other providers.
- Contact other service providers working with the participant to collaborate and determine the criterion.
- Identify a key support worker and contact participant, family/advocate, and the other providers.
- Participant and family / advocate will select the person.
- Record information in participant's support plan.

Collaborating with other Providers
- Make sure consent has been given prior to contacting other providers.
- The CEO (or their delegate) is to make initial contact.
- Maintain contact through emailing, phoning and networking.
- Record contact in participant's support plan.

Transition and Exit
The participant's needs, interests or aspirations may change during the delivery of their supports. This may lead to a need to transition to or exit from their current service. If this occurs then we will, with consent of participant, contact the relevant service provider to:
- Send or request documents relevant to the participant.
- Communicate current supports, practices and needs to enable the participant to transfer or exit smoothly.
- Document the process in the participants support plan.

Risks associated with each transition to or from CALDS are identified, documented and responded to. (See Participant Transition and Exit Policy and Risk Management Policy)

Capacity building
To build the participant's capacity to support and increase functional capacity of the participants, CALDS will:
- Collaborate with participant and family to affirm, challenge, and support
- Collaborate with providers to:
    - Further develop participant's skills; and
    - Improve practice and relationships

Participant Outcomes
- Collaboration with participant and family is the basis ensuring function outcomes are based on their needs, priorities, and the skills.
- Record collaboration in support plan.

Support Planning
During the assessment and support planning process, collaboration is undertaken with participant, family and/or advocate to:
- Complete a risk assessment
- Document a risk assessment
- Plan appropriate strategies to treat known risks
- Implement appropriate strategies to treat known risks
- Review annually or earlier according to their changing needs or circumstances

Service Agreements
CALDS will collaborate with the participant to:
- Develop a service agreement which establishes.

Expectations,

- Explains the supports to be delivered; and
- Specifies any conditions to the delivery of supports, including why these conditions are.

With the consent or direction from the participant, CALDS collaborates in the development of the support plan, with other providers to:

- Develop links
- Maintain links
- Share information
- Meet participant's needs

RELATED DOCUMENTS

- Support Plan
- Consent Form
- Consent Policy

REFERENCES

- National Disability Insurance Agency
- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)

Community Engagement & Referral Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2020/01	11/23	NA	KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

To guide CALDS staff in e provision capacity including the priority of access process and eligibility criteria requirements.
Encourage and manage requests for service from potential participants and referrals to and from other agencies.

This policy will apply to all CALDS services and employees who are managing or coordinating services for any participants.

POLICY

People with disability have the same right as other members of Australian society to realise their full potential. The NDIS was introduced in part to give choice and control to a service user. A participant should be supported to participate in and contribute to social and economic life. Inclusion of, and access for, people with disability to mainstream and community-based activities and other government initiatives. (National Disability Strategy 2010-2020)

CALDS will access links between other service systems (for example, education) which will improve and support the varying needs of people with disability, their families and carers.

It is our commitment to:

- Deliver services to our participants which takes note of Community Engagement, to the level of the participants wishes.
- Make Referrals for participants, only after discussing the referral and its' purpose with the either the participant or their person responsible.

All information gained from potential participants will be recorded and assessed to ensure privacy and confidentiality is maintained. participants: whom we are unable to assist will be referred to a relevant organisation.

To ensure that CALDS refers participants to appropriate external services within the community, through timely responsive service integration and referral, and in a manner appropriate to meet individual needs. CALDS will contact organisations and networks within the community and relevant to target group. Staff will be required to contact networks and maintain contact on a regular basis.

The CALDS commitment is to make sure people with disability are connected into their

communities by:

- Providing information on mainstream services and community activities which will benefit people with disability, as well as their families and carers.
- Contributing to linkage and networks within the community.
- Providing participation and inclusion of people with disability by working in partnership with community organisations.
- Supporting carers to build the capacity of carers and families to help sustain their caring role, by linking them into direct carer support services.
- Linking carers and families to social and recreational activities that provide carers with a break from their caring role and connect them with the community.
- Sourcing activities that promote carer's well-being such as personal development, peer support and mentoring.

CALDS is committed to identifying and liaising with other stakeholders including:

- local community support organisations
- job networks
- training organisations
- housing agencies etc.

PROCEDURE

CALDS will actively engage with the community to ensure appropriate supports for the participant. This may include:

- Actively pursuing contacts that have been chosen by the participant.
- Contacting local communities such as cultural, religious, sexual orientation groups or spiritual groups including Aboriginal and Torres Strait Islander communities.
- Contacting government agencies to support individual participants.
- Seeking community members and groups to receive input into the service including policy or support mechanisms.
- Contacting advocates to assist with the development of community support plans for participants.
- Actively supporting the rights of the participant to seek contact with those in the community, relevant to their wishes, goals and aspirations.
- Participant will be encouraged to participate with relevant community links as required.
- Following the participant’s aspirations and needs to actively participate in the community.

CALDS will make relevant contacts for the participant to assist in initial involvement. Establishing and communicating with community including community leaders and elders. The outcome for people with disability will maintain their ability to:

- Be connected and have the information they need to make decisions and choices.
- Have the skills and confidence to participate and contribute to the community and protect their rights.
- Use and benefit from the same mainstream services as everyone else.
- Participate in and benefit from the same community activities as everyone else.
- Actively contribute to leading, shaping and influencing their community.

Refer to Aboriginal and Torres Strait Islander Policy for specific community engagement mechanisms on ATSI referrals.

Referral Principles

- Engage with and inform the community on how to access our services
- Undertake assessment/re-assessment, and consultation with the participant to

identify the need for referral
- Seek consent from the participant (or person responsible) before making a referral
- Monitor the results and participant satisfaction in relation to the referral and re-adjust if the results are not in line with the Plan

Referral may be received for services through:
- face-to-face contact.
- email.
- website information; and / or
- advertising materials

Types of Referrals

Active referral- CALDS, with the person's consent, provides the organisation to which it is referring the person with information that it has collected about the person or with its professional assessment of the person's needs.

Cold referral – A caller is transferred to another service, without any immediate communication between CALDS and the other service.
Facilitated referral – The person is helped to access the other service, for example, CALDS makes an appointment with the other service on the person's behalf, asks the other service to make contact with the person or a caller is transferred to the other service.
Passive referral – The person is given contact information for appropriate service/s so they can make their own contact at a time that best suits them.
Warm referral - A 'live' three-way conversation in the presence of the participant (whether face to face or by telephone) in which CALDS introduces the participant, explains what has already been done to assist the participant and why the participant is being referred.

Making referrals
Staff will be responsible for maintaining an accurate and current contact and referral database. The data base will be [describe what format it will be in and how it will be accessed by staff.

Informal referrals are made by providing the client with contact information about other services or agencies.

Formal referrals are made to other agencies using a Referral Form and ensuring a Sharing of Information Consent Form. These are to be kept on the participants File.

When a referral is made to another agency, the staff member making the referral will ensure that:
- confidentiality and privacy of the client is maintained at all times
- they have clarified with the client the service needs they have expressed
- the client is given an accurate picture of the other agency and its service
- the other agency is given full and honest referral information
- information about [specify any items] is put in writing to [the client or other agency] when appropriate
- records of contact with the client and the other agency are kept
- the culturally specific needs of the client are considered e.g., referring Aboriginal and Torres Strait Islander clients to services provided by Aboriginal community organisations

Other procedures may include making contact with an agency on behalf of, or with, clients

who are self-referring; follow up with the client or other agency about the appropriateness and suitability of the referral; specific guidelines when referring excluded or ineligible clients.

REFERENCE:

- NDIS Quality and Safety Standards 2018

Transitions: Entering or Exiting a Service Provider

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2020/01				
	11/23		KK	11/2025 or in response to any legislative triggers

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.

(3) Processes for transitioning to or from the provider (including temporary transitions referred to in subsection (2)) are developed, applied, reviewed and communicated.

POLICY PURPOSE AND SCOPE

The purpose of the policy is to guide staff in the way in which they manage a participant's exit, entry or cyclic exit and entry when associated with health or medical issues.

This policy applies to all participants receiving supports and all staff supporting or facilitating the processes within this policy.

DEFINITIONS

Word	Definition
Entry	Entry to a service, is the time at which a 'participant' first starts the formal engagement with a service provider.
Exit	Exit (or discharge) is the process through which clients transition out of a service. Depending on the circumstances, the exit process may occur when the client has reached their goals outlined in the client individual service plan. Other clients may require ongoing services and may wish to stay with one provider or move around.
Transition	For some clients there may be a period of transition to exit or some form of continuing care.

POLICY

CALDS is committed to providing participants with information and support throughout any

transition, for example:

- Entering the service
- Exiting the service
- Re-entering the service.

NDIS participants may move around until they find the right fit for themselves. Even once a participant finds a 'right fit', small or large changes may take place and the participant could decide to move again.

In the spirit of choice and control, it is a participant's right to move where they choose. However, this does leave a provider at times with a responsibility to ensure that:

- We do our best to ensure that the new provider has all of the key information they will need to be able to continue services for the participant.
- We do our best to ensure, as the NEW provider, that we are doing our best as a provider to preserve continuity of care during the exit, entry or transition.
- Maintaining excellent customer service through-out the entire process.
- Ensuring a non-discriminatory process is upheld throughout the exit or transition process.

Case Example:
Hunter Supports was providing support coordination and support work for John Smith. John's Aunty who is an experienced NDIS auditor and veteran in the social and health services sector was not impressed with the way her nephews supports and NDIS money were being managed. In her view there were no support records on file, she was not able to see any progress against goals and in 18 months it seemed like the support work was more of a baby-sitting service than a skill building (as per the goals) opportunity for her nephew.

John's Aunty ended the agreement and found another support coordination to manage the supports for John.John's Aunty requested Hunter Supports provide a transition plan (as she was aware the organisation had a transition template as she had supplied this template to the service some 1 year ago.)Hunter Supports refused and sent multiple emails, with multiple pieces of information. Much of the content in the emails was confusing and not on point. (This is often the case when a provider is offended by a client's decision to end the service).

John's Aunty was annoyed as Hunter Supports had spent all the support coordination budget except for just enough for a plan review. But that plan review was not due for 5 months.

The impact of being refused a Transition Plan was:

- *A new support coordinator had to read multiple confusing emails, speak at length to the family and use funding from a support plan that had limited funds. In fact, John's Aunty had to pay out of her own pocket as almost half of the remaining plan funds in support coordination were spent by Hunter Supports writing multiple emails and arguing with John's Aunty about sending a transition plan.*
- *So much more effort was required by all parties except from the Exiting provider who chose to breach the practice standard.*
- *Subsequently, John's Aunty made a complaint about Hunter Supports, to the NDIS Commission.*

Note: A transition plan is the right of every participant Entering or Exiting from a service and it is a risk strategy to ensure that all the needed information is transferred in 1 document not multiple hard to read and nonsensical emails.

PROCEDURE
Transition Plan – Exiting our service
When a participant is terminating our services the support coordinator (or their delegate) will:

- Complete a Participant Transition or Exit Plan.
- Where a risk is noted within the Participant Transition or Exit Plan a CALDS staff

member (support coordinator or manager) will also complete a Participant Risk Management Strategy/Plan.

Transition Plan – Entering our service from another NDIS Provider
When a participant is entering as a transfer from another provider, the support coordinator (or their delegate) will:

- Contact the Exiting provider and request a transition plan.

Where a risk is noted within the Participant Transition or Exit Plan a CALDS staff member (support coordinator or manager) will also complete a Participant Risk Management Strategy/Plan.

 Note: If the provider refuses to provide a transition plan, CALDS will attempt to create one by speaking over the phone with representative from the Exiting service provider.

Temporary Transitions – Hospital / Rehabilitation / Respite
Transition planning is not just for people leaving a service permanently. It is very important to create a transition plan for anyone with complex needs, risks, health concerns or where there are no family or friends to support the person.

 Transitioning from one service to another can be the catalyst for deterioration in their condition whether that be physical, psychiatric or spiritual in nature.

 All actions must be recorded in the participant's file.

Risk Management
The elements CALDS will be aware of during a participant exit or transition are:

- That risks are managed appropriately to ensure that no harm will come to the participant throughout the exit or transition process.
- That collaboration with new service providers and any relevant stakeholders, is undertaken where the participant gives their consent to do so.
- That the participant and family or carer understand the process.

Collaboration
Where collaboration with external providers occurs, a record must be created and stored in the participant file.

Monitoring of participant transitions

- The effective management of a participant transition will be monitored by the CEO (or their delegate) to ensure each consenting participant has a plan in place.
- The only exception will be where the participant has refused to have a transition plan put in place.

