ABLE TO THRIVE PTY LTD

NDIS Registered Provider · ID 4-IPX11F6

Policy and Procedure Manual

VERSION 1.0

ISSUED MAY 2026

Supersedes Policy and Procedure Manual V3 (May 2023)

Able to Thrive Pty Ltd
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Document control

This Manual is itself a controlled document. Each policy contained in this Manual is also a controlled document in its own right, with its own version, owner, approver and review schedule recorded in its Document Control panel at the start of each policy.

Manual identifier

Document title	Able to Thrive Pty Ltd — Policy and Procedure Manual
Version	1.0
Date issued	May 2026
Supersedes	Policy and Procedure Manual V3 (issued 1 May 2023, prepared by Sarah Sword)
Manual owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review of the Manual	May 2027, or upon material change to the underlying policy set
NDIS registration	4-IPX11F6 (30 August 2024 – 30 August 2027)
NDIS registration groups	0102, 0106, 0107, 0108, 0115, 0116, 0117, 0120, 0125, 0136
Bundled supports	Medication management; hazardous waste disposal

Manual version history

V3 (May 2023)	Templated Policy and Procedure Manual prepared by external consultant Sarah Sword, used to support initial NDIS Certification. 261 pages. Superseded.
V1.0 (May 2026, this Manual)	Comprehensive refresh aligned to organisation's actual operating model, the labour hire arrangement with Able to Thrive Personnel Pty Ltd, the NDIS Practice Standards (Core Module including Outcomes 4.3, 4.4 and 4.5), the Conditions of Registration (including Condition 2), the NSW Child Safe Standards, and the strategic priorities recorded in the Business Plan v2.0. Issued in support of mid-term audit by DNV scheduled June 2026 and the registration scope variation applications for Module 2a (Behaviour Support Implementation) and Module 5 (Specialist Disability

	Accommodation).

Foreword from the Directors

Welcome to the Able to Thrive Policy and Procedure Manual.

This Manual sets out how we work — the rules we hold ourselves to, the practices we follow, and the standards our participants and our workers can expect from us. It is a working document, not a compliance shelf-piece. Every policy in this Manual is owned by a named person, reviewed on schedule, refreshed when the world changes, and held to account in operation.

Able to Thrive was founded to deliver disability supports that meet people where they are. We focus on participants whose situations are not always well served by larger or more generic providers — young adults living with psychosocial disability, children with autism, people emerging from acute mental health admissions, people moving toward more independent living after time in restrictive settings. We support people to find their footing, to choose their lives, and to thrive on their own terms.

That work is serious. The trust that participants, families, support coordinators, referrers and regulators place in us is significant. This Manual is part of how we honour that trust.

The Manual is a v2 refresh — a substantial rewrite of the Sarah Sword V3 manual that supported our initial NDIS Certification in 2024. The original served us well at the time. The refresh reflects two years of operating reality, the November 2021 amendments to the NDIS Practice Standards, the NSW Child Safe Standards as they apply to our holiday programs, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability findings, and the things we have learned by doing this work.

Two things are different about how this Manual is structured compared to the V3:

First, the Manual reflects our actual workforce model. Our support workers are employed by our related entity, Able to Thrive Personnel Pty Ltd, and are directed and supervised by Able to Thrive Pty Ltd as the NDIS-registered provider. The Manual makes this division of responsibility explicit — most clearly in the Human Resources Policy (P-1.23) and the Labour Hire Agreement between the two entities (which sits alongside this Manual as a separate controlled document).

Second, the Manual contains a number of new policies that did not exist (or did not exist in this form) in the V3 manual: the Living Alone Risk Assessment Policy (P-1.31) addressing our Condition 2 of Registration; the Behaviour Support Implementation Policy (P-1.32) supporting our application to vary scope for Module 2a; the Specialist Disability Accommodation Policy (P-1.33) supporting our application for Module 5; the Cyber Security and Acceptable Use Policy (P-1.34); and the Mealtime Management Policy (P-2.08) addressing the NDIS Practice Standard added in the November 2021 amendments.

Two things are not different: our commitment to participants comes first, and our commitment to acting with honesty and care has not moved.

We are jointly accountable to the Board of Able to Thrive Pty Ltd for the contents of this Manual, for its faithful implementation, and for its continued improvement. Where we fall short, we want to know. The Feedback, Compliments and Complaints Policy (P-2.03) and

the Incident Management Policy (P-2.06) describe how to raise concerns. We read every complaint and every incident. We act.

Eyad Shadid

Director — Compliance, HR, Operations & Client Experience

Dante Michael

Director — Finance, Technology, Sales, Marketing & Growth

May 2026

How to use this Manual

Structure

The Manual contains twenty-two controlled policies organised in two series:

- **P-1.x policies** — governance and organisation-wide policies that apply across all activity of Able to Thrive. These cover topics such as Governance, Risk Management, Human Resources, Privacy, Cyber Security, and the Living Alone Risk Assessment framework.
- **P-2.x policies** — service-line and operational policies covering matters such as Feedback and Complaints, Incident Management, Medication, Mealtime, Waste, Support Coordination, Child Safety, and Suicide Prevention.

Each policy is self-contained

Every policy in this Manual has the same structure:

- **Document Control** — identifies the policy number, version, owner, approver, related documents and next review date.
- **Purpose and Scope** — explains what the policy is for and to whom and what it applies.
- **Legislative and Regulatory Framework** — records the legal sources the policy gives effect to.
- **Definitions** — defines the technical terms used.
- **Policy Statement** — states the organisation's position in plain terms.
- **Operational sections** — describe how the policy is implemented.
- **Roles and Responsibilities** — records who is accountable for what.
- **Review** — states the review schedule and triggers for out-of-cycle review. Director endorsement of every policy in this Manual is captured in the Master Endorsement at the back of this Manual; the Document Control panel at the start of each policy records the Directors as the approving authority.

Page numbering

The Manual uses continuous page numbering from page 1 (this cover) through to the end. Every page carries the same footer identifying the Manual, the version, and the page number. The Table of Contents lists every policy with the page on which its title block begins, so any policy can be located quickly.

Each policy also exists as a stand-alone controlled document in its own file. If a single policy needs to be printed and circulated on its own (for example, for worker induction on a specific topic), the stand-alone file is the more practical option, as it carries its own per-policy footer and Page X of Y pagination.

Updates and revisions

When a policy is revised, the revised policy is issued under the Policy Review Action Plan and the relevant entry in this Manual is replaced. Each policy carries its own version number, so the Manual's version (currently 1.0) may include policies at different revision points over time.

Related documents not in this Manual

Some documents that the policies in this Manual refer to are held separately and are not reproduced in this Manual. These include:

- the Business Plan v2.0 (current strategic priorities, organisational KPIs, financials);
- the Labour Hire Agreement between Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd;
- the Policy Review Action Plan (the schedule under which this Manual is refreshed);
- operational registers maintained in Brevity (Risk Register, Incident Register, Complaints Register, Continuous Improvement Register, Living Alone Register, Conflict of Interest Register, Gifts and Benefits Register, Information Asset Register, Key Personnel record);
- the operational forms and templates referenced by individual policies (Service Agreement template, Mealtime Management Plan template, Medication Administration Record template, PRN Medication Protocol template, Grievance Lodgement Form, etc.).

Table of contents

The Manual contains twenty-two controlled policies. The page reference below is the page on which each policy's title block begins.