Withdrawing services
On an occasion where CALDS is withdrawing services, CALDS will give notice of intent to withdraw/terminate services to a participant in accordance with the CALD Service Agreement.

Customer feedback
At the completion of the exit or transition process, a participant will be sent a feedback

survey. The result of the survey will be placed in the Feedback Register and will be reviewed by the CEO (or their delegate) in line with the *Complaints and Feedback Policy and Procedure.*

RELATED DOCUMENTS

- NDIS Service Agreement
- Participant Support Plan
- Collaboration Template
- Consent to Share Information Policy
- Participant Transition or Exit Plan
- Complaint or Feedback Form
- Code of Conduct

REFERENCES

- NDIS Practice Standards and Quality Indicators 2018
- Privacy and Confidentiality Act (1988)
- NSW Anti-Discrimination Act

Support Planning and Collaboration with Agencies Policy and Procedures

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	11/23	NA	KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

The purpose of this policy is to guide staff in the practice associated with support planning and collaboration with other agencies for the benefit of our participants.

This policy applies to any staff responsible for the planning of supports or the coordination of agencies or providers to fulfil the participant plan.

POLICY

It is the policy of CALDS that all participants and their support networks are aided to participate in the development of a goal-oriented Support plan.

The Support plan will reflect an individual's goals and aspirations and will look at strengths and functionality of the participant. It is based on the presumption of capacity and will safeguard risks and needs of the participant.

The CALDS support plan will incorporate both general supports (described as nature of a coordination, strategic or referral service or activity) and reasonable and necessary supports funded under NDIS (activities that support goals, maximise independence, allow to live independently and undertake mainstream activities).

The Plan will provide clear and written information to the participant, detailing the services and type of supports they will receive from CALDS. Where there is a change in the participant's needs, preferences and goals, an amended Support plan will communicate this change in supports required to the participant.

Support Planning Principles:

Principle	**Description of principle in action**
Consult	Support planning process is consultative where the participant, family, friends, carer or advocate work together to identify strengths, needs and live goals with a focus on choice and decision-making.

Choice and control	The participant's preferences, values and lifestyle choices should be supported (wherever possible).
Independence	Promotion of functional and social independence and quality of life. Support plans will contain goals. Service choices agreed to should reflect the participant's personal goals
Flexible	Support plans should be creative, flexible and not developed by set patterns or methods of service delivery.
Person centred	Care must be inclusive of the participant's chosen communities and maintain connections with their community to allow for active participation.
Culture	If a participant identifies as Aboriginal or Torres Strait Islander, then this community will be contacted to allow for engagement and support services.
Review regularly	The Support plan is reviewed regularly and amended to respond to participant needs and preferences.
Focus on strength	Support plans should be strength based, seeking to maximise independence, and build on the participants existing networks.
Easy to read and understand	The Support plan should be provided to the participant in their first language where appropriate and/or requested.
Responsive and respectful	Participants or their advocates may request a review of the support plan at any time. Staff conducting support plan development will have the necessary skills and competence to undertake this function.

PROCEDURE – SUPPORT PLANNING

	Process flow
	Once a participant has consented to CALDS undertaking service delivery, an assessment will be undertaken to collect the relevant information staff will require to put together a person centred, participant directed support plan aligning to the goals and aspirations of the participant.
	The assessing team member will draw from a range of information sources such as: service directories, local services, family and other informal supports and any relevant allied health or primary health contacts which will enhance the quality of the support plan.
	Where the initial or comprehensive participant assessment indicates a 'risk' in any areas of the participants profile, a risk assessment will be completed; and where a

	risk indicated, a risk strategy will be developed and recorded in the participant risk register. *Participant risk management* documentation may be found in the *Participant Risk Management Folder.*
	The CALDS initial assessment, comprehensive assessment, and participant support plan (both for level 1 and 2 support coordination and general support plan), must be completed in collaboration with the participant and/or the family or informal support of their choosing.
	The support plan will be the repository of the participants goals and the strategies developed by CALDS and the participant.
	The career coach or support coordinator assigned to the participant is responsible for recording a support plan review date, recording a risk management strategy review date and updating the goals and strategies after each interaction with the participant.
	Every opportunity for review of a support plan or risk management strategy will be done so in collaboration with the participant.
	During a support plan or risk plan review, the CALDS team member will seek to integrate the participate feedback, stakeholder feedback and family or carer feedback as well as the observed functionality of the participant, to maintain a responsive and person-centred plan.
	Where progress to meeting goals varies from the estimated or hoped for outcomes, a collaboration discussion and re-calibration may be necessary to support good outcomes for the participant. At this point the CALDS team member may call on expert consultation with broader members of the team.
	At the completion of each support plan review, the forecast date for support plan and risk management plan review will be entered into the support plan register and the participant risk register.
	Where it is the agreed upon by the participant, progress against the goals may be shared with family members or stakeholders.

Monitoring of the support plan
The CEO (or their delegate) will monitor the support plan register within the compliance management system. Monitoring of the register is to safeguard the timely review of participant support plans and risk plans.

Although a support plan can be in place for up to twelve months, it is not the practice of CALDS to review support plans or risk management strategies any less frequently than every three months.

RELATED DOCUMENTS

- Participant Support plan
- Charter of Participant Rights
- Participant Risk Assessment Plan
- Participant Support Plan Register

- Participant Risk Register

REFERENCES

- Work Health and Safety Act 2011
- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)
- My first plan and Developing the Plan, NDIS, 2016

Working with Individuals and Families Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	11/23	NA	KK	11/2025 or in response to any legislative triggers

Supporting a person directed approach

A person directed approach means that people with a disability and the people who care about them take the lead in deciding what is important, which community opportunities should be taken or created and what the future could look like.

Professionals move from being the 'experts on the person' to being 'experts in the process of problem solving with others.

Person directed planning:

- Requires that it is the person who defines what is meaningful in their life.
- Accommodates the person's style of interaction and preferences regarding time and the setting for planning.
- Occurs with the support of a group of people chosen by the person or people who are important to the person.
- Ensures the person is listened to and chooses their own goals or that goals reflect the things that are important to them.
- Ensures the person's cultural background and spirituality is acknowledged and valued in the planning and decision making process.

The role of a planner is to support the person to lead planning to the greatest extent possible. In some circumstances, this could mean taking a 'backseat' and providing guidance and support only where required, or it could mean making a significant effort to actively encourage and support the person to participate and be heard.

Tips

- Staff are advised to have an initial meeting with the person and their network to find out how they would like planning to occur.
- Take time to pre-plan planning meetings. Get to know the person and any issues.
- Be creative about how the person can be involved during planning. The planner could:
  - Make a tape recording of the person to be played at the start of the meeting.
  - Ask the person to draw a picture of him/her to put up at the meeting/photo board
  - At the start of the meeting, read something the person has written

Supporting Communication

What is involved?

Everybody has a 'voice' and can be heard when others listen carefully. Some people find it difficult to use speech or to understand what is said to them. They may rely on forms of non-verbal communication such as body language, ways of behaving and sounds to express their views.

The support planner must maximise the person's capacity to communicate during planning. For planning, the planner will need to find out:

- How does the person best communicate with others?
- Who should be involved to support the person with their communication?
- How does the person best communicate with? Do they use communication aids?
- What visual or audible planning materials could be used to maximise the person's participation?
- If developing a written plan, what format would be most meaningful to the person?

Tips

- Listening to someone who does not use words means finding out:
  - How does the person show if they are happy or sad, bored or excited, angry or frustrated in different settings and at different times?
  - How does the person indicate choice or preference?
  - What do their facial expressions or posture mean?
  - What does their behaviour mean?
- Plans can be formatted in a number of creative ways including using pictures, photos, posters, audiotapes etc.

Tools

- **Communication Chart** is a person-centred thinking tool designed to support people who do not use words or have difficulty in communicating with words. It explores other people's different perspectives about how the person communicates. An example of this type of chart can be found at: http://www.ldicn.org.uk/upload/public/attachments/28/bpcommunicationchart1.pdf
- **Communication Passport** is a person-centred tool that can help a person to communicate how they feel, what they like and dislike, what they want and don't want. An example can be found at: http://www.csrpcp.net/Libraries/Local/761/Docs/PCP%20tools/Communication%20Passport.doc

References and Resources

- **Creating Accessible Information, Communication Etiquette and Communication Tips**, Communication Aid Users Society: http://www.caus.com.au/
- **Information on complex communication needs,** Scope Victoria: http://www.scopevic.org.au/therapy_crc.html
- **Communications support information**, Comtec (managed by Yooralla): http://www.yooralla.com.au/comtec/info/index.php
- **Total Communication Minibook: Person centred thinking, planning and practice**. Copies of this book are available as a free download from: http://helensandersonassociates.co.uk/Reading_Room/How/Person_Centred_Practice/Person_Centred_Communication.html
- **Communication for Person Centred Planning.** This information pack was designed to help staff, self-advocates, families and friends to make communication better and is available for free download: http://www.learningdisabilities.org.uk/publications?EntryId=22381&p=2

Emergency & Disaster Management Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/11	2021/11	New Practice Standard	Gina Ingrouille	2022/11
	2023/09	NA	KK	09/25 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This policy and procedure seek to ensure the safety of staff, clients and other stakeholders during emergencies.

This policy and procedure apply to all staff, students, contractors and volunteers providing services for CALDS facility.

POLICY

People with disabilities may be more vulnerable to fire and other emergencies than others in the community. Consideration of risk must extend beyond fires and other emergencies in the workplace.

This means, management of your organisation (and every NDIS, Homecare or Community Service) have ultimate responsibility for safeguarding the organisation and its personnel, clients and visitors.

It is the responsibility of the management of your organisation to ensure that emergency and evacuation procedures for facilities are:

- established
- maintained
- reviewed regularly
- ***appropriate and adequate for the organisation's identified needs.***

It is also the responsibility of the CEO (or their delegate) for ensuring that personnel have the appropriate training, information and instruction in emergency procedures and the use of emergency equipment and facilities.

With the introduction of the COVID-19 situation, it is also required that CALDS have processes in place to deal with outbreaks and any required lock-down situations.

As a part of its risk management processes CALDS will do everything in its control to prevent injury or harm to individuals as a result of any emergency. To reduce the risk to personnel the CEO (or their delegate) will be responsible for providing a work environment where all personnel are trained and prepared for emergencies. For the purpose of this policy, a 'disaster' response and emergency response can be considered one and the same. Examples of disasters or emergencies might be:

- Fire (bush or other)

- Medical emergency
- Power outage
- Bomb threat
- Personal threat
- Hazardous materials
- Natural disaster (flood, lightening, earthquake, heatwave)
- Evacuation for any reason
- COVID-19 outbreak

The CEO (or their delegate) will ensure that adequate resources are allocated to enable an appropriate response to any emergency (e.g., staff training, personal protective clothing or first aid equipment).

Any of the above-mentioned emergencies/disasters could cause prolonged interruptions to power supply or transport systems. Consideration must be given to risk on a case-by-case basis, including the client's mobility, dependence upon critical services, geographic isolation and other environmental factors especially when CALDS staff or contractors are in the community or in an office setting. With particular focus to be given to areas within Australia which may be prone to flood, bushfire or heatwave conditions.

Please refer to the CALDS Business Continuity Plan 2023.

If any manager or staff member of CALDS requires information not contained in this policy, please refer to https://www.disasterassist.gov.au/or contact the manager.

Signage
Every premises (accommodation or office) operated by CALDS, will provide an Emergency Plan (wall mounted) in any office, kitchen or communal area.

Documentation of Significance

PCEPP: The Person-Centred Emergency Preparedness Plan must be completed at admission to service and reviewed annually to ensure all information is current.

Signage: Every office and accommodation or workplace will ensure that an Emergency Plan is wall mounted in key areas such as: office, kitchen, common areas.

Business Continuity Plan: Triggered by the CEO or their delegate.

Emergency & Disaster Process Review Register: A register within the compliance management system captures: Warden identification and contact details, review schedule for Emergency Drills, PCEPP's reviews and participant level of dependency on services (High Moderate or Low).

Client – Service Prioritisation Matrix: This is an excel based tool to assist the manager to identify which participants are unable to care for themselves without daily care and therefore support triage of service supports during a pandemic or other service interruption situation.

PROCEDURE

PROCEDURES	HOW IMPLEMENTED
Person Centred Emergency Preparedness	

All participants receiving supported independent living services (either in our residences or their own), will have a Person-Centred Emergency Preparedness Plan (PCEPP) in place.	PCEPP completed annually
The plan must be updated at least annually (refer PCEPP register in the Compliance Management System and version control exists on the back page of the PCEPP.	Register of review in the compliance system
The PCEPP is part of the participant onboarding process and reviewed annually.	Onboarding checklist must be completed
In the event of an emergency, triggered by a disaster or pandemic, the PCEP for each person will be activated.	All PCEPPs will be kept electronically and accessible if needed.
Where an interruption to business is inevitable, the CEO will trigger the use of the Client – Service Prioritisation Matrix which seeks to assess o The level of dependency a participant has on services to meet their most basic needs; and o What level of interruption can be tolerated without risking the safety and wellbeing of the person.	Client – Service Prioritisation Matrix
The CEO will be responsible for ensuring that:	
▪ All staff are aware of their responsibilities and are provided with training relevant to that responsibility e.g. First Aid Warden, Fire Warden.	Information recorded in delegations' matrix found in the compliance system.
▪ Emergency drills or training are provided to all staff.	Either in house or via a consultant.
▪ All reasonably foreseeable situations that constitute an emergency have been identified and assessed with appropriate controls in place.	Corporate Risk Register
▪ Regular emergency evacuation drills are conducted to test procedures.	Refer Emergency and Disaster Drill and Training Schedule in compliance system
▪ Staff designated as emergency contacts (e.g., Fire Wardens and First Aid officers) receive appropriate training for coordinating emergency responses.	Listed in the delegation's matrix found in compliance system.
▪ All workers are familiar with the emergency response procedures and emergency alarm sounds.	Onboarding and induction process checklist.
▪ Staff actively participate in the development and review of the emergency policy and procedures.	Annual participant/staff and stakeholder review.
▪ In the event of an emergency, the CEO (or a nominated member of staff) are to be responsible for alerting people to the emergency and communicating adequately with all stakeholders during the emergency (designated Wardens).	Wardens, CEO, Managers

▪ All staff employed will hold a current First Aid Certificate	Monitored via the compliance system
Management Responsibilities of a Systemic Nature	
▪ Management, led by the CEO will review all emergency and disaster preparedness plans at least annually and record the outcome of the review in meeting minutes or in the Governance Decision Log.	Internal Audit
▪ Where a new plan is to be tested, this action will be carried out using the Continuous Quality Improvement methodology and register within the Compliance Management System. This will support the evidence base for any changes made to emergency, disaster or person-centred emergency plans.	Internal Audit
▪ Ultimately it is the CEO's responsibility to oversee compliance registers and ascertain whether staff training in emergency preparedness has been achieved and where training completion is under 100%, seek to address the reason why training has not been completed.	Internal Audit
▪ All training and onboarding processes will be reviewed by the CEO annually and recommendations made where Emergency Management education has not been provided.	Internal Audit

Authorities to Trigger Plan (at the end of this policy)
The CEO (or their delegate) will be responsible for:

- triggering a business continuity management plan (Folder: Emergency & Safety/Emergency and Disaster Preparedness)
- assigning duties to staff to implement the plan
- overseeing communications with staff regarding any updates; and
- informing staff when the organisation returns to 'business as usual'.

RELATED DOCUMENTS

- Compliance Management System
- Infection Control and Prevention Policy
- Risk management Policy
- Business Continuity Plan
- Delegations Matrix
- Disaster Preparedness Checklist
- Person Centred COVID-19 Emergency Plan
- Person Centre Disaster & Emergency Plan
- Emergency Plan – Wall Mount.

REFERENCES

- NDIS Quality and Safety Standards 2018
- NADA Policy and Procedure Toolkit

Zero Tolerance Policy& Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2023/03	2/09/23	Grammer corrections	KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This policy deals with how CALDS will implement the prevention of abuse, neglect, exploitation in all of its' forms; in the context of participants CALDS comes into contact with.

This policy applies to all staff or contractors and all participants CALDS may come into contact with.

DEFINITIONS

Word	Definition
Abuse	In the context of this policy) – verbal, physical and/or emotional mistreatment and/or lack of care of a person. Abuse can include bullying, child abuse physical abuse, sexual abuse, emotional and psychological abuse, racial, cultural and religious abuse, domestic violence.
Incident	For the purpose of this Policy and Procedure: • an act, omission, event or circumstance that has, or could have, caused harm to a person with disability receiving supports or services. • an act by a person with disability that happened in connection with the provision of supports or services and that caused serious harm, or a risk of serious harm, to another person; or • a reportable incident that is alleged to have occurred in connection with the provision of supports or services.
Neglect	The failure to provide a person with the necessities of life, such as food, clothing, shelter, medical attention, or supervision, to the extent that their health and development is, or is likely to be, significantly harmed.
Mandatory reporting -	The legal obligation of certain professionals and community members to report when they believe, on reasonable grounds, that a child needs protection from harm. A broad range of professional groups are identified in the Children and Young Persons (Care and Protection) Act 1998 (NSW) as 'mandatory reporters.
Negligence	Doing, or failing to do something that a reasonable person would, or would not do in a certain situation, and which causes another person damage, injury or loss as a result.
Offender or **Perpetrator**	A person who mistreats and/or harms another person.

Word	Definition
Procedural Fairness	A principal that requires a fair and proper procedure be used when making a decision.
Reportable Incident	• the death of a person with disability. • serious injury of a person with disability. • abuse or neglect of a person with disability. • unlawful sexual or physical contact with, or assault of, a person with disability. • sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or • the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation of a State or Territory in relation to the person.[2] **Reportable Incidents include alleged Reportable Incidents.**
Restrictive practice	Any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.[3]

Commitment to a Zero tolerance culture

- CALDS is committed to all elements of the "Code of Conduct" for Disability Support Workers.
- CALDS will train staff in all elements of the Code of Conduct and ensure a Zero Tolerance approach is incorporated into practices.

POLICY

Management and Staff of CALDS will:

- Support and facilitate a Preventative approach to Abuse, neglect and exploitation of participants.
- Ensure timely and effective responses are taken to address immediate client health safety and wellbeing.
- Support clients who have experienced physical, psychological, or sexual assault.
- Be accountable to clients for actions taken immediately and planned in response to their experience of an assault.
- Ensure due diligence and responsibilities to clients are met; and
- Hold perpetrators of physical, psychological, and sexual assault accountable for their actions.

PROCEDURE

- CALDS will train staff to be able to understand and act on a Zero Tolerance approach and ensure that staff appreciates people with disability are people first, who have needs, aspirations, preferences, and feelings.
- CALDS will focus on prevention. We will ensure all staff are inducted and receive on going annual follow up training in recognising the signs of abuse, neglect, and exploitation. See table on following page.

[2]Based on the definition set out in the *National Disability Insurance Scheme Act 2013.*

[3]As above

- Our Policy and Procedure provides a clear and uncomplicated 'immediate response. (See on next page).

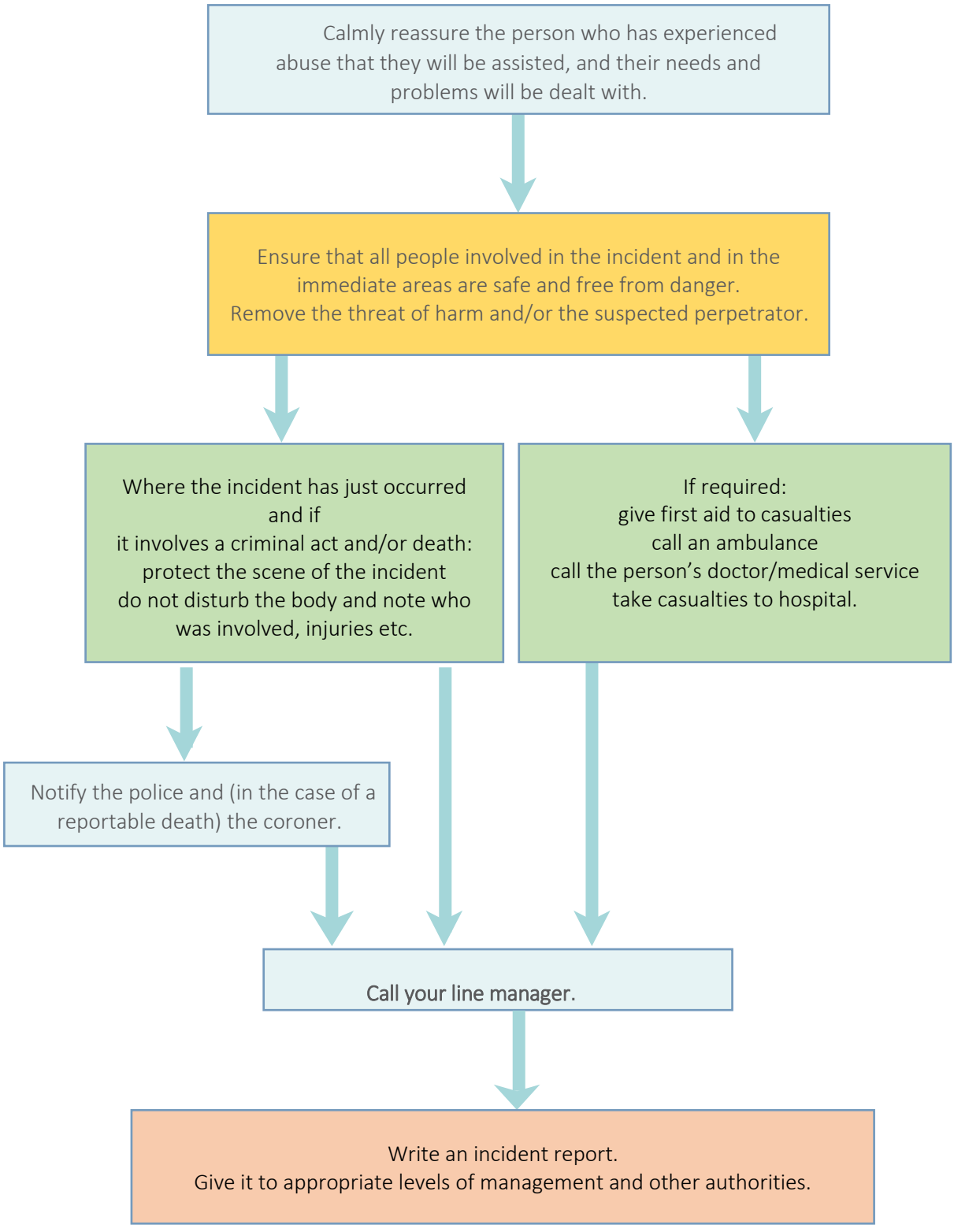
PREVENTION

Abuse, neglect, and exploitation can take many forms. Being aware of common indicators may improve your recognition of and response to them. Although no single behaviour is an absolute indicator of abuse, neglect and exploitation, some examples have been provided in the table below *indicators and signs of abuse, neglect, and exploitation*

Type of abuse	Physical indicators	Behavioural signs
Physical abuse	unexplained cuts, abrasions, bruising or swelling, in various stages of healing unexplained burns or scalds including cigarette burns, especially on soles, palms, back or buttocks rope burns on arms, legs, neck, torso unexplained fractures, strains, or sprains, especially to skull, nose, or facial structure; dislocation of limbs bitemarks dental injuries ear or eye injuries ligature marks welts	avoidance of staff fear of a particular person sleep disturbance obvious changes in behaviour changes in appetite changes in daily routine unusual mood swings withdrawal unusual passivity out-of-character aggression self-harm inappropriate explanation of how an injury occurred excessive compliance
Sexual abuse	direct or indirect disclosure of abuse or assault difficulty walking or sitting pain or itching in genital and/or anal area; bruising, bleeding, or discharge self-abusive/self- destructive behaviour attempts at suicide torn, stained or blood-stained underwear or bed clothes sexually transmitted diseases trauma to the breasts, buttocks, lower abdomen, or thighs unexplained money or gifts pregnancy	Sleep disturbances changes in eating patterns inappropriate or unusual sexual behaviour or knowledge changes in social patterns sudden or marked changes in behaviour or temperament anxiety attacks refusal to attend usual places (e.g., work, school, respite) depression going to bed fully clothed excessive compliance to staff
Psychological/ emotional abuse	Speech disorders in the case of a child, there may be lags in physical development or anon-organic failure to thrive. injuries sustained from self-abuse or self-destructive behaviours. Suicide attempts. Anxiety attacks	self-harm or self-destructive behaviour. challenging/extreme behaviours. Excessive compliance. very low self-esteem. depression. feelings of worthlessness. marked decrease in interpersonal skills, necessary for adequate functioning. extreme attention-seeking behaviour

Type of abuse	Physical indicators	Behavioural signs
Chemical abuse	prescribed medication withheld by a staff member, service provider, carer or support person. medication administered by a staff member, service provider, carer, or support person more frequently than prescribed or warranted	Persistent over-activity. unusual levels of confusion

Diagram 1: Example of a service provider's immediate response to an incident



Risk factors for abuse, neglect, and exploitation

The below provides a template that service staff could use to assess an individual's exposure to risk of abuse, neglect, and exploitation.