No.	Title	Version	Page
P-1.01	Governance Policy	v2.0	**11**
P-1.03	Conflict of Interest Policy	v2.0	**19**
P-1.05	Continuous Improvement Policy	v2.0	**28**
P-1.09	Risk Management Policy	v2.0	**35**
P-1.23	Human Resources Policy	v2.0	**44**
P-1.26	Staff Code of Conduct	v2.0	**53**
P-1.27	Disputes and Grievances Policy	v2.0	**62**
P-1.29	Information Management Policy	v2.0	**70**
P-1.30	Privacy and Confidentiality Policy	v2.0	**78**
P-1.31	Living Alone Risk Assessment Policy	v1.0 (new)	**86**
P-1.32	Behaviour Support Implementation Policy	v1.0 (Module 2a)	**95**
P-1.33	Specialist Disability Accommodation Policy	v1.0 (Module 5)	**103**
P-1.34	Cyber Security and Acceptable Use Policy	v1.0 (new)	**111**
P-2.03	Feedback, Compliments and Complaints Policy	v2.0	**119**
P-2.06	Incident Management Policy	v2.0	**127**
P-2.07	Medication Management Policy	v2.0 (Outcome 4.3)	**137**
P-2.08	Mealtime Management Policy	v1.0 (Outcome 4.4)	**146**
P-2.09	Management of Waste Policy	v2.0 (Outcome 4.5)	**154**
P-2.15	Support Coordination Policy	v2.0	**162**
P-2.17	Child Safety Policy	v2.0	**170**
P-2.20	Child Safe Environment Policy	v2.0	**179**

P-2.21	Suicide Prevention and Response Policy	v2.0	187

Series at a glance

The policies are grouped by series in the order they appear in the Manual:

- **P-1 series (governance, organisation-wide)** — thirteen policies, P-1.01 through P-1.34.
- **P-2 series (service-line, operational)** — nine policies, P-2.03 through P-2.21.

Numbers in each series are non-consecutive because they map to the section numbers of the superseded V3 manual where applicable, or are allocated to new policies in a manner that allows future additions in the same range.

The policies

What follows is the policy set. Each policy starts on its own coloured title block and runs through its complete set of sections, including its own Document Control panel, Roles and Responsibilities, and Director endorsement.

Auditors, workers, participants and any other reader can:

- read a policy in full to understand the framework in a particular area;
- search the headers of the Manual (each policy carries its number in the running header) to navigate quickly; or
- print an individual policy for circulation or training without disturbing the others.

The policies are arranged in numerical order, P-1.01 first through P-2.21 last.

ABLE TO THRIVE PTY LTD

Policy P-1.01

GOVERNANCE POLICY

Document control

Policy number	P-1.01
Policy title	Governance Policy
Version	2.0
Date issued	August 2026
Supersedes	Governance Policy and Procedure (Section 1.1 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	August 2027, or upon material change to the Directors, the senior management team, NDIS Practice Standards, or the corporate structure
Related policies and documents	Risk Management Policy (P-1.09); Conflict of Interest Policy (P-1.03); Human Resources Policy (P-1.23); Continuous Improvement Policy (P-1.05); Business Plan; Labour Hire Agreement between Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd; Constitution of Able to Thrive Pty Ltd; Director meeting minutes; Delegations Schedule

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) is governed. It records the structure of the Board of Directors, the division of responsibilities between Directors, the relationship with Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel), the management structure that reports to the Directors, the decisions reserved to the Directors, and the meetings, reporting and review cadence that supports good governance.

The Policy supports compliance with the NDIS Practice Standards on governance and operational management, the Directors' duties under the Corporations Act 2001 (Cth), and the conditions of registration applying to Able to Thrive's NDIS registration (ID 4-IPX11F6).

2. Scope

This Policy applies to:

- the Directors of Able to Thrive Pty Ltd in their capacity as directors of the company and as key personnel of the NDIS-registered provider;
- the relationship between Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd;
- the senior management team that reports to the Directors;
- decision-making forums within the organisation (Director meetings, management meetings); and
- the production of governance documents (Business Plan, policies, registers, minutes).

3. Legislative and regulatory framework

- *Corporations Act 2001* (Cth) — Directors' duties (duty of care and diligence, duty to act in good faith and in the best interests of the company, duty not to misuse position or information, duty to avoid undisclosed conflicts of interest, duty to prevent insolvent trading).
- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards (governance and operational management indicators).
- NDIS Provider Registration and Practice Standards Rules — sections 13 and 13A (key personnel notifications) and the conditions of registration applying to Able to Thrive.
- Constitution of Able to Thrive Pty Ltd.

4. Definitions

- **Board** means the board of directors of Able to Thrive Pty Ltd. At the date of this Policy, the Board comprises Eyad Shadid and Dante Michael.
- **Director** means a person duly appointed to the Board.
- **Key personnel** has the meaning given by section 11A of the NDIS Act and includes the Directors and senior managers responsible for executive decisions of the registered NDIS provider.
- **Reserved decision** means a decision that may be made only by the Board, listed in Section 8.
- **Delegations Schedule** means the document approved by the Board recording the financial and operational authorities delegated from the Board to management.

5. Policy statement

Able to Thrive is governed by a Board that acts with integrity, care and diligence, in the best interests of the company and of the participants whose supports it is registered to deliver. The Board sets strategy, oversees risk and compliance, approves the matters reserved to it, and holds management to account through structured reporting. Management implements strategy and operates the organisation within the authorities delegated by the Board.

6. Board composition and division of responsibilities

At the date of this Policy, the Board comprises two Directors. Each Director has portfolio leadership in addition to joint responsibility for the matters reserved to the Board.

Director	Portfolio leadership
Eyad Shadid	Compliance, Human Resources, Operations and Client Experience. Qualified compliance lead. Designated Child Safety Officer. Director on-call for serious incidents. Lead point of liaison with the NDIS Quality and Safeguards Commission and other regulators. Owner of short-term accommodation (STA) operations.
Dante Michael	Finance, Technology, Sales, Marketing and Growth. Director responsible for financial management, technology platforms (including Brevity, ClickUp and the integrated systems backbone), revenue and growth strategy, and the related-party relationship with Able to Thrive Personnel Pty Ltd.

Both Directors are registered as key personnel with the NDIS Commission. Both Directors are signatories on this and every other policy issued under the Policy Review Action Plan.

7. Decision-making

7.1 Joint approval threshold

Financial decisions or commitments in excess of $2,000 require joint approval of both Directors. Decisions below this threshold may be made by the Director with portfolio responsibility, recorded in writing where material.

7.2 Joint approval also required for

- any matter that materially affects participant safety, child safety, the conditions of registration, or the organisation’s NDIS registration status;
- any change to a current Tier 1 or Tier 2 policy issued under the Policy Review Action Plan;
- any change to the Labour Hire Agreement with Able to Thrive Personnel Pty Ltd;

- engagement or termination of senior management;
- engagement of external auditors, legal counsel, or any consultant engaged for more than $5,000;
- any related-party arrangement;
- any matter that the Directors agree to record as requiring joint approval.

7.3 Disagreement between Directors

Where the Directors are unable to agree on a matter requiring joint approval, the decision is deferred and the matter is recorded in writing. If a resolution cannot be reached within a reasonable time and the matter cannot be deferred (for example, urgent participant safety or regulatory matters), the Directors will seek external advice (legal, accounting, or NDIS-experienced advisory) before any decision is taken.

8. Reserved decisions

The following decisions are reserved to the Board and may not be delegated:

- approval of the annual Business Plan and any material change to it;
- approval of the annual budget and any material variation;
- approval of Tier 1 and Tier 2 policies under the Policy Review Action Plan, including this Policy;
- approval of acceptance of any Extreme- or High-band residual risk under the Risk Management Policy;
- approval of related-party arrangements;
- engagement of, and termination of, key personnel;
- any application to vary the NDIS registration scope (including Module 2a, Module 5, or future additions);
- material commercial commitments (over $20,000 or with a term over 12 months);
- any matter that would require notification to the NDIS Commission under sections 73Y, 73Z, 13 or 13A;
- any acquisition, divestment, merger or material restructuring of either entity in the group; and
- appointment of external auditors.

9. Delegations to management

Authorities not reserved to the Board are delegated to management in accordance with the Delegations Schedule approved by the Board. The Delegations Schedule sets out:

- financial approval limits at each management level (HR Coordinator and Operations Manager, Lead Compliance Officer, Finance Manager, Client Services and Acquisition lead);
- operational authorities (rostering, worker allocation, intake, supplier engagement under the threshold, communications);

- the requirement to escalate matters to a Director where a decision is at or near the limit of delegation, or where the matter is novel or contentious; and
- record-keeping requirements for delegated decisions.

The Delegations Schedule is reviewed at least annually and updated whenever there is a material change in the management structure.