Service Characteristics

- Segregated service environments (e.g., residential care facilities, sheltered

employment)
- Overcrowding
- Incompatibility between residents and/or co-workers or other service users
- Clients not valued and respected
- Tolerance of violence
- Lacking quality management systems
- High staff turnover

Family Characteristics
- Low levels of attachment between family members (parent–child, sibling relationships)
- Past or current substance abuse Perceived caregiver stress social isolation
- Power and control issues
- Poor health and wellbeing, including social determinants such as low income, inadequate housing etc.
- Negative attitudes towards people with a disability demonstrated by family members
- High levels of dependency (either on or by the person with a disability)
- Lack of awareness and use of formal supports
- History of family violence and attitudes suggesting a tolerance of family violence

Individual Characteristics
- Social isolation and lack of close relationships
- Communication difficulties
- Challenging or disruptive behaviour
- Risk taking and reckless behaviour
- Inappropriate sexual behaviour
- Learnt over-compliance or complete dependence on caregivers
- Limited physical mobility
- Limited sense of personal power
- Low self-esteem
- Low income or restricted access to resources
- Limited sex education or age-appropriate sexual experiences
- High tolerance of violence
- Lack of self-protection skills
- Limited life experiences
- Lack of knowledge of rights

Note: Several people with a disability have significant communication and sensory issues, and as a result may have difficulty raising concerns about incidences of abuse, neglect, and exploitation. It is essential that people with communication and sensory issues are provided with appropriate communication tools.

Values associated with abuse prevention
Abuse prevention in disability services is underpinned by a commitment to basic values. These values are important in guiding and motivating CALDS to create workplace systems and processes that prevent abuse, neglect and exploitation and encourage staff to use abuse-free practices in their work.

Other values are associated with abuse, neglect or exploitation prevention in disability services:
- People with a disability are valued as individuals
- The personal dignity and rights of individual clients are respected
- The security, welfare and safety of service clients are essential

RELATED DOCUMENTS

- Compliance Register
- Audit schedule
- Continuous Improvement Register
- Whistle-blower Policy

REFERENCES

- Disability Discrimination Action 1992 (Commonwealth)
- Disability Amendment Act 2017
- Privacy Act (1988)
- Practice Standards NDIS

DIVISION 4 – SUPPORT ENVIRONMENT

Safe Environment Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2019/07				09/2022 or in response to any legislative triggers
2020/01	2/09/23		KK	09/25 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy about the way in which the organisation ensures a safe, comfortable physical environment for clients, and ensures that they are protected from harm or injury within the service.

This Policy applies to every member of staff, contractors and any visitors into a workplace of CALDS.

Managing Participant Safety – Wall Mount for office or accommodation site

Environmental Safety Requirement	CALDS Process
Standard Precautions – infection control and prevention.	Measures include physical or social distancing, quarantining, ventilation of indoor spaces, covering coughs and sneezes, hand washing, and keeping unwashed hands away from the face. The use of face masks or coverings has been recommended in public settings to minimise the risk of transmissions. **Refer Infection Control Policy.**
Infection Control (refresher)	Every staff member working with CALDS is required to complete an annual refresher in Infection Control. However, if a staff member is observed to be in breach of the policy and procedure for infection control, they can be directed to complete additional training. **Refer Human Resource Policy.**
Infection Control (environmental cleaning)	Monthly COVID-19 appropriate sanitizing is required every month, and additionally, is mandatory in the event of a suspected outbreak of COVID-19. Scope of environment: office, group spaces, accommodation services, vehicles, or any other areas where participants are supported excluding a participant's own residence. **Refer Infection Control Policy and Sanitizing Register.**

Environmental Safety Requirement	CALDS Process
All participant risk plans, or behaviour support plans must be viewed by the support worker.	If you are not sure how to interpret a participant risk plan or behaviour support plan it is required that you contact your supervisor. **Refer Managing Participant Risk Guide**.
Staff must be identifiable via photo identification.	All staff, volunteers and student who will be interfacing with a participant or the family/carer of a participant must be issued with verifiable identification. A participant must be able to verify a CALDS staff member is who they report to be. **Refer Human Resource Policy**.
Health and wellbeing of participant in accommodation – particularly those with complex needs.	**Every participant** in CALDS accommodation as relevant will have Health assessment Plan (CHAP) in place and this must be reviewed at minimum on an annual basis**. Refer In Home Support Folder.**
Health and wellbeing of a participant for whom CALDS provides personal care or in home support.	Where CALDS is the only agency or lead agency (lead meaning provides the personal care) to a participant, a Community Health assessment Plan (CHAP) in place and this must be reviewed at minimum on an annual basis. **Refer In Home Support Folder.**
Participants with difficulties in communication of their needs.	Where a person has been assessed as having difficulty with communication; a risk plan must be in place outlining how the participant should be managed in the case of a medical or non-medical emergency. This plan must be listed on the participant risk registered and a date for review noted and adhered to.
Documented guidance to staff and volunteers on their duty of care obligations	CALDS guides staff on their duty of care within Risk Management, Incident Management, WH&S Policies and Procedures as well as at induction.
Incident and accident reporting procedures	CALDS requires all staff to report incidents (reportable and non-reportable).
Escalation in an emergency.	Where a participant's assessment has identified health or behaviour needs; a risk plan together with a suggest process for escalation must be attached to each participant file. Where an emergency relating to a participant or staff members health or wellbeing exists, a staff member is directed to contact the Operations Manager or Governance Manager.
CALDS has policies and procedures to respond to: protection and sensitivity to young	CALDS has a Whistle-blower Policy and a Zero Tolerance Policy. These areas are also covered at worker induction.

Environmental Safety Requirement	CALDS Process
or vulnerable persons who report sexual abuse, discrimination, or exploitation	
Protection of children or young people from online risks.	Where children or young people under the age of 18 are residing for short-, medium- or longer-term stays; staff will ensure internet protections are in place and young people in care understand the dangers present in the online community.
Protecting children and young people under 18 from harm.	Third party contractors, visitors and non-staff members must sign a visitor book, have identification, and must not be left alone in the presence of a child or young person under 18. **Refer Working with Children Policy and Procedure.**

REFERENCES:

- NDIS Quality and Safety Standards 2018

Medication Management Policy

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2019/07				09/2022 or in response to any legislative triggers
2020/01 2023/11	2/11/23	Med assess/competency assessment included to Policy section	KK	11/25 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
This Policy is about the way in which the organisation ensures that medication storage, transportation and administration is safe, effective, and is in accordance with relevant legislation and standards.

This Policy applies to all staff who assist Participants with medication.

DEFINITIONS

Word	Definition
Medication Support	involves reminding or prompting a Participant to take medication, assist with opening medication containers and other assistance; not involving medication assistance
Medication Assistance	involves storing medicines, opening the container, removing the prescribed dosage (from approved container), and giving the medication as per instructions.

Incidents:
An incident occurring in relation to management of medication will require the initiation of an Incident Report. An incident could be (but is not limited to):

- Medication given at the wrong time
- The wrong medication has been given
- An outdated medication has been given
- Medication was missed – not given
- An adverse reaction to a medication has been observed
- A serious physical reaction requiring an ambulance or CPR has occurred
- Documentation was not completed
- Documentation was not satisfactory
- Medication was given by the wrong route
- Too much medication was given
- Update the incident register
- Note any reflective practices which may assist in avoiding a similar situation in future.

POLICY

The health and safety of all CALDS staff and participants is of utmost importance, including in

the management and administration of participants' medications.

Any staff member assisting a participant with medications will be required to have:

- Completed the medication management assessment successfully and face to face competency assessed by an RN.

PROCEDURES

CALDS will assist participants in managing their medication based on the following order of the participant's preference:

1. the participant manages all aspects of their medication.
2. The participant is supported or assisted by their family or support network to manage all aspects of their medication.
3. the participant manages their medications with CALDS staff providing medication support.
4. the participant manages their medications with CALDS staff providing medication assistance; or
5. CALDS staff administering medication.

When providing medication prompting, assistance or administration support CALDS staff must ensure the participant consents to being helped and maintains responsibility for their health, including their use of medication.

All participants requiring medication, regardless of the level of medication assistance required, must have a *Medication Chart* that contains a list of current medications (or any other pharmacy prescribed items) developed by a Medical Practitioner or Pharmacist, kept in their home and on their file. This list must be updated with any change in medications (or any other pharmacy prescribed items).

Staff must ensure they are never involved in the management of medication that is beyond their skills and training.

Staff must maintain up-to-date records of participants' medicines. NDIS Service Agreements and Support Plans must include clear instructions, agreed with the participant, about what steps staff will take to help the participant with their medication.

The following documents must be used where CALDS staff are providing medication support:

- Medication Prompt Record Log.
- Medication Assistance Record Log; or
- Medication Administration Record Log.

This enables direct care staff and registered nursing staff to ensure there are detailed records of each prompt/assist/administration for each participant at each service/visit.

For all participants who require medication, the CEO (or their delegate) will include a *Medication Plan* in their Medication Plan that includes:

- a description of key tasks.
- participant's name and date of birth.
- participant allergies and reaction to allergens.
- medication to be taken as per blister pack.
- dose to be taken.

- specific route.
- time to be taken.
- specific instructions regarding the medication, e.g., to be taken with food.
- commencement date of medication; and
- cessation or review date of the medication.

Staff must consult with the CEO (or their delegate) if they have concerns or questions about a participant's medication. This includes where:

- a participant needs to be monitored because of unstable health, where medication needs change on a regular basis.
- a participant consistently displays inappropriate behaviour, such as taking too much medication, refusing to take medication, taking incorrect doses or misusing medication; or
- medication instructions are unclear, out of date, omitted, or open to interpretation.

Medication is not under any circumstances to be given out or administered to a participant by another participant.

Participants Self-administering and Managing their Own Medications.
Where possible, participants will manage and administer their own medication or be supported by their family or support network to do so.

Where it is not clear whether a participant is able to manage their own medication, a general practitioner, registered nurse, or pharmacist must complete an assessment of the participant's ability to self-medicate and provide it to CALDS in writing.

Participants Unable to Self-administer their Own Medications
Medication Prompting
Staff must:

- identify on the care plan that the participant requires prompting to self-medicate at specific times.
- prompt the participant to self-medicate at the specified times; and
- record each prompt in the participant's *Medication Prompt Record Log*.

Medication Assistance
Staff must:

- identify on the care plan that the participant requires assistance to self-medicate at specific times.
- assist the participant to self-medicate at the specified times in the way set out in the care plan; and
- record each instance of assistance in the participant's *Medication Assistance Record Log*.

Medication Administration
Staff who provide medication administration support will be provided with appropriate training.

All medication must be administered in strict accordance with the directions of the prescribing medical practitioner or the manufacturer's directions.

All participant medications are to be taken or administered from the original containers or packages in which they were originally dispensed. Where the participant is not able to administer their own medication, this must be administered by staff trained in medication administration and be dispensed only from the participant's Webster pack.

When administering medication to a participant, staff must always comply with the Six Rights of medication management:

1. **Right person**: Check photographic identification on the medication packs or the participant's file to ensure the medication is for the right person.
2. **Right medication**: Check the name of the medication on the blister pack or medication packaging against the name on the medication chart for the person.
3. **Right dosage**: For blister packs, check that the right number of tablets or pills is contained in the blister. For other medications, ensure the dose is clearly documented on the pharmacist's label to the medication.
4. **Right time**: Ensure medication is being taken at the prescribed time. Some medications will have further instructions that must be followed such as, to be taken with food, 30 minutes before food or after other medications.
5. **Right route**: ensure medication is taken, applied or inserted using the prescribed route.
6. **Right record keeping**: All instances of medication administration must be recorded in the participants' *Medication Administration Record Log*.

Prohibited Practices

Staff must not administer any medication that is not prescribed in accordance with this Policy, including 'over the counter medication.

Staff must not administer medication to a participant who is clearly objecting in an informed manner unless there is an approved protocol in place.

Staff must not administer medications to participants in a manner that is clearly for organisational convenience and not reflecting the preference or needs of the participant.

Staff must not leave medications of any type in an area where they are unsupervised and accessible to participants or unauthorised persons.

Storing Medication

Medication for participants will generally be stored in an accessible container in a cupboard or on top of the fridge (where storage at room temperature is suitable). Medications that require refrigeration must be stored in the fridge.