10. Senior management team

The senior management team reports to the Directors. At the date of this Policy, the team comprises:

Role	Reports to
Lead Compliance Officer (Massy)	Director (Compliance) — Eyad Shadid
HR Coordinator and Operations Manager (Kriz)	Director (Compliance) — Eyad Shadid
Client Services and Acquisition (Akash)	Director (Compliance) — Eyad Shadid (for compliance and client experience); Director (Sales and Growth) — Dante Michael (for acquisition)
Finance Manager (Alex)	Director (Finance) — Dante Michael
Admin (Compliance and HR) (Mikha)	Lead Compliance Officer (functional) and Director (Compliance) (oversight)

Changes in senior management are notified to the NDIS Commission under the key personnel notification process described in Section 12 and in the Human Resources Policy (P-1.23, Section 17).

11. Meetings and reporting

11.1 Director meetings

The Directors meet not less than monthly. Each meeting is recorded in written minutes including: attendees; matters discussed; decisions taken (with the basis for each decision); action items with named owners and due dates; and any conflicts declared by a Director under the Conflict of Interest Policy. Minutes are signed off at the next meeting.

11.2 Standing items at Director meetings

Each Director meeting includes the following standing items:

- participant safety and incidents since the last meeting, including any Reportable Incident;
- current Extreme- and High-rated risks (Risk Management Policy);

- continuous improvement summary (Continuous Improvement Policy);
- financial performance against budget;
- KPI performance against the organisational KPIs set in the Business Plan;
- any complaint of medium or high complexity, and any NDIS Commission referral;
- progress against the Policy Review Action Plan;
- workforce matters of materiality;
- any matter requiring Director decision under Section 7 or Section 8.

11.3 Management reporting

The senior management team prepares standing reports to the Directors covering compliance, operations, finance, and growth. Reports are circulated in advance of each Director meeting. The Lead Compliance Officer is responsible for the compliance and continuous improvement report; the Finance Manager for the financial report; and the Client Services and Acquisition lead for the participant base and acquisition report.

11.4 Annual governance review

The Directors conduct an annual governance review (typically aligned with the annual Business Plan refresh) covering the operation of this Policy, the Delegations Schedule, the senior management structure, the standing items framework, and any feedback from external reviews or audits. Material changes are recorded as updates to this Policy.

12. Key personnel notification

Changes in key personnel (Directors and senior managers responsible for executive decisions) are notified to the NDIS Commission as required by sections 13 and 13A of the NDIS Provider Registration and Practice Standards Rules. The Lead Compliance Officer maintains a record of current key personnel and prepares notifications. The Director (Compliance) signs off on each notification before submission.

Current key personnel registered with the NDIS Commission are maintained as an appendix to this Policy and are updated whenever a change is notified.

13. Conduct of Directors

- Directors act with care and diligence, in good faith, in the best interests of the company, and for proper purposes.
- Directors do not misuse their position or information obtained through their role.
- Directors disclose actual, potential and perceived conflicts of interest under the Conflict of Interest Policy. Conflicts are recorded in the Conflict of Interest Register and managed through the controls in that Policy.
- Directors do not allow Able to Thrive to trade while insolvent. The Director (Finance) monitors solvency continuously and escalates immediately on any concern.
- Directors comply with the NDIS Code of Conduct in the same way as workers.

- Directors maintain currency of NDIS Worker Screening as required by key personnel obligations.

14. Relationship with Able to Thrive Personnel Pty Ltd

Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd are related entities operating under a Labour Hire Agreement. Both entities are directed by overlapping Directors. The arrangement is governed as follows:

- the Labour Hire Agreement is the primary instrument recording the commercial and operational terms between the entities;
- changes to the Labour Hire Agreement require joint Director approval (Section 7);
- the related-party nature of the arrangement is recorded in the Conflict of Interest Register and disclosed to the NDIS Quality Auditor and the NDIS Commission on request;
- an annual review of the Labour Hire Agreement is conducted by the Lead Compliance Officer with sign-off by both Directors; and
- the entities maintain separate financial records and separate compliance with employment, tax and workers compensation obligations.

15. External advisers

Able to Thrive engages external advisers where governance requires it, including:

- an external accountant or auditor for the financial statements;
- external legal counsel on commercial, employment, NDIS and child safety matters; and
- NDIS-experienced advisory support for matters such as registration scope, audit preparation and complex compliance.

Engagement of an external adviser for more than $5,000 requires joint Director approval (Section 7).

16. Governance documents

- the Constitution of Able to Thrive Pty Ltd;
- the Business Plan;
- this Policy and the policies issued under the Policy Review Action Plan;
- the Labour Hire Agreement;
- the Risk Register, Conflict of Interest Register, Continuous Improvement Register, Complaints Register, Incident Register, Living Alone Register, Gifts and Benefits Register;
- Director meeting minutes;
- the Delegations Schedule;
- the key personnel record;

- audit reports (internal and external);
- insurance certificates of currency.

17. Roles and responsibilities

Role	Responsibility under this Policy
Board (Directors jointly)	Strategy. Reserved decisions (Section 8). Joint approval matters (Section 7). Oversight of management. Annual governance review.
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Sign-off on key personnel notifications. Liaison with the NDIS Commission and other regulators. Owner of the relationship with the senior management team in his portfolio.
Director (Finance) — Dante Michael	Financial oversight and solvency monitoring. Oversight of technology platforms. Owner of the related-party relationship with Able to Thrive Personnel Pty Ltd from the Pty Ltd side.
Lead Compliance Officer	Owner of this Policy. Maintenance of the key personnel record. Coordination of Director reporting. Maintenance of governance documents. Annual review preparation.
Senior management	Compliance with the Delegations Schedule. Escalation of matters at or beyond delegation. Timely management reporting. Honest engagement with Director oversight.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in Directors, a material change in the senior management team, a material change in the corporate structure, a change in NDIS Practice Standards on governance, or following an audit finding bearing on governance.

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Policy P-1.03

CONFLICT OF INTEREST POLICY

Document control

Policy number	P-1.03
Policy title	Conflict of Interest Policy
Version	2.0
Date issued	May 2026
Supersedes	Conflict of Interest Policy and Procedure (Section 1.3 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to the NDIS Code of Conduct, Practice Standards, or any change in Able to Thrive's service mix that affects the conflict profile
Related policies and documents	Service Agreement template; Conflict of Interest Disclosure Form; Conflict of Interest Register; Gifts and Benefits Register; Alternatives Offered Log; Support Coordination Policy; Incident Management Policy; Risk Register; NDIS Code of Conduct

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) identifies, declares, manages and documents conflicts of interest — actual, potential or perceived. The Policy applies the choice-and-control principles of the NDIS Code of Conduct and Practice Standards to Able to Thrive's specific operating model, in which the same provider delivers both direct supports and support coordination to some participants.

2. Scope

This Policy applies to:

- the Directors of Able to Thrive Pty Ltd;
- all employees, management, support coordinators and administrative staff of Able to Thrive;
- all support workers engaged through Able to Thrive Personnel Pty Ltd;
- all contractors and consultants engaged by Able to Thrive; and
- any decisions or interactions involving NDIS participants, prospective participants, suppliers, referrers, or other parties whose interests may compete with the interests of Able to Thrive or of a participant.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth).
- NDIS Code of Conduct (in particular the requirement to act with integrity, honesty and transparency, and to respect choice and control).
- NDIS Practice Standards and Quality Indicators, including the indicators relating to governance, operational management, and the rights of participants.
- NDIS Terms of Business for Registered Providers.
- *Corporations Act 2001* (Cth) — Directors' duties in respect of related-party transactions and conflicts.

4. Definitions

- **Conflict of interest** means a situation in which a personal, financial, professional or other interest of a worker, manager, Director or related person may, or may be perceived to, influence the proper performance of duties owed to Able to Thrive or to a participant.
- **Actual conflict** means a conflict that exists at the time of the decision or interaction.
- **Potential conflict** means a situation that could give rise to an actual conflict if circumstances develop in a particular way.
- **Perceived conflict** means a situation that may reasonably appear to a third party to be a conflict, regardless of whether one exists in fact.
- **Related person** means a member of a worker's immediate family, a person with whom the worker is in a close personal relationship, and any business or entity in which the worker or a related person has a material interest.
- **Support coordination** means the support delivered under NDIS registration group 0106 to help participants understand and use their plan, choose and engage providers, and resolve service issues.

5. Policy statement

Able to Thrive acts with integrity, honesty and transparency in every decision and interaction. When the interests of a worker, manager, Director or Able to Thrive itself may compete with the interests of a participant, the participant's interests take priority. Participants are always

informed about their choices and never directed toward Able to Thrive's services in preference to alternatives.

Conflicts of interest are declared as soon as they are identified, recorded in the Conflict of Interest Register, and managed through the controls in this Policy. Failure to declare a conflict is treated as a serious matter and may lead to disciplinary action up to and including termination of employment or engagement.

6. Specific conflict: support coordination and direct services

Able to Thrive is registered to provide both direct supports (including assistance with daily living, community access, household tasks, short-term accommodation and group activities) and support coordination under NDIS registration group 0106. The combination of these services in one organisation creates a structural conflict of interest: a participant's Able to Thrive support coordinator could, in principle, steer the participant toward Able to Thrive's own direct services in preference to other providers.

Able to Thrive identifies, declares and manages this conflict through the operational controls in this Section.

6.1 Written disclosure to the participant

Where Able to Thrive is engaged to provide support coordination to a participant who is also (or may also become) a recipient of Able to Thrive's direct services, the support coordinator gives the participant a written disclosure at the commencement of the support coordination engagement. The disclosure is provided in a format accessible to the participant (plain English, Easy Read, translated or with interpreter support where required) and:

- explains that Able to Thrive provides both support coordination and direct services;
- explains the participant's right to choose any provider for their direct supports, including providers other than Able to Thrive;
- confirms that the support coordinator will present alternative providers and will not advocate for Able to Thrive in preference to them;
- confirms that the participant may request a different support coordinator (internal or external) at any time without affecting their other supports; and
- provides the contact details of the Lead Compliance Officer for any concern about how the conflict is being managed.

A copy of the signed or acknowledged disclosure is filed in the participant's Brevity record. The disclosure is reissued and re-acknowledged whenever Able to Thrive begins providing a new category of direct support to the participant.

6.2 Service Agreement clause

Each Service Agreement entered with a participant for whom Able to Thrive provides both support coordination and direct services includes a Conflict of Interest clause that:

- records that the participant has received the written disclosure described in Section 6.1;

- confirms the participant's right to choose alternative providers;
- confirms that Able to Thrive will document alternatives offered (see Section 6.3); and
- confirms that the participant may raise concerns through the Complaints Policy without affecting their supports.

6.3 Alternatives Offered Log

Where the support coordinator recommends, arranges or facilitates a direct support, the support coordinator records in the Alternatives Offered Log:

- the support type proposed;
- the alternative providers considered;
- the basis on which Able to Thrive was selected (or not selected); and
- whether the participant's preference informed the decision.

The Log is maintained in Brevity, reviewed quarterly by the Lead Compliance Officer, and made available to NDIS auditors on request.

6.4 Separation of incentives

Support coordinators at Able to Thrive are not paid on the basis of direct-service utilisation by their participants. No commission, bonus, or other incentive structure rewards a support coordinator for steering participants toward Able to Thrive's own direct services. This separation is documented in each support coordinator's employment terms.

6.5 Periodic conflict review

At each quarterly compliance review, the Lead Compliance Officer reviews:

- the participants for whom Able to Thrive provides both support coordination and direct services;
- the Alternatives Offered Log entries for the quarter; and
- any feedback or complaints relating to the conflict.

The review outcome is reported to the Director (Compliance) and recorded in the Conflict of Interest Register.

7. Disclosure obligations

Every worker, manager, Director, contractor and consultant has a continuing obligation to disclose any actual, potential or perceived conflict of interest as soon as they become aware of it.

7.1 When disclosure is required

Disclosure is required where any of the following may exist:

- a financial, commercial or professional interest in a participant, a supplier, a competitor, a referrer, or any party with whom Able to Thrive is dealing;

- a personal relationship with a participant, the participant's family member, another worker, a referrer or a supplier;
- secondary employment or consultancy that intersects with Able to Thrive's activities;
- the receipt or offer of gifts, hospitality, benefits or commissions (see Section 8);
- a board or advisory role in another organisation operating in the disability sector or in adjacent sectors; or
- any other circumstance in which the worker's judgement may, or may appear to, be affected.

7.2 How disclosure is made

Disclosure is made by completing a Conflict of Interest Disclosure Form, which is submitted to the worker's manager and to the Lead Compliance Officer. Workers may also raise the matter verbally with their manager in the first instance, but a written disclosure follows within two business days.

7.3 What happens after disclosure

On receipt of a disclosure, the Lead Compliance Officer:

- records the disclosure in the Conflict of Interest Register;
- assesses the nature of the conflict (actual, potential or perceived) and the level of risk;
- determines, with the Director (Compliance) where required, the appropriate management response — which may include exclusion of the worker from the relevant decision or interaction, additional supervision, transparency to affected parties, or no action where the conflict is determined to be immaterial;
- communicates the management response to the worker and their manager; and
- reviews the response at the next quarterly compliance review.

8. Gifts, benefits and commissions

Able to Thrive workers do not accept any offer of money, gifts, services or benefits that would cause them to act in a manner contrary to the interests of a participant or of Able to Thrive. The receipt or offer of commissions in connection with the provision of NDIS supports is prohibited.

The following standard applies to gifts and benefits:

- **Gifts of nominal value** (token thank-you gifts of less than $50 in value) may be accepted from participants or families, but are recorded in the Gifts and Benefits Register within five business days.
- **Gifts of greater value** (more than $50, or of any value where the donor has a commercial relationship with Able to Thrive) are not accepted in the worker's personal capacity. Where refusal would cause offence, the gift is accepted on behalf of Able to Thrive, recorded in the Register, and dealt with by management (e.g. donated to a community organisation).

- **Commissions or financial benefits** from suppliers, other providers, allied health practitioners or referrers, in connection with NDIS supports, are not accepted in any circumstance.
- **Hospitality and travel** offered by suppliers or external parties is declared to the Director (Compliance) before acceptance.

The Gifts and Benefits Register is maintained by the Lead Compliance Officer and reviewed at each Director meeting.

9. Personal relationships

Workers disclose any close personal relationship (including family relationships, partnerships, and significant friendships) with:

- a participant or a participant's family member;
- another Able to Thrive worker who reports to them or to whom they report;
- a referrer, supplier or other party with whom Able to Thrive is dealing.

Where a close personal relationship exists with a participant, the worker is not allocated to provide personal support to that participant. Where a close personal relationship exists between workers in a reporting line, the reporting line is restructured (which may include reassignment of the supervisory function to another manager) to ensure that performance management is conducted at arm's length.

10. Outside interests and secondary employment

Workers and managers may hold outside interests and secondary employment, subject to the following:

- outside interests and secondary employment are disclosed at engagement and whenever they change;
- the outside interest or secondary employment must not conflict with Able to Thrive's interests or the worker's ability to perform their role;
- Able to Thrive resources, time, information or relationships are not used for the outside interest;
- the worker must not solicit Able to Thrive participants for the benefit of the outside interest; and
- approval of the Director (Compliance) is required where the outside interest or secondary employment is in the disability, aged care, mental health, or adjacent sectors.

11. Related-party arrangements

Able to Thrive enters into a related-party arrangement with Able to Thrive Personnel Pty Ltd for the supply of labour. The arrangement is documented in a Labour Hire Agreement and managed in accordance with the Directors' duties under the Corporations Act 2001 (Cth).

Other related-party arrangements may be entered from time to time. Each related-party arrangement:

- is documented in a written agreement on arm's-length terms;
- is approved by both Directors, with the conflict explicitly recorded in the approval;
- is reviewed annually by the Lead Compliance Officer with sign-off by the Director (Compliance); and
- is disclosed to the NDIS Quality Auditor and NDIS Commission on request.

12. Training

All workers complete training in this Policy at induction. The training covers:

- what a conflict of interest is and how to recognise actual, potential and perceived conflicts;
- the specific conflict described in Section 6 and how the operational controls work in practice;
- how to make a disclosure, including use of the Disclosure Form;
- gifts, benefits and commissions;
- personal relationships and reporting lines;
- outside interests and secondary employment; and
- consequences of failing to disclose.