For participants who are at risk of mistaking medications, medication must be stored in a locked container (e.g., filing cabinet or cupboard), which can only be accessed by staff. The CEO (or their delegate) is responsible for the security of all medication stored on CALDS's premises.

Staff must adhere to the manufacturer's instructions for storing medication.

When medication needs to be transported, it should be placed in an appropriate storage container where required.

Disposing of Medications

All medications (including those self-administered and managed by participants) are to be returned to the pharmacist when ceased.

No 'prescription only' medication may be kept as CALDS's stock. Any participant's medication is to be returned to the participant at the end of the medication regime.

No medications are to be used by or for another participant or kept or allowed to accumulate with

other participant's medication for use sometime later as 'stock' medication.

Reporting
Incidents relating to medication misuse should be reported in accordance with CALDS's Incident Management policies and procedures.

REFERENCES:

- NDIS Quality and Safeguards Commission (2018)
- NDIS Provider and Registration and Practice Standards
- Australian Pharmaceutical Advisory Committee (APAC) Guidelines July 2006
- 12 Guiding Principles for Medication Management in the Community developed by the Australian Pharmaceutical Advisory Council. (June 2006 updated January 2012)
- The "Medication Management Framework" (Poisons Regulations 95AA January 2018)
- ACIA Administration of Non-Oral and Non-Injectable medications in the Community by Support Staff (2015)
- ACIA Administration of Oral Medications in the Community by Support Staff (2017)

Mealtime Management Practice Policy

Record of policy development		
Version	Date approved	Date for review
2021/12		12/2022 or in response to any legislative triggers
2022/06	25/06/2022	Additional information regarding other conditions that may require mealtime management.
	2023/09	09/25 or in response to any legislative triggers

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.

PURPOSE OF THIS PRACTICE POLICY

- Improve the knowledge and confidence of care staff about supporting people with eating and drinking.
- Improve the mealtime experience, quality of life, health, and care of participants in care homes and other care settings.
- Reduce avoidable distressing incidents related to eating, drinking, and swallowing.
- Reduce hospital admissions relating to aspiration.

SCOPE
This policy applies to any participants who require support at mealtime. Whether the support is active supervision or preparation of specific foods to make mealtime safe and enjoyable.

Some reasons why a participant might require mealtime management are as follows:

- Participants who may have a swallowing difficulty and are therefore at risk of:
  - Choking (severe difficulty in breathing because of a constricted or obstructed throat or a lack of air).
  - Aspiration (**when something enters your airway or lungs by accident)**.
- Participants with a diagnosis of diabetes
- Participants who can experience anaphylaxis if certain foods are ingested.
- Participants with food allergies or food intolerances.
- Participants with irritable bowel syndrome (diagnosed)
- Participants who are underweight or overweight.
- Participants with a variety of chronic health conditions.
- Participants experiencing a range of oral health conditions.
- Other conditions as relevant to each person.

INTRODUCTION
Our organisation will take every care to identify all participants who will require mealtime

management. This commitment includes:

- Identification at admission to our service
- Identification during service delivery as staff become aware of a change in a participants need
- Identification during a schedule review

 Before assisting anyone with mealtime management:

Prior to formally assisting a participant with their mealtime, (insert position name) will ensure all support workers are aware that a mealtime plan can only be administered after assessment by an appropriately qualified health practitioner.

There are many reasons why a person might require a mealtime management plan and the assessment of the following areas may be necessary:

- A person's swallowing reflex
- Oral health for example a loss of dentition (teeth), infection associated with soft tissue or teeth
- A range of environmental factors pertaining to where the person lives or places the person chooses to visit
- Positioning, seating, utensil requirements.
- Food allergies and intolerances including any foods known to cause an anaphylactic reaction
- Size of meal required, frequency of meal required, textures
- Likes and dislikes for food and beverages (some people simply can't tolerate some textures due to preference.

Swallowing Difficulties:
There are certain people who will be more at risk of developing difficulties in swallowing; stroke (the most common cause of dysphagia).

- Traumatic brain injury.
- Cerebral palsy.
- Parkinson's disease.
- Amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease),
- Multiple sclerosis,
- Progressive supranuclear palsy,
- Huntington disease,
- Myasthenia gravis
- Muscular dystrophy and myotonic dystrophy are **accompanied by dysphagia.**

Other complex health issues
Many individuals with have a variety of health issues some of which have been listed under SCOPE (above).

Who area the appropriately qualified health practitioners?
There are a range of health practitioners that may be engaged depending on the specifics of each case. This is why the practice standards refer to 'the appropriately qualified health practitioner' Some examples:

- Speech therapist also knowns as a speech pathologist
- Dietician
- Occupational Therapist
- Registered nurse
- General practitioner

- Specialist medical practitioner
- Physiotherapist

Remember - only an appropriately qualified professional can make the assessment which leads to any diagnosis and the development of a mealtime management plan.

Steps in preparing for a participant mealtime management plan:

1. Ensure the plan has been developed by the appropriately qualified health practitioner and that the participant or their representative has been involved in the development process.
2. Place mealtime management plan in the participants file and ensure that any risk assessments undertaken can be accessed easily if needed.
3. If the client has requested access to their mealtime management plan, ensure this arranged for them and instructions are clear for other staff in relation to the access to the plan.
4. Ensure the practitioner has completed a handover with a key member of staff (such as a Registered Nurse.
5. Registered Nurse will organise training of all support workers who will be involved in the participant's care inclusive of:
    - How to read and follow the mealtime management plan; and
    - Mandatory trainings for supporting participants with a mealtime plan (below).

Steps for the development of a participant's menu:

The Registered Nurse will ensure the following:

1. Within the scope of the mealtime plan, as many options as possible will be provided.
2. Staff must encourage the participant to make suggestions about their food and beverage preferences remembering that sometimes a participant my require longer to consider their choices.
3. If a support worker has trouble in obtaining preferences and choices, consider collaborating with family, friends or the participant's networks.
4. While developing each menu support workers or managers will always refer to the mealtime management plan as a guide to ensure the participant's safety is always at the forefront of support delivered.
5. Menu planning must be guided by health conditions, allergies, intolerances, nutrition guidance contained in the plan.
6. If at any time a support worker is unsure, please contact your immediate manager in the first instance.

The plan should allow for as much or as little participation as the individual would like. For example:

- How does the person express themselves in a group setting?
- Do they prefer to make their decisions and choices in a private or one-to-one environment?
- Does the person easily choose the meals they would like and identify which meals they don't like?
- How do they choose an alternative meal?
- Does the person need to see photographs or drawings or actual physical objects to be able to make a choice?
- How does the person express a definite choice?

The texture of foods

Food texture for each participant with a mealtime management plan will be guided by the mealtime plan. A worker must:

- Consult with the mealtime management plan to be clear about the texture required
- Read the menu and make a plan as to the development of the meal (when unsure please contact your immediate supervisor).
- Before serving the meal or purchasing the meal (if on an outing) ensure the texture is in alignment with the mealtime plan.
- Always prepare food as outlined in the mealtime plan, store the food as outlined in the mealtime plan and label the food to ensure no one else will be accessing the participant's food by mistake.

Environment

If the mealtime plan sets our requirements for the participants environment, the worker must comply with these guidelines. This might refer to:
Seating, utensils, positioning.

HOWTO USE THE PERSON'S MY EATING AND DRINKING PROFILE

- The My Eating and Drinking Profile (the Profile) can be stored in the kitchen / dining area of the person's residence.
- All support workers must read and implement the Profile in keeping with the person's preferences.
- The line manager must provide new and casual support workers with access to the person's Profile as part of their induction.
- All support workers must read and ensure they understand the person's Profile before preparing any food or drinks.
- The person is supported to take the Profile with them when dining out as well as any supports or aids identified in the Profile.

ADHERANCE TO FOOD SAFETY

- All food preparation areas must be kept clean and tidy by staff on shift.
- At the end of your shift, it is your responsibility to check.
- All cooking utensils must be washed thoroughly and stored safely.
- Fridge, freezers and pantries must be cleaned on a regular cycle.
- All food must be stored according to the relevant food standards.
- The kitchen will be inspected on a regular basis with or without warning, by managers.

FOOD PREPARATION

- Anyone preparing or handling food must adhere to infection control and handwashing protocol.
- Perishable items must be stored below 5 degrees Celsius.
- Dry foods such as flour, rice and pasta are to be stored in a cool, dark, and dry pantry or cupboard.
- Frozen foods are to be placed in the freezer and stored at -15 degrees Celsius.
- Any thawed food must be discarded after use. This must not be reheated.
- All cooked left-over food must be labelled used within 24hrs,
- All foods prepared for participants must be labelled accordingly – no unlabelled foods in a share home.
- All staff must adhere to cross contamination protocol when preparing food for participants.
- A colour coded chopping board system must be in place to ensure raw food such as meet is never able to contaminate other foods.

MANAGING RISKS

Workers will:

- Check the correct meal is being served to the correct participant.
- Observe participants for the following:
  - Lack of alertness
  - Difficulty with chewing, or swallowing
  - Excessive coughing or gagging
- Stop food consumption immediately if you suspect the food being consumed is creating discomfort. Refer to the risk escalation plan within the mealtime management plan.
- Treat as an incident and manage according to the CALDS Incident Management Policy.
- Prepare a meal that will be more suitable for the participant and don't hesitate to seek assistance in doing so.

Staff Training Requirements

Any CALDS staff working with a participant with mild, moderate, or severe dysphagia must have:

1. Complex health issues awareness
2. Mealtime management training
3. Dysphagia awareness training online and have successfully completed the assessment.
4. Diabetes awareness and management training
5. Anaphylaxis training
6. Food allergy and intolerance training
7. Food safety training
8. **Completed a session of training** with the participant's health professional (unless the health professional has trained a member of CALDS in overseeing a participant's meal plan. This is non-negotiable and must be document in the training register and HR Matrix.

REFERENCES

- NDIS Quality and Safety Standards and Quality Indicators
- Supporting people with eating, drinking and swallowing difficulties (Dysphagia) – Scottish Care 2020

RELATED DOCUMENTS

- Comprehensive Assessment Tool
- Nutrition and Swallowing Checklist
- Speech Therapist referral form
- Comprehensive Health Assessment Plan (CHAP)
- Incident Management Policy

Money or Property (Participant) Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	2/09/23			09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
This policy and procedure provide guidance for staff who assist participants to manage their financial affairs, or who have access to participants' personal belongings. It aims to ensure staff do so in an honest, transparent, and accountable manner, and in the best interests of participants.

The policy and procedure apply to all staff and meets relevant legislation, regulations, and Standards.

DEFINITIONS

Word	Definitions
Financial abuse	Any act which involves misusing the money or property of a person with disability without their full knowledge and consent. This includes theft of money, pension cheques or property as well as misuse of a power of attorney.

POLICY OUTCOME
Participant money and property is secure, and each participant uses their own money and property as they determine.

POLICY
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.

If required, each participant is supported to access and spend their own money as the participant determines.

Participants are not given financial advice or information other than that which would reasonably be required under the participant's plan.

If a situation arises where a CALDS employee or contractor is required to manage any belongings or money on behalf of a participant, the following processes will be in place.

PROCEDURE

CALDS recognises that there is a balance between providing assistance to participants to manage their own financial affairs as much as possible and protecting the rights of people who may be vulnerable to exploitation.

Direct responsibility for managing a participant's financial transactions should only be assumed by staff where the participant is unable to do so themselves.

CALDS has processes in place to ensure any staff access to a participant's money or other property is managed, protected and accounted for.

Any assistance provided should promote autonomy, choice and independence as well as protect the participant and CALDS staff.

Participant Money

Where a staff member believes a participant cannot manage their own financial affairs with some assistance from a support worker, they must refer the matter to the CEO (or their delegate) A substitute decision maker may need to be appointed for the participant (see CALDS's *Decision Making and Choice Policy and Procedure* [or equivalent]).

Staff must maintain confidentiality regarding participants' funds and accounts. Any inquiries about a participant's finances by third parties must be directed to the CEO (or their delegate).

Where assistance in managing financial affairs is required, a *Consent Form* must be obtained from the participant and retained on their file. Participants' money may only be used for the purposes intended by the participant. The arrangements for supporting participants to manage their finances must also be clearly set out in their NDIS Service Agreement and Support Plan, which are to be reviewed on at least an annual basis.

Staff must support participants to keep their funds safe and not use a participant's PIN or other access codes when assisting them to manage their finances. A participant's funds may only be used for their benefit of that participant – staff must not make personal purchases with the participant's money or borrow money from the participant.