Refresher training is delivered annually and recorded against each worker's file.

13. Audit and monitoring

The Lead Compliance Officer monitors conflict-of-interest matters through:

- quarterly review of the Conflict of Interest Register;
- quarterly review of the Alternatives Offered Log (Section 6.3);
- quarterly review of the Gifts and Benefits Register (Section 8);
- reporting of all of the above to the Director (Compliance) and to the Directors at scheduled meetings; and
- inclusion of conflict-of-interest matters in the Annual Compliance Report.

Trends or material issues are escalated to the Directors. Material conflicts are recorded in the Risk Register and tracked through the Continuous Improvement Register.

14. Reporting failures and complaints

Anyone may raise a concern that a conflict of interest is not being properly managed. Concerns may be raised through:

- the Complaints Policy (for participants, families, support coordinators and the public);
- the Disputes and Grievances Policy (for workers);
- directly to the Lead Compliance Officer or the Director (Compliance); or

- externally to the NDIS Quality and Safeguards Commission.

Reports made in good faith are treated confidentially and the reporter is protected from retaliation. Confirmed failures to declare or properly manage a conflict are treated as a serious matter and may lead to disciplinary action.

15. Roles and responsibilities

Role	Responsibility under this Policy
Directors (joint)	Approval of related-party arrangements with conflict disclosed in the approval. Review of conflict-of-interest reports at scheduled Director meetings. Final decision-making on material conflicts.
Director (Compliance) — Eyad Shadid	Qualified compliance lead for this Policy. Sign-off on the Lead Compliance Officer's assessments of complex or material conflicts. Approval of secondary employment in the disability sector. Annual Compliance Report.
Lead Compliance Officer	Owner of this Policy. Maintenance of Conflict of Interest Register, Alternatives Offered Log and Gifts and Benefits Register. Quarterly review. Assessment of disclosures. Recommendation of management response.
Support coordinators	Written disclosure to participants under Section 6.1. Service Agreement clause under Section 6.2. Recording of alternatives in the Log. Active offering of alternative providers. Escalation of any concern about the management of the conflict.
All workers and managers	Recognition of conflicts. Disclosure at first awareness. Compliance with management response. Maintenance of arm's-length conduct in any relationship with participants and external parties.

16. Record keeping

- Conflict of Interest Disclosure Forms are retained for not less than seven years from the date of the disclosure.
- The Conflict of Interest Register, Alternatives Offered Log and Gifts and Benefits Register are retained for not less than seven years from the date of last entry.
- Written disclosures to participants (Section 6.1) are retained in the participant's Brevity record for not less than seven years from the date of service exit.

17. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in the NDIS Code of Conduct or Practice Standards; a change in Able to Thrive's service mix that affects the conflict profile (in particular, the addition of Specialist Disability Accommodation or any new registration group); a material related-party arrangement; or an audit finding bearing on this Policy.

ABLE TO THRIVE PTY LTD

Policy P-1.05

CONTINUOUS IMPROVEMENT POLICY

Document control

Policy number	P-1.05
Policy title	Continuous Improvement Policy
Version	2.0
Date issued	October 2026
Supersedes	Continuous Improvement Policy and Procedure (Section 1.5 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	October 2027, or upon material change to NDIS Practice Standards or organisational governance
Related policies and documents	Risk Management Policy (P-1.09); Incident Management Policy (P-2.06); Feedback, Compliments and Complaints Policy (P-2.03); Business Plan; Policy Review Action Plan; Continuous Improvement Register; Audit reports (internal and external); NDIS Practice Standards; NDIS Code of Conduct

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) systematically identifies opportunities to improve the quality and safety of its supports, the effectiveness of its governance, and the satisfaction of its participants, families, workers and partners. The Policy gives effect to the NDIS Practice Standards on continuous improvement.

Continuous improvement is not a separate workstream. It is the discipline by which everything Able to Thrive does is examined, learned from, and made better over time.

2. Scope

This Policy applies to:

- every service line and activity of Able to Thrive;
- every worker, manager and Director;
- every interaction with participants, families, support coordinators, referrers, partners and regulators; and
- the operations of Able to Thrive Personnel Pty Ltd as the labour hire entity.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards and Quality Indicators, in particular the Quality Management indicator and the Continuous Improvement indicator.
- ISO 9001 (Quality Management Systems) as a methodological reference.

4. Definitions

- **Continuous improvement (CI)** means the ongoing effort to improve services, governance, systems, workforce capability and participant outcomes through structured identification, planning, action, review and learning.
- **Continuous Improvement Register** (CI Register) means the consolidated record of improvement items, maintained by the Lead Compliance Officer, tracking each item from identification to closure.
- **CI item** means a discrete improvement activity recorded in the CI Register with an owner, description, source, target completion date and current status.
- **Trend** means a pattern observed across multiple incidents, complaints, items of feedback or other sources that may indicate a systemic improvement opportunity.

5. Policy statement

Able to Thrive maintains a culture in which improvement is everyone’s business. Workers are encouraged to raise ideas without fear of blame. Mistakes are reviewed for learning. Trends are taken seriously. Improvement is resourced and tracked through completion. The Directors model the culture by acting on what is identified.

6. Principles

- **Participant-centred.** Improvement starts with the question "is this better for participants?".
- **Evidence-based.** Improvement priorities are informed by data — incidents, complaints, audits, feedback, KPIs — rather than by intuition alone.

- **Systemic, not blame-based.** Improvement focuses on systems, processes and capability, not on identifying individuals to blame.
- **Accountable.** Every improvement item has a named owner and a target completion date. Progress is reviewed at scheduled intervals.
- **Transparent.** The CI Register is open to all workers and is shared with participants and auditors on request.
- **Closed-loop.** Improvement items are not closed until the change is implemented and the outcome reviewed.

7. Sources of continuous improvement

Improvement opportunities are identified from the following sources, all of which feed the CI Register:

- **Incidents.** Every incident review under the Incident Management Policy considers whether the matter reveals a systemic gap. Reportable Incidents and serious internal incidents normally generate at least one CI Register entry.
- **Complaints.** Themes identified through complaint handling, including patterns of similar complaints across participants, are recorded as CI items.
- **Audits — internal.** Quarterly internal audits conducted by the Lead Compliance Officer identify gaps which become CI items.
- **Audits — external.** NDIS Quality Auditor findings, NDIS Commission observations, and audit findings from any other regulator are recorded as CI items and prioritised.
- **Participant feedback.** Structured satisfaction surveys, plan-review feedback, and informal feedback raised at any time are reviewed for improvement signal.
- **Worker input.** Any worker may raise an improvement idea through Brevity, in supervision, in team meetings, or directly to the Lead Compliance Officer. Workers are recognised for the improvement ideas they raise.
- **Strategic planning.** Capability uplift items identified through the strategic priorities in the Business Plan are recorded as CI items where they need to be tracked and resourced.
- **Sector and regulatory developments.** Changes in the NDIS Practice Standards, NDIS Code of Conduct, NSW child safety law, employment law, WHS law, privacy law and sector best practice are reviewed by the Lead Compliance Officer and result in CI items where action is required.
- **KPI monitoring.** The organisational KPIs recorded in the Business Plan are reviewed quarterly. Underperformance against KPI thresholds generates a CI item.

8. The Continuous Improvement Register

The CI Register is the single source of truth for improvement activity at Able to Thrive. The Lead Compliance Officer maintains the Register. For each CI item, the Register records:

- a unique CI identifier;

- the source (incident reference, complaint reference, audit finding, feedback, worker idea, strategic priority, sector development, KPI variance);
- a description of the opportunity or issue;
- the planned action;
- the named owner;
- the target completion date;
- linkage to any related Risk Register entry, policy or operational change;
- progress notes; and
- the date of closure and the basis for closure (including, where appropriate, evidence that the change has had the intended effect).

The Register is held in Brevity (or such other organisational system as is in use from time to time) and is accessible to all workers.