While staff may share, at no cost to themselves, in meals and other special occasions that are part of a participant's activities, they must pay for their own meals when solely accompanying participants.

The use of a Companion Card is encouraged to cover the cost of entry into venues or entertainment for a staff member when they are accompanying a participant as part of their Support Plan. Where a Companion Card is not available or accepted, staff must not allow a participant or their family to pay for their entrance to any venues or entertainment. Such instances should be referred to the CEO (or their delegate).

Staff must not provide participants with financial advice or information, other than that reasonably be required under the participant's NDIS or Support Plans.

More generally, in managing participants' Support Plans, the Support Coordinator must:

- assist participants with budgeting and the purchase of goods and services from CALDS and other services, ensuring that as far as possible, participants get value for money and are not taken advantage of; and

- monitor the appropriateness of fees asked of participants.

Participant Property
CALDS does not accept liability for loss or damage to property, valuables or essential participant equipment, but staff must take all reasonable care in the management of participant belongings.

Reporting
Suspected or alleged financial abuse must be reported in line with CALDS's Incident Management Policy and Procedure. Where loss or damage to a participants' property, including money, may have involved a CALDS staff member, or occurred during service delivery, it must also be reported in accordance with the Incident Management Policy and Procedure [or equivalent].

Participants and their supporters also have access to CALDS's Feedback and Complaints processes, should they wish to provide feedback or make a complaint regarding the handling of their finances or property.

RELATED DOCUMENTS
- Financial Management Policy and Procedure [or equivalent]
- Participant Charter [or equivalent]
- Feedback and Complaints Policy and Procedure [or equivalent]
- Human Resources Policy and Procedure [or equivalent]
- Staff Code of Conduct Policy and Procedure [or equivalent]
- Protecting Participants from Harm Policy and Procedure [or equivalent]
- Service Access Policy and Procedure [or equivalent]
- Compliance Policy and Procedure [or equivalent]
- Risk Management Policy and Procedure [or equivalent]
- Participant Incident Management Policy and Procedure [or equivalent]
- Participant Rights and Responsibilities Policy and Procedure [or equivalent]
- Service Delivery and Participation Policy and Procedure [or equivalent]
- Records and Information Management Policy and Procedure [or equivalent]

REFERENCES
http://www.companioncard.gov.au/

Infection Control Policy and Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2021/02 2023/07	09/23	Mandatory COVID training online no longer available	KK	09/2025 or in response to any legislative triggers

Policy purpose and scope
The purpose of this policy is to minimise risks of harm from infection to CALDS, employees, clients, volunteers, contractors, visitors, and others in the workplace. CALDS is committed to the promotion of a safe and hygienic environment and will take all reasonable steps to minimise, as far as possible, and manage the spread of infectious diseases through implementation of procedures that are consistent with best practice standards and guidelines and Australian Government recommendation.

Responsibilities of CALDS staff

- It is preferred that staff complete infection control training (including use of PPE) or induction either internally with a CALDS staff member or externally
- Staff are to always practice appropriate infection prevention and control precautions commensurate with level of training and area of risk
- Staff must report potential or actual infection risks as soon as becoming aware of them
- Staff must report any illness because of workplace exposure
- Staff must ensure they do not present for work if unwell

Responsibilities of CALDS

Ensure personal protective equipment is readily available and distributed as required.
COVID19 updates are communicated through appropriate channels as per QLD health directives.

Quality Improvement and Risk Management

CALDS management and team members are required to provide an environment that will ensure the safety, health and wellbeing of all employees, clients, volunteers, contractors, visitors and others across CALDS.
Additionally, the aspects of privacy, confidentiality, discrimination, disability and vulnerable person protection related to infection control are supported CALDS will plan and implement infection control policy and procedures aligned to its quality framework to ensure compliance with regulatory / compliance standards.
CALDS has established clinical governance and work health and safety management systems to ensure the highest level of planning for quality management and effective dissemination of information relating to infection control across all services and venues.

Engage in standard precautions

Standard Precautions are applied to all services; regardless of whether it is known the person has an infection, to provide a basic level of infection prevention and control.

Standard precautions are evidence - based practices designed to both protect CALDS employees, clients, volunteers, and visitors and prevent the spread of infections.

Standard Precautions include:

- Hand hygiene and hand and skin care
- Use of personal protective equipment (PPE) (gloves, gowns, facemasks, eye protection) depending on the anticipated exposure
- Using the correct procedure for donning and doffing PPE
- Respiratory hygiene and cough etiquette
- Safe injection practices including the appropriate use and disposal of sharps
- Protocols for preventing and managing occupational exposures to body substances
- Social distancing
- Safe handling of potentially contaminated equipment or surfaces in the care / service environment.
- Use of disposable equipment where applicable and available
- Correct cleaning, disinfection and sterilisation of non-disposable equipment
- Environmental controls such as performing routine environmental cleaning
- using appropriate cleaning agents and the management of spills
- Safe collection, storage and disposal of waste

Infection Control (environmental cleaning)	
Monthly COVID-19 appropriate sanitizing is required every month, and additionally, is mandatory in the event of a suspected outbreak of COVID-19. Scope of environment: office, group spaces, accommodation services, vehicles or any other areas where participants are supported excluding a participant's own residence.	**Sanitizing to be recording in Environmental Sanitizing Register**

Related Documents

- COVID Response Flowchart
- Incident and Accident Management Policy
- Incident Report Form
- Incident Management Policy

References

- National Health and Medical Research Council (Australian Government)

Working with Children Policy and Procedures

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2020/07				09/2022 or in response to any legislative triggers
2021/07				09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE
This Policy is about how the organisation meets its obligations to ensure the safety of children and that any staff employed within the NDIS service arm are not prohibited persons. It also provides guidance on how it ensures staff understand how to be appropriate around children they make come into contact with and their obligation as a mandatory reporter.

This Policy applies to all staff employed by CALDS within the arm of the NDIS Service.

POLICY
CALDS staff will have and maintain a clear Police Records Check, and a Working with Children (WWC) check. It is the legislative policy that staff engaged in a "Risk Assessed Role" must have the required state checks.

PROCEDURE
Identifying a risk assessed role
Registered NDIS providers are responsible for identifying which roles are risk assessed roles and ensuring all workers in these roles have an NDIS Worker Screening clearance or an acceptable check under the transitional and special arrangements.

A risk assessed role is:

- a key personnel role of a person or an entity as defined in s 11A of the National Disability Insurance Scheme Act 2013 (for example, a CEO or a Board Member)
- a role for which the normal duties include the direct delivery of specified supports or specified services to a person with disability
- a role for which the normal duties are likely to require 'more than incidental contact' with people with disability, which includes:
    - physically touching a person with disability; or
    - building a rapport with a person with disability as an integral and ordinary part of the performance of normal duties; or
    - having contact with multiple people with disability as part of the direct delivery of a specialist disability support or service, or in a specialist disability accommodation setting.

Record keeping requirements
Registered NDIS providers are required, for each risk assessed role, to document:

- the title or other organisational identifier for the role
- the paragraph or paragraphs of the definition of risk assessed role (as contained in the National Disability Insurance Scheme (Practice Standards—Worker Screening)

Rules 2018) that applies to the role
- a description of the role
- the date the role was assessed and the name and title of the person who made the assessment

When a new risk assessed role is identified, or an existing role is reclassified as a risk assessed role following a review, the written list of roles must be updated within 20 business days of the identification or review of the risk assessed role.

Registered NDIS providers must, for each worker in a risk assessed role, document:
- the full name, date of birth and address of the person
- the risk assessed role or roles in which the person engages
- if the worker may engage in a risk assessed role without an NDIS worker screening clearance:
  - the basis on which they may do so (refer to sections below regarding the exemptions to the requirement for a worker to have an NDIS Worker Screening clearance)
  - the start and end date of the period in which the exemption that allows them to work in a risk engaged role applies
  - the name of the person who supervises the worker during this period

- the worker's NDIS Worker Screening Check application reference number
- the worker's NDIS Worker Screening Check outcome expiry date
- whether the worker's NDIS Worker Screening clearance is subject to any decision which has the effect that the registered NDIS provider may not allow the worker to engage in a risk assessed role, and the nature of any such decision (for example, interim bar, suspension, exclusion)
- records relating to an interim bar, a suspension, an exclusion, or any action taken by the provider in relation to these kinds of decisions in relation to any worker
- allegations of misconduct against a worker with a check and the action taken by the registered NDIS provider in response to that allegation

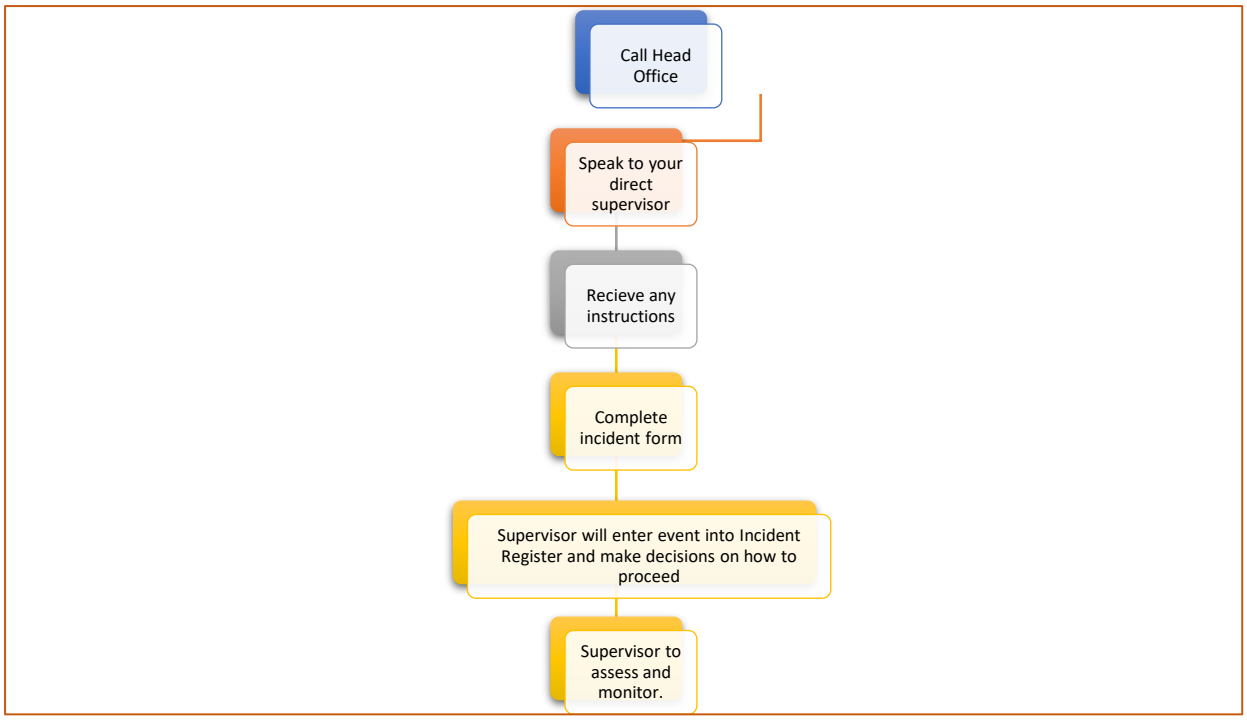
It is important these lists are kept up to date. A record must be kept for seven years from the date the record was made. Records should be kept in an organised, accessible and legible manner. It is important that the registered NDIS provider keeps records in a way that would allow the NDIS Commission or a quality auditor to know which workers were engaged in a risk assessed role on any given day in the past seven years.

Mandatory Reporting

CALDS NDIS staff in risk assessed roles or otherwise are supported to:
- If a mandatory reporter; exercise that responsibility.
- If not a mandatory reporter to alert their manager if they think something is wrong.

How to Report an Abusive Situation
In the first instance, any concerns are to be reported to your 'supervisor' within CALDS.In a situation where an Emergency arises, and your supervisor is not contactable, it is satisfactory to call the NDIS Commission for advice.

Figure 1 - Internal response to suspected child abuse



RELATED DOCUMENTS

- Incident Form
- Incidents, Accident and Emergencies Policy and Procedures
- Reportable Incidents Guide (NDIS)
- Help at Home Risk Assessed Roles (Info Sheet)
- Code of Ethics and Conduct Form
- Participant Notes
- Risk Management Form
- Policies and Procedures

REFERENCES

- The Child Protection (Working with Children) Act 2012
- United Nations Convention on the Rights of the Child 1989
- The National Framework for protecting Australia's Children
- NDIS (Quality and Safeguards) Commission 2018
- NDIS (Practice Standards - Worker Screening) Rules 2018
- Children and Young People (Care and Protection) Act 1998

Client Matching Policy and Procedure

Policy version	Change	Last amendment	Reason	Approved by
2022/04	Added Client Matching Policy	20/014/2022	Scheduled review	Gina Ingrouille
		02/11/23	11/2025 or in response to any legislative triggers	KK

Purpose and Scope

The purpose of this policy is to set out how vacancies in the group homes managed by CALDS will be occupied.

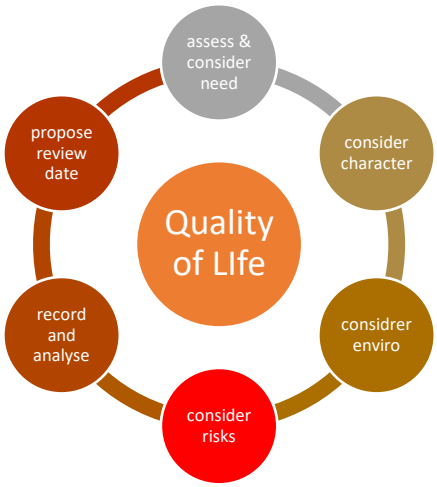
NDIS Documents relevant to this policy and procedure:

- *Participant Matching Assessment.*

Policy

CALDS takes its responsibility to identify and provide most suitable vacancy to a Shared Home participant.

CALDS's vacancy manager is responsible for identifying and providing best accommodation to its participants. CALDS's approach to client matching *includes Matching surrounding participants disability, establishing character match between participants, matching of needs among all the participants in a group home and Respecting participants choice for their choice of ideal housemate.*



Procedure

The Model below underpins CALDS's approach to Client Matching

CALDS's approach to client matching must:

- Align with CALDS's Vision and Mission.

- Be embedded within its operations, processes, and systems.
- Have clear accountability, ownership and governance.
- Be systematic, transparent, and consistently applied.
- Include effective consultation and communication.
- Consider the context (both the internal and external environment).
- Support evidence-based decision-making; and
- Facilitate continual improvement.

Client Matching Model

CALDS's Client Matching Model consists of the following steps:

- Match surroundings to participants disability: Identify participants needs and ensure the environment of accommodation matches participants needs. For e.g., Offer a disable assessable house with ramps installed to a wheelchair bound participant.
- Develop character match between the participants: Ensure there is match in character between different participants living in same group home. Factors such as nature of disability, age factor, kind of support required etc. to be considered. Use a Safe Hands character matching document to develop a character match. Other important factors to consider include the following:
    - *Behaviours of concern for any participant in the context of the shared environment and other participant behaviours.*
    - *Mental health diagnosis: for example, it is difficult to support healthy relationships where more than one person experiences borderline personality disorder. It could even be said that just one person in a group situation can place the dynamic under substantial stress. Consider the risks and quality of life of all participants and to the staff who will be supporting the participants.*
    - *Trauma: be aware of a participant's past trauma and the triggers that may initiate a negative experience for them.*
- Align support needs: Try to align support required by each participant in a facility. For e.g., Ratio of support or kind of assistance required during night-time should be aligned.
- Respecting participants choice of house mate: Develop and respect understanding of participants choice in terms of kind of participant they want to share accommodation with.
- Record and review: Record participants interaction with each other and with the surroundings. Review annually or if there is change in circumstances.

Refer to the Participant Matching Assessment Form

REFERENCE:

- https://www.effectivepolicy.com.au
- Emergency Response Program, *Aging Disability And Homecare*, Evaluation Of Emergency Response Transition Program 2012

Whistle-blower Policy*

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
	02/11/23		KK	09/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This policy is confirming that "Whistleblowing" is encouraged and is that Whistle-blowers will be protected within the CALDS service.

This policy covers all staff whether employee, contractor, volunteer or student.

POLICY

Internally: Whistleblowing (in the context of this policy and within CALDS Pty Ltd), is the reporting in good faith by an individual, of misconduct that is within our ability as NDIS provider to control.
Reporting in good faith means the complainant has a reasonable and honest belief that the alleged misconduct occurred.

The person to whom a report under this Policy is made (The CEO (or their delegate)) and who has the responsibility to safeguard the interests of the whistle-blower. It is the commitment of the CEO (or their delegate) to maintain the safety and tenure of the person making the report.

Externally: NDIS providers should not direct their workers to undertake duties they are not qualified or skilled to deliver.

If an NDIS provider, a person with disability, or their family or carer directs a worker to deliver supports and services for which they do not have the necessary training, competence and qualifications, workers should decline to do so.

Workers can also make a report to the NDIS Commission that such a direction has been made.
Whistle blower protections are in place for workers who raise issues with the NDIS Commission, so their NDIS provider cannot take or threaten to take adverse action against them for pursuing this course of action.

Scenario:
Angela is living in shared accommodation in a small regional area in Northern NSW that does not have many support workers. One evening, disability support worker Tamara comes in to relieve another support worker, Julia, for the nightshift. Recently, Tamara has noticed that when she takes over from Julia, Angela is withdrawn and upset. When she asks Angela why she is upset, Angela says that Julia has been shouting at her, calling her stupid and useless. Tamara follows Housing Plus's policy to report Julia's behaviour to her supervisor. However, over the next few weeks, it is apparent to Tamara that the supervisor is not acting on her concerns. There has been no change to shifts or supports, and Angela tells her that Julia is continuing to verbally abuse her. Tamara is worried that taking her concerns to the

CEO (or their delegate) as it may compromise her employment, but she re-reads the Code of Conduct and understands that she has whistle-blower protections and an important role in ensuring the situation is addressed. Together, Angela and Tamara make a complaint to the CEO (or their delegate). The CEO (or their delegate) Investigates the situation.

PROCEDURE

Making a report
In the first instance, prior to action under this Policy, the whistle blower is encouraged to follow normal reporting channels and discussing the matter with their immediate supervisor/manager.

If the nature of the matter is such that it is not appropriate to report through normal channels, or if the whistle-blower has a reasonable concern about doing so, or if the matter has been previously reported under normal channels but the whistle-blower believes no appropriate action has been taken, the whistle-blower can contact the CEO (or their delegate) directly to discuss the matter and lodge a report.

A whistle-blower may choose to report a matter anonymously; however, they should recognise that anonymity may be inconsistent with natural justice for the person or persons that the complaint is made about and may severely hamper the investigation process. Anonymity may also mean that it is difficult to provide feedback on the status of the investigation to the whistle-blower and also to provide the protection afforded to whistle-blowers under this Policy.

Whistle-blowers should ensure as far as they are able that their report is factually accurate, complete, based on first-hand knowledge, without material omission and presented in an unbiased fashion. The report should be as detailed as practicable and include (but not be limited to):

- the exact nature of the alleged misconduct believed to have occurred
- when the alleged misconduct took place, if known
- where the alleged misconduct took place, if known
- who was involved in the alleged misconduct?
- the names of witnesses who may know information that is relevant to investigating the alleged misconduct

Methods of Reporting	
Internal	Chief Operating Officer CALDS Group Pty Ltd Email: kiran@calds.com.au
External	NDIS Commission Phone: 1800 035 544 (free call from landlines) or TTY 133 677. Interpreters can be arranged by calling 800 035 544. Completing a complaint contact form.
Anonymous	4 Goshawk Court, Bahrs Scrub, QLD , 4207

Conducting an Investigation
All reports made under this Policy will be investigated with the objective of obtaining evidence that either substantiates or refutes the claims made by the whistle-blower.

Investigations will be carried out by the CEO (or their delegate), who will be fair and independent in their investigation. A person accused within or connected to the matter must

not be involved in the investigation. If the CEO (or their delegate) believes he/she may have a conflict of interest by acting as Whistle-blower Support in the matter, he/she is to notify an alternative or provide details to of the NDIS Quality and Safety Commission who will ensure that the matter is addressed without conflict of interest.

Where appropriate, for example where this is a potential risk to resident/client care or staff safety, the person alleged to have engaged in misconduct may be stood down from duty pending investigation. Where a person is stood down while the investigation takes place, no inference of wrongdoing or assumed guilt will apply. The principles of natural justice will be observed in the investigation, which will be conducted without bias and any person against whom an allegation has been made will be given the opportunity to respond.

If requested, the identity of the whistle-blower may be kept confidential, noting that any commitment to confidentiality will be subject to reasonableness and the requirements of the law.

As soon as practicable after the investigation is concluded, the CEO (or their delegate) will prepare a report providing a summary of the facts of the suspected misconduct and of the findings of the investigation (i.e., whether the misconduct was substantiated or unsubstantiated).

The report shall outline appropriate measures to be taken in light of the findings in the report, which may include notification to regulatory and/or enforcement agencies.

Protecting Whistle-blowers
If a whistle-blower makes a report under this Policy in good faith, then provided he/she has not been involved in the conduct reported, the whistle-blower will not be penalised or disadvantaged because they have reported a matter.

CALDS staff must not victimise, harass or discriminate against anyone who raises a concern under this Policy or who participates in an investigation.

Such victimisation, harassment or discrimination is serious misconduct and may result in disciplinary measures, up to and including summary dismissal.

A whistle-blower or participant in an investigation who believes he/she has been penalised or disadvantaged, including by being subjected to victimisation, harassment, discrimination or other unfavourable treatment.

Any employee, supervisor or manager who is found to have penalised or disadvantaged a whistle-blower or participant in an investigation by reason of their status as a whistle-blower or witness to the alleged misconduct may be subjected to disciplinary measures, up to and including summary dismissal.

Where it is established by the CEO (or their delegate), that the whistle-blower has not acted in good faith or he/she intentionally made a false, malicious or vexatious report of alleged misconduct, then this may result in the whistle-blower being the subject of disciplinary measures, up to and including summary dismissal.

RELATED DOCUMENTS

- Complaint Form
- Complaint Policy
- Incident Report
- Incident Policy
- Whistle-blower Template

REFERENCES

- National Disability Insurance Scheme Act 2013
- Information Sheet 238 Whistle-blower rights and protections (INFO 238)I
- Information Sheet 239 *How ASIC handles whistle-blower reports* (INFO 239)

DIVISION 4.5 – MANAGEMENT OF WASTE

Waste Management Policy & Procedure

Record of policy development				
Version	Date approved	Nature of amendments	Approved by	Date for Review
2021/02				09/2022 or in response to any legislative triggers
2020/01	02/11/23		KK	11/2025 or in response to any legislative triggers

POLICY PURPOSE AND SCOPE

This Policy deals with the way the organisation manages the disposal of clinical and hazardous waste, as well as investigation and review of any incidents relating to hazardous materials.

This Policy applies to all staff working with clinical or hazardous materials and the managers who are responsible for these materials.

Word	**Definition**
Bulk	Free flowing liquids normally contained within a disposable vessel or tubing, not capable of being safely drained to the sewer
Cytotoxic waste	Material contaminated with residues or preparations containing materials toxic to cells, principally through action on cell reproduction. This includes any residual cytotoxic drug, and any discarded material associated with the preparation or administration of cytotoxic drugs.
Chemical waste	Waste generated by the use of chemicals in medical, veterinary and laboratory procedures. Chemical waste should be classified in accordance with the step-by-step waste classification process in the ADG Code.
Clinical waste (Including pathological waste)	Waste that has the potential to cause sharps injury, infection or offence. Includes: ▪ sharps. ▪ human tissue (excluding hair, teeth and nails). ▪ bulk body fluids and blood. ▪ visibly blood-stained body fluids and disposable material and equipment. ▪ laboratory specimens and cultures; and ▪ animal tissues, carcasses or other waste arising from laboratory investigation or for medical or veterinary research
Clinical and related waste	Waste resulting from medical, nursing, dental, pharmaceutical, skin penetration or other related clinical activity, being waste that has the potential to cause injury, infection or offence. It includes: ▪ clinical waste. ▪ cytotoxic waste. ▪ pharmaceutical, drug or medicine waste; and ▪ sharps waste.

Word	Definition
Hazardous waste	Waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practices, and wastes generated in clinical or other facilities resulting from the investigation or treatment of patients or research projects. Typical hazardous waste includes sharps, anatomical waste, clinical waste, chemically contaminated waste, infectious waste, human tissue, cytotoxic waste, pharmaceutical waste, animal waste, laboratory waste, chemical waste and radioactive waste (or items contaminated with this material such as paper towels, gloves, etc).
Pharmaceutical waste	Pharmaceuticals or other chemical substances specified in the Poisons List under the T*herapeutic Goods Act 1989* Pharmaceutical substances include expired or discarded pharmaceuticals, filters or other materials contaminated by pharmaceutical products.
Sharps	Any object capable of inflicting a penetrating injury, which may or may not be contaminated with blood and/or body substances. This includes needles and any other sharp objects or instruments designed to perform penetrating procedures.