9. Prioritisation

Improvement items are prioritised against three criteria:

- **Participant safety and rights.** Items affecting participant safety, child safety, or participant rights are prioritised over other items.
- **Compliance.** Items addressing identified compliance gaps, conditions of registration, or regulator findings are prioritised over discretionary items.
- **Magnitude of benefit.** Among discretionary items, those expected to produce the greatest benefit relative to effort are progressed first.

Prioritisation is reviewed at each quarterly CI review. Items are deferred only with documented reason. Items are not deferred where they affect participant safety or a current compliance obligation.

10. Action and closure

Each CI item is progressed through a structured cycle:

- **Plan** — the owner defines the action, the resources required, the timeline and the evidence of effect that will be looked for.
- **Do** — the action is implemented, with progress notes recorded in the Register.
- **Check** — the owner and the Lead Compliance Officer review whether the action has had the intended effect.
- **Adjust and close** — if the effect is achieved, the item is closed with the basis for closure recorded. If the effect is not yet achieved, the item is adjusted and continues. Closure decisions for high-priority items require sign-off by the Lead Compliance Officer.

11. Reporting and review cadence

- **Quarterly CI review.** The Lead Compliance Officer reviews the full CI Register quarterly. The review confirms that items are progressing, identifies overdue items for escalation, reviews trends across items, and reports to the Directors.
- **Director meeting reporting.** At each scheduled Director meeting, the Lead Compliance Officer presents a summary of CI activity since the last meeting, including items closed, items added, and any item requiring Director input.
- **Annual continuous improvement review.** Once per year, the Directors and senior management review the operation of the CI system itself — whether sources are feeding the Register effectively, whether items are progressing in reasonable time, and whether the culture is supporting honest improvement.

12. Examples of recent continuous improvement activity

Examples of continuous improvement undertaken since the Certification audit, recorded in the CI Register and reviewed by the Directors, include:

- Development and roll-out of the Suicide Prevention and Response Policy (Policy P-2.21), following the death of a participant by suicide, with training of all staff in its application.
- Integration of Brevity, ClickUp, Outlook and Microsoft Teams into a single digital workflow, materially improving CRM, communication and workflow management across in-house and remote teams.
- Redesign of the worker induction program and delivery through a structured online Onboarding Classroom, standardising induction content and reducing time-to-first-shift.
- Substantial redevelopment of the Able to Thrive website to reflect the current brand, services and participant-facing information requirements.
- Relocation of the head office to B103/548–568 Canterbury Rd, Campsie in March 2026, supporting growth in the Sydney office team.
- Commencement of the comprehensive Policy Review Action Plan, with Tier 1 priority policies operational and Tier 2 and Tier 3 scheduled.

These examples are illustrative; the live record of CI activity is the CI Register.

13. Linkage with other policies and processes

- Incidents under the Incident Management Policy may give rise to CI items. The CI Register cross-references the relevant incident records.
- Complaints under the Feedback, Compliments and Complaints Policy may give rise to CI items, particularly where complaint themes emerge.
- Risk treatment plans under the Risk Management Policy may be recorded as CI items where they involve discrete project work.

- Audit findings (internal and external) are recorded as CI items with their source identified.
- Capability uplift items arising from the Business Plan strategic priorities are recorded as CI items where they require tracking.
- Policy refresh activity under the Policy Review Action Plan is itself a CI program tracked through the CI Register.

14. Training and culture

All workers complete training in this Policy at induction. Training covers what continuous improvement means at Able to Thrive, how to raise an idea or concern, what happens when an item is raised, and the worker's expectation to participate honestly in incident and complaint reviews. Managers complete additional training in running CI conversations, conducting closures with reference to evidence of effect, and recognising staff who contribute.

The Directors reinforce the CI culture by acting on what is identified, recognising contributions visibly, and avoiding any practice that would discourage honest reporting.

15. Roles and responsibilities

Role	Responsibility under this Policy
Directors (joint)	Modelling and reinforcing the CI culture. Reviewing the CI summary at each scheduled meeting. Resourcing improvement work. Sign-off on the annual CI review.
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Sign-off on closure of compliance- or safety-related CI items. Liaison with auditors and regulators in respect of CI commitments. Annual CI review report.
Lead Compliance Officer	Owner of this Policy and of the CI Register. Coordination of all sources of input into the Register. Quarterly CI review. Director reporting. Coordination of training. Recognition of worker contributions.
CI item owners	Planning, execution, progress reporting and closure of assigned items. Documentation of evidence of effect. Escalation of any blocker.
All workers	Raising improvement ideas, observations and concerns. Honest participation in incident and complaint reviews. Constructive engagement with the CI culture.

16. Record keeping

- The CI Register is retained for the life of the organisation. Closed items are retained in the Register for not less than seven years from the date of closure.
- Evidence of effect collected at closure is retained against the relevant item.
- Audit findings, incident records and complaint records linked to CI items are retained under their own retention periods.

17. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a material change in the NDIS Practice Standards, the organisation's governance structure, or its CI operating model.

ABLE TO THRIVE PTY LTD

Policy P-1.09

RISK MANAGEMENT POLICY

Document control

Policy number	P-1.09
Policy title	Risk Management Policy
Version	2.0
Date issued	August 2026
Supersedes	Risk Management Policy and Procedure (Section 1.9 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	August 2027, or upon material change to NDIS Practice Standards, ISO 31000, the organisation's service mix, or following any audit finding or material incident
Related policies and documents	Incident Management Policy (P-2.06); Living Alone Risk Assessment Policy (P-1.31); Suicide Prevention and Response Policy (P-2.21); Child Safety Policy (P-2.17); Child Safe Environment Policy (P-2.20); Conflict of Interest Policy (P-1.03); Feedback, Compliments and Complaints Policy (P-2.03); Risk Register; Business Plan; Continuous Improvement Register; Business Continuity Plan; WHS Policy

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) identifies, assesses, treats, monitors and reports risks. The Policy applies to risks of any kind that may affect the safety and wellbeing of participants, workers and the public; the achievement of organisational objectives; compliance with legal and regulatory obligations; and the financial and reputational position of the organisation.

The Policy is the framework. The current risks of the organisation are recorded in the Risk Register, reviewed by the Directors at each scheduled meeting, and treated through controls assigned to named owners.

2. Scope

This Policy applies to:

- the Directors, all employees, support workers engaged through Able to Thrive Personnel Pty Ltd, contractors and consultants of Able to Thrive;
- every service line and activity of the organisation, including community access, daily personal activities, short-term accommodation, support coordination, school holiday programs, and any future service line; and
- every decision-making forum within the organisation, including Director meetings, management meetings, program planning, intake decisions, and procurement decisions.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth), the NDIS Code of Conduct, and the NDIS Practice Standards (governance, operational management and risk management indicators).
- *Work Health and Safety Act 2011* (NSW) and the WHS Regulation 2017 (NSW).
- *Corporations Act 2001* (Cth) — Directors' duties including the duty of care.
- *Privacy Act 1988* (Cth) — handling of personal information and notifiable data breaches.
- ISO 31000 (Risk Management — Guidelines) as a methodological reference.

4. Definitions

- **Risk** means the effect of uncertainty on objectives. Effects may be positive or negative; this Policy is principally concerned with risks of harm or loss.
- **Risk appetite** means the amount and type of risk Able to Thrive is willing to accept in pursuit of its objectives, as set out in Section 6.
- **Inherent risk** means the risk before any treatment or control is applied.
- **Residual risk** means the risk that remains after treatment.
- **Risk owner** means the named individual accountable for the management of a specific risk.
- **Control** means any policy, procedure, practice or other measure that modifies risk.
- **Risk Register** means the consolidated record of identified risks, ratings, controls, owners and review dates, maintained by the Lead Compliance Officer.

5. Policy statement

Able to Thrive takes a proactive, structured approach to risk. Risk management is not a separate activity but is integrated into governance, strategy, service delivery, workforce management and continuous improvement. The Directors are accountable for setting risk appetite, reviewing the Risk Register, and resourcing risk treatment. The Lead Compliance Officer owns the framework and the Register. Every worker has a role in identifying and reporting risks they encounter.

6. Risk appetite

Able to Thrive has different risk appetites for different categories of risk, reflecting the nature of its work as an NDIS provider serving vulnerable participants:

- **Participant safety and child safety risk: zero tolerance.** We do not accept any preventable risk of harm to a participant or to a child in our care. Controls are designed to prevent harm, not merely to respond to it.
- **Regulatory and compliance risk: conservative.** We hold ourselves to compliance with the NDIS Practice Standards, the Code of Conduct, our conditions of registration and applicable law. We resource compliance proportionately to the risk.
- **Worker safety risk: conservative.** We take all reasonably practicable steps to provide a safe workplace for our workers, in line with our WHS duties.
- **Reputation and information security risk: conservative.** We protect the trust of participants, families, regulators and partners by acting with integrity and protecting personal information.
- **Commercial and strategic risk: moderate.** We are growing and diversifying, and we accept commercial risk consistent with the strategic priorities recorded in the Business Plan, subject to documented business cases for material commitments.

7. Risk categories

The Risk Register classifies risks under the following categories. Categories may overlap; a single risk may sit in more than one.

- **Participant safety and clinical risk** — risks of harm to participants from service delivery, including suicidal ideation, sole-worker arrangements (Condition 2), falls, medication, choking, abuse or neglect, and behavioural escalation. Specialist policies apply (P-2.21, P-1.31, P-2.06, P-2.17, P-2.20).
- **Child safety risk** — risks of harm to children in holiday programs and other child-related services. The Child Safety Policy (P-2.17) and Child Safe Environment Policy (P-2.20) apply.
- **Workforce risk** — risks arising from the workforce, including worker conduct, screening currency, training currency, supervision adequacy, retention, fatigue, and dependency on the labour hire entity (Able to Thrive Personnel Pty Ltd).
- **Compliance and regulatory risk** — risks of breach of the NDIS Act, the Code of Conduct, conditions of registration, employment law, WHS law, privacy law, mandatory reporting law, and the Reportable Conduct Scheme.
- **Strategic and commercial risk** — risks to the achievement of the strategic priorities recorded in the Business Plan, including diversification execution, partnership formation, scope extension, and NDIS pricing changes.
- **Financial risk** — risks of solvency, cash flow, revenue concentration, plan utilisation accuracy, fraud and financial mismanagement.

- **Information, privacy and cyber risk** — risks to the confidentiality, integrity and availability of personal information and organisational data, including unauthorised access, data loss, and notifiable data breach.
- **WHS risk** — risks of injury or harm to workers and visitors at our premises, in participants' homes, on transport, and during community-based activities.
- **Reputation risk** — risks to the trust of participants, families, regulators, referrers and the community, including risks arising from any of the other categories.

8. Risk rating matrix

Risks are rated using the following 5x5 matrix combining Likelihood and Consequence. The resulting score determines the rating band, the required level of management attention, and the frequency of review.

8.1 Likelihood scale

Rating	Descriptor	Indicative frequency
1	**Rare**	May occur only in exceptional circumstances (less than once in five years).
2	**Unlikely**	Could occur at some time (once in two to five years).
3	**Possible**	Might occur at some time (once per year).
4	**Likely**	Will probably occur in most circumstances (several times per year).
5	**Almost certain**	Is expected to occur in most circumstances (monthly or more often).

8.2 Consequence scale

Rating	Descriptor	Indicative impact
1	**Insignificant**	No injury or harm. No regulatory or financial consequence. Easily absorbed in normal operations.
2	**Minor**	First aid required. Minor compliance breach with no enforcement consequence. Financial impact under $10,000. Localised inconvenience.
3	**Moderate**	Medical treatment required. Reportable matter to NDIS Commission or other regulator with no enforcement action. Financial impact $10,000 to $100,000. Material service disruption.
4	**Major**	Serious injury, abuse or neglect of a participant. Enforcement action by NDIS Commission. Financial impact $100,000 to $500,000. Significant reputational impact in sector.
5	**Catastrophic**	Death of a participant. Loss or suspension of NDIS registration. Financial impact over $500,000 or

		insolvency risk. Severe public reputational damage.

8.3 Risk rating bands and required action

Score	Band	Required action
1–3	**Low**	Manage by routine procedures. Review annually. Recorded in Risk Register.
4–9	**Medium**	Specific monitoring required. Review at least quarterly by Lead Compliance Officer. Reported to Directors quarterly.
10–16	**High**	Active management by named risk owner. Treatment plan with milestones. Reported to Directors at each meeting.
17–25	**Extreme**	Immediate Director attention. Urgent treatment plan. Continuous reporting to Directors. Director sign-off on acceptance of any residual risk.

Risks involving potential harm to participants or children are rated against the highest plausible consequence, not the average outcome. Risks affecting Condition 2 compliance, or any condition of registration, are not rated below High.

9. Risk identification

Risks are identified through:

- the strategic planning cycle, including SWOT analysis for the Business Plan;
- incident reviews, complaint reviews, and audit findings (internal and external);
- participant feedback and satisfaction surveys;
- worker reports of concerns, near-misses and unsafe practices;
- horizon scanning of regulatory and sector changes by the Lead Compliance Officer;
- financial monitoring by the Finance Manager;
- information security monitoring by the technology and finance team; and
- proactive risk workshops held at least annually by the Directors and senior management.

Any worker may raise a risk by notifying their manager or the Lead Compliance Officer through Brevity. The Lead Compliance Officer assesses each raised risk and, where appropriate, adds it to the Risk Register.

10. Risk assessment

Each identified risk is assessed by:

- describing the risk in concrete terms (the trigger, the affected parties, the consequence pathway);
- rating the inherent risk using the matrix in Section 8;
- identifying the existing controls that already modify the risk;
- rating the residual risk on the same matrix; and

- assigning a named risk owner.

The assessment is documented in the Risk Register. Risk owners are accountable for their assigned risks and for the timeliness of any treatment.

11. Risk treatment

For each risk, treatment options are considered in the following order of preference:

- **Avoid** — discontinue or decline the activity giving rise to the risk where the residual risk is not acceptable and no proportionate control exists.
- **Reduce** — implement controls (policy, procedure, training, supervision, equipment, system) that reduce the likelihood or consequence of the risk.
- **Transfer** — share the risk with another party through contract or insurance, recognising that contractual transfer does not eliminate operational responsibility for safety or regulatory matters.
- **Accept** — accept the residual risk where it is within risk appetite and no proportionate further treatment is available. Acceptance of any Extreme- or High-band risk requires written Director sign-off recorded in the Risk Register.

Treatment plans for Medium-band risks and above include named actions, owners, target dates and progress notes. Closure of a treatment item is recorded with the date and the basis for closure.

12. Risk Register

The Risk Register is maintained by the Lead Compliance Officer. For each recorded risk, the Register includes:

- a unique risk identifier;
- the category (Section 7);
- a description of the risk;
- the inherent rating (likelihood, consequence, score, band);
- the existing controls;
- the residual rating after existing controls;
- the treatment plan and target residual rating;
- the named risk owner;
- review dates (last review, next review);
- linkage to relevant policies and to any related entries in the Incident or Continuous Improvement Registers.

The Register is reviewed in full at least quarterly. Individual high-rated risks are reviewed at every Director meeting. The Register is made available on request to the NDIS Commission and to the NDIS Quality Auditor.

13. Monitoring, reporting and review

13.1 Continuous monitoring

Risk owners monitor their assigned risks continuously and report any material change to the Lead Compliance Officer without delay.

13.2 Quarterly review

The Lead Compliance Officer reviews the full Risk Register quarterly. The quarterly review confirms that ratings are current, controls are operating as intended, treatment plans are progressing, and new risks are captured. The review outcome is reported to the Directors.

13.3 Director reporting

At each scheduled Director meeting, the Lead Compliance Officer reports on:

- the current Extreme- and High-rated risks and their status;
- material changes since the last meeting (new risks, downgraded risks, closed risks);
- progress against treatment plans; and
- linkage to incidents, complaints and continuous improvement activity.

13.4 Annual risk workshop

The Directors and senior management hold an annual risk workshop. The workshop refreshes the strategic risk view (including the risk table in the Business Plan), reassesses risk appetite, and identifies any emerging risk not yet captured.