POLICY

Where disposal of hazardous or clinical waste is required, CALDS will ensure that staff have the necessary training and protective equipment to carry out the task safely.

The CALDS Waste Management Policy and Procedure is informed by

- AS/NZS 3816:1998 Management of clinical and related waste
- AS/NZS 4123:2008 Mobile waste containers
- AS 4031-1992 Non-reusable containers for the collection of sharp medical items used in health care areas
- AS/NZS 4261:1994 Reusable containers for the collection of sharp items used in human and animal medical applications

Our Compliance Register houses a Register for Incidents. We record any actual or 'near miss' occurrences. The CEO (or their delegate) follows through on the recording, reporting, investigating and continual improvement activities associated with this kind of risk and /or Incident. We use the data to inform better and safer practices.

How are workers exposed to infectious diseases?

Workers may be exposed to infectious diseases through activities such as:

- Health and personal care of clients
- Contact with a client's blood and body substances
- Handling contaminated items and equipment
- Household cleaning, including cleaning spills of blood and body substances
- Handling soiled laundry
- Handling and disposing of clinical waste including sharps
- Unsafe food handling and storage practices
- Contact with a client's animals and animal excreta.

Staff Training

The Business will undertake training of all employees who are involved handling waste or hazardous substances. This training will include:

- Safe handling of hazardous materials and substances
- Body waste
- Infectious materials such as used dressing

- Hazardous substances such as chemicals – toxic or corrosive substances, blood borne pathogens, biological hazards, chemical exposures, respiratory hazards, sharps injuries
- Protective equipment
- Clothing requirements
- Removing or mitigating the hazard – inform the CEO (or their delegate) of any problems
- Use of Off-site Work Kit – includes emergency contact details, gloves, aprons.

Staff involved in the management of waste and hazardous substances are trained to ensure safe and appropriate handling. This includes training on any protective equipment and clothing required when handling waste or hazardous substances.

Staff must provide evidence of training in waste management and the use of PPE at the time of onboarding. If there is no evidence of training the staff member will be asked to attend training and assessment.

Refresher training is conducted annually, unless there are issues with a staff member handling of waste in the interim.

PROCEDURE

Emergency Plan
In the event of an emergency involving Waste Product, such as chemical spill or biohazard, employees will:

- Contact the CEO (or their delegate)
- Contact local emergency services, for example police, fire brigade and poison information centre details are supplied.
- Alert people at the workplace to an emergency or possible emergency, for example siren or bell alarm or if in home environment inform participant and/or others at the site.
- Evacuate participants ensuring that correct processes for assisting any hearing, vision or mobility-impaired people.
- Follow the map in the workplace illustrating the location of fire protection equipment, emergency exits, assembly points. If in a home environment, then take participant and/or others at the site to a safe location away from the home.

After the emergency the CEO (or their delegate) will:

- Record the incident
- Notifying the regulator (if applicable),
- Organise trauma counselling or medical treatment

Reviewing and Evaluating

- The CEO (or their delegate) will train employees in this process
- Analyse the emergency to feed into Continuous Improvement Policy and Procedure

GENERAL PROCEDURES
Storage and disposal of waste
Waste generated in the delivery of our services can be generally categorised in to three groups:

- General
- Clinical
- Pharmaceutical

General waste disposal
General waste constitutes the bulk of waste generated by health care organisations and is no more of a public health risk than standard domestic waste. If properly managed, it should prevent no actual risk to workers or other individuals.

Incontinence pads and disposable nappies can be treated as general waste, unless the material is judged to have come from an infectious patient, is visibly blood stained, or is disposed of in a manner likely to cause offence, such as in unusually large quantities, in which case it must be treated as clinical waste.

General waste should be contained in white or opaque bags which are labelled accordingly.
General waste is to be placed in the general waste bin for disposal.
General waste may be further separated into recyclable or compostable streams as described in the local Council Guidelines.

What is Clinical Waste?
Types of clinical waste categories include:

- Sharps
- a clinical specimen such as blood or tissue
- A specimen of urine or faeces is taken for laboratory testing includes specimens for analysis to ascertain disease status.
- A laboratory cultures
- Human tissue
- Tissue, carcasses, or other waste arising from animals used for laboratory investigation or for medical or veterinary research other than psychological testing.
- Human blood or body fluids other than urine or faeces.
- Materials or equipment containing human blood or body fluids
- Urine or faeces, or materials or equipment containing urine or faeces, where there is visible blood
- Waste from patients known to have, or suspected of having a communicable disease

Clinical waste disposal

Requirements under clinical waste disposal regulations
It is essential that clinical and related wastes are properly segregated, packaged, labelled, handled and transported to minimise risk to waste handlers and the community, such as needle stick injuries and transmission of infectious diseases.

All sharps and other waste containers should meet the specific Australian Standards requirements. Clinical cytotoxic waste and related waste must be segregated and identified by colour coding and marked according to the following:
Colour code – clinical waste bins Australia: yellow
Wording: clinical waste displayed on at least 2 sides
Clinical waste sign: black biological hazard
Clinical waste symbol/logo: as above.

Personnel must ensure:

- The clinical waste logo or clinical waste symbol should be clearly marked on the bags, sacks or bins.
- To ensure staff education and to facilitate effective clinical waste segregation from non-clinical waste CALDS should utilise clinical waste disposal posters in suitable locations.
- Using a suitable and clear clinical waste poster – with the symbol as above – will facilitate correct treatment and safe handling of the waste.
- All clinical waste is placed in biohazard bags as soon as reasonably possible.

- Biohazard bags are available and are used where infectious materials are being disposed of.
- Clinical waste (including sharps) can be disposed as waste for incineration, or for autoclaving and shredding.
- Autoclave tape and bag indicators must be used to show autoclaving has been completed.
- Single-use sharps are to be placed into a sharp's container, that is rigid-walled and meets the Australian and New Zealand Standards AS 4031 and AS/NZS 4261.
- All sharps and waste containers must meet the Australian and New Zealand Standards AS/NZS 3816: Management of clinical and related waste and AS/NZS 4123: Mobile waste containers.
- Reusable sharps containers must be readily emptied and cleaned before reuse, in accordance with AS/NZS 4478.

Pharmaceutical waste disposal

- Pharmaceutical waste can include patients' unused medications, pharmaceuticals that are unwanted or out-of-date, packages, containers or equipment contaminated by pharmaceutical substances and their residues, and pharmaceutical substances rejected by the manufacturer due to quality control considerations.
- Pharmaceutical waste bins must be lockable.
- Pharmaceutical waste must be incinerated at a licensed controlled waste facility.
- When uncertain about disposing of leftover pharmaceuticals, workers should return them to the pharmacy for safe disposal.
- Most disinfectants are to be disposed through the sewer system by running cold water before pouring the disinfectant in to the sink.
- Once disinfectants are disposed, the cold water should be left running for a few moments to dilute the disinfectant.

Waste handling and storage

- Waste should be stored in a dedicated storage area to prevent environmental impacts.
- Storage areas are to be cleaned regularly and kept free of odour.
- Where small quantities of clinical waste are generated, waste storage will be managed using 120/240 litre mobile garbage bins (wheelie bins), or using other waste containers, placed on a tray which has sufficient construction to prevent spills.
- Mobile garbage bins must be washable, with a lid that is lockable.
- Mobile garbage bins must be securely closed during movement, but do not have to be locked, unless the mobile garbage bin is a pharmaceutical waste bin.
- Workers should minimise the handling of waste bags and avoid decanting from one bin to another.
- When clinical waste is being handled, workers should hold bags away from the body by the closed top of the bag and place directly into the appropriate bin.
- Appropriate protective clothing and equipment is to be worn when closing clinical waste bags and placing them into the bin.
- Sharps must never be placed in waste bags.
- Waste must never be stored in plastic liners placed directly on floors.

Waste minimisation

CALDS will aim to minimise waste without compromising work standards or client/worker safety.

All CALDS staff will be guided by the local council Waste Minimisation and Management Act 1995 No 102 and any overriding requirements within their local government area. This should be observed by each manager, employee or contractor in each local government area.

Incident reporting

- Any incident involving infectious material, body substances or hazardous substances is to be reported to the CEO (or their delegate) using an Incident Report Form.
- The CEO (or their delegate) will input the incident to the Incident Register after managing any urgent matters in relation to the “incident”.
- Incidents involving hazardous materials or waste management are also to be reported promptly to the CEO (or their delegate).
- All reported incidents will be internally investigated and reviewed by the CEO (or their delegate) to determine the cause of the incident, and to improve organisational procedures to reduce future risk.

Hygiene and cleaning

The CEO (or their delegate) will provide hand hygiene facilities for workers and promote regular hygiene procedures that comply with all health and hygiene standards and legislation including Work Health and Safety Act (2011).

Additionally, CALDS will (where applicable):

- Regularly clean and maintain equipment used to contain and transport waste.
- Clean all contaminated items as soon as possible, using appropriate detergents and hospital grade disinfectants.
- Ensure that when cleaning contaminated items, staff wear appropriate Personal Protective Equipment (PPE), including face protection, use a scrubbing brush and avoid splashing the water. If any item of PPE becomes contaminated, the item must be changed before continuing with the task.

Personal Protective Equipment (PPE)

Workers must use appropriate PPE when necessary. CALDS will provide all workers who deal with waste and hazardous substances with necessary protective equipment and clothing.

Staff will be trained in the proper selection, fitting, storage and maintenance of PPE.

Regular review

Waste Management and Hand Hygiene are subject to regular internal Audit.

RELATED DOCUMENTS

- Hazard Form
- Incident Report Template
- Incident Register
- Continuous Improvement Policy
- Work Health and Safety Policy

REFERENCES

- Work Health and Safety Act (2011)
- NDIS Practice Standards and Quality Indicators 2018
- AS/NZS 3816:1998 Management of clinical and related waste
- AS/NZS 4123:2008 Mobile waste containers
- AS 4031-1992 Non-reusable containers for the collection of sharp medical items used in health care areas
- AS/NZS 4261:1994 Reusable containers for the collection of sharp items used in human and animal medical applications
- Waste Minimisation and Management Act 1995 No 102.

Legislation Register

Module	Division	Legislations	Applied
Core	1	United Nations Universal Declaration of Human Rights NDIS Act 2013 (Cth) and NDIS Practice Standards (2018) United Nations Convention on the Rights of Persons with Disabilities, NDIS Act 2013 (Cth) Disability Inclusion Act and Regulation 2014 Privacy Act (1988) Health Records and Information Privacy Act 2002 No 71 Human Rights and Equal Opportunity Commission Act 1986 Disability Discrimination Action 1992 (Commonwealth) Racial Discrimination Act 1975 Sex Discrimination Act 1984	Mandatory
Core	2	National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018. The National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018 Disability Discrimination Act 1992 (Cth) Fair Work Act 2009 (Cth) Human Rights and Equal Opportunity Commission Act 1986 (Cth) Racial Discrimination Act 1975 (Cth) Sex Discrimination Act 1984 (Cth) Child Protection (Working with Children) Amendment (Miscellaneous) Regulation 2013 Health Practitioner Regulation National Law (NSW) No 86a Work Health and Safety Act (2011) Freedom of Information Act 1982 National Archives of Australia Records 2017/00015859 National Archives of Australia Records 2017/00015859 Sections 4, 9, 26, 36, 50, 53-57, 60-68, 186-187 and 197(2) of the National Disability Insurance Scheme Act 2013 (NDIS Act). National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013 (Protection and Disclosure of Information Rules). Sections 6 and 52(1) of the Privacy Act 1988 (Privacy Act) Archives Act 1983 (Archives Act) Australian Privacy Principles	Mandatory
Core	3	National Disability Insurance Scheme Act 2013 Disability Inclusion Act and Regulation 2014 Human Rights and Equal Opportunity Commission Act 1986 (Cth)	Mandatory
Core	4	Work Health and Safety Act (2011) Child Protection (Working with Children) Amendment	

Module	Division	Legislations	Applied
		National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018. United Nations Universal Declaration of Human Rights, United Nations Convention on the Rights of Persons with Disabilities, NDIS Act 2013 (Cth)	Mandatory
4.3	Medication	Australian Pharmaceutical Advisory Committee (APAC) Guidelines July 2006 Poisons Standard October 2021	n/a
4.4	Waste	Work Health and Safety Act (2011) Waste Minimisation and Management Act 1995 No 102	Yes