13.5 Audit linkage

Audit findings (internal and external) are reviewed against the Risk Register. Findings that identify a previously unrecorded risk are added; findings that identify control failures lead to treatment plan updates.

14. Integration with other policies

Risks identified through the operation of other Policies are recorded in the Risk Register:

- Incidents and Reportable Incidents under the Incident Management Policy are reviewed for systemic risks and updates to existing risks.
- Complaints under the Feedback, Compliments and Complaints Policy are reviewed for themes that may indicate emerging risk.
- Conflict-of-interest matters under the Conflict of Interest Policy are recorded in the Register where they may have a material risk consequence.
- Living Alone Risk Assessments under P-1.31, and the Living Alone Register, feed the participant safety risk view.
- Continuous improvement activity links risk treatment items to the CI Register where they are tracked through to completion.

15. Business continuity

Risks that may threaten the continuity of services to participants are addressed by the Business Continuity Plan. The Business Continuity Plan is reviewed in conjunction with this Policy at least annually and is tested through tabletop exercise at least every two years. The triggers for Business Continuity Plan activation are recorded against the relevant risk lines in the Register.

16. Training

All workers complete training in risk identification and reporting at induction. Managers complete additional training in risk assessment and treatment. The Lead Compliance Officer maintains training records. The Directors complete refresher training in their governance role at least annually.

17. Roles and responsibilities

Role	Responsibility under this Policy
Directors (joint)	Setting and reviewing risk appetite. Review of the Risk Register at each meeting. Sign-off on acceptance of Extreme- and High-band residual risks. Resourcing of risk treatment. Annual risk workshop.
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Final sign-off on participant safety, child safety and regulatory risk treatments. Liaison with NDIS Commission and other regulators where risks crystallise as incidents.
Director (Finance) — Dante Michael	Final sign-off on financial, technology and cyber risk treatments. Linkage to financial monitoring and forecasting.
Lead Compliance Officer	Owner of this Policy and of the Risk Register. Quarterly Register review. Quarterly Director reporting. Coordination of the annual risk workshop. Linkage to incident, complaint and CI Registers.
Risk owners	Continuous monitoring of assigned risks. Execution of treatment plans. Prompt escalation of material change. Maintenance of accurate Register entries for assigned risks.
All workers	Identification and reporting of risks encountered in work. Compliance with controls. Participation in risk-related training.

18. Record keeping

- The Risk Register is retained for the life of the organisation, with version history for each entry retained for not less than seven years from the date of any change.
- Treatment plans, sign-offs and reviews are retained for not less than seven years.
- Annual risk workshop minutes are retained for not less than seven years.

- Audit findings, incident-derived risk updates and Continuous Improvement Register entries are linked to the Register and retained alongside it.

19. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on any of the following: a material change in NDIS Practice Standards or other regulatory framework; a material incident, complaint or audit finding bearing on risk management; a material change in the organisation’s service mix, structure or workforce arrangements; or a Director-endorsed change in risk appetite.

ABLE TO THRIVE PTY LTD

Policy P-1.23

HUMAN RESOURCES POLICY

Document control

Policy number	P-1.23
Policy title	Human Resources Policy
Version	2.0
Date issued	August 2026
Supersedes	Human Resources Policy and Procedure (Section 1.23 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	HR Coordinator and Operations Manager
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	August 2027, or upon material change to the Labour Hire Agreement with Able to Thrive Personnel Pty Ltd, the NDIS Worker Screening framework, Fair Work or WHS law, or the workforce model
Related policies and documents	Labour Hire Agreement between Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd (v2.0); Staff Code of Conduct (P-1.26); Disputes and Grievances Policy (P-1.27); Child Safety Policy (P-2.17); Conflict of Interest Policy (P-1.03); Incident Management Policy (P-2.06); WHS Policy; Return to Work Policy; Privacy and Confidentiality Policy; Onboarding Classroom (online induction); Brevity case management system; NDIS Code of Conduct

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) and Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel) jointly manage the workforce that delivers NDIS supports to participants. The Policy reflects the labour hire arrangement between the two related entities and assigns responsibilities clearly between them.

The Policy supports Able to Thrive's obligations under the NDIS Code of Conduct, the NDIS Practice Standards (workforce indicators), the Fair Work Act 2009 (Cth) and applicable modern awards, NDIS Worker Screening requirements, the Working with Children Check regime (where applicable), and WHS law.

2. Scope

This Policy applies to:

- all support workers engaged through Able to Thrive Personnel and supplied to Able to Thrive for the delivery of NDIS supports;
- all employees and contractors of Able to Thrive Pty Ltd, including management, client services, support coordination, compliance, finance, technology and administrative staff;
- the Directors of both entities in their capacity as employers and as key personnel of the NDIS-registered provider;
- the full life-cycle of each worker, from recruitment and selection through induction, ongoing development, performance management, supervision, leave, return to work, conduct, grievance and separation.

3. Legislative and regulatory framework

- *Fair Work Act 2009* (Cth) and the National Employment Standards.
- Applicable modern awards (most commonly the Social, Community, Home Care and Disability Services Industry Award 2010, as applicable to each role).
- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards, including the indicators relating to human resource management.
- NDIS Worker Screening framework.
- *Child Protection (Working with Children) Act 2012* (NSW) — WWCC for workers delivering services to children.
- *Work Health and Safety Act 2011* (NSW) and the WHS Regulation 2017 (NSW).
- *Workers Compensation Act 1987* (NSW) and the Workplace Injury Management and Workers Compensation Act 1998 (NSW).
- *Privacy Act 1988* (Cth) — handling of worker personal information.

4. Definitions

- **Worker** means any individual engaged to perform work for, or on behalf of, Able to Thrive, including employees, support workers supplied by Able to Thrive Personnel, contractors, and consultants.
- **Support worker** means a worker employed by Able to Thrive Personnel and supplied to Able to Thrive to deliver NDIS supports to a participant.

- **Employee** means a worker directly employed by Able to Thrive Pty Ltd (typically office, management, administrative and professional staff).
- **Key personnel** has the meaning given by section 11A of the NDIS Act and includes the Directors and any senior managers responsible for executive decisions of the NDIS provider.
- **NDIS Worker Screening Check** means a current worker screening clearance issued under the NDIS Worker Screening framework.
- **WWCC** means a Working with Children Check clearance under NSW law.

5. Policy statement

Able to Thrive maintains a workforce that is suitable, supported and accountable. We comply with employment law, NDIS workforce requirements and our duties under WHS law. We attract and retain workers by treating them with respect, offering structured induction and development, providing appropriate supervision, and supporting their wellbeing. We act decisively where conduct or performance falls short of the standards required by the NDIS Code of Conduct and our Staff Code of Conduct.

6. Workforce model — division of responsibilities

Able to Thrive's workforce model uses two related entities. The division of responsibilities is summarised below and is recorded in detail in the Labour Hire Agreement between the entities.

Able to Thrive Personnel Pty Ltd (the Provider)	Able to Thrive Pty Ltd (the registered NDIS Provider)
Recruitment, selection and employment of support workers; payroll, superannuation, PAYG, leave entitlements; workers compensation insurance; compliance with Fair Work Act and applicable awards; pre-engagement screening verification (NDIS Worker Screening, WWCC, right to work, references, qualifications); employer-level conduct of personnel matters.	Direction, supervision and accountability for NDIS service delivery; verification that pre-engagement screening evidence has been received; allocation of workers to participants and shifts; operational supervision; training in NDIS-specific content (Code of Conduct, Practice Standards, Able to Thrive policies); incident management; complaint handling; NDIS reportable incident notifications; participant-facing accountability.

Workers are employees of Able to Thrive Personnel. They are not employees of Able to Thrive Pty Ltd. Where this Policy refers to obligations of the employer, those obligations sit with Able to Thrive Personnel. Where this Policy refers to obligations of the registered NDIS provider, those sit with Able to Thrive Pty Ltd. The combined arrangement is operated as one workforce in practice, with clearly identified accountabilities.

7. Recruitment and selection

7.1 Workforce planning

Workforce planning is conducted jointly by the HR Coordinator and Operations Manager (Kriz), the Client Services and Acquisition lead (Akash), and the Lead Compliance Officer. The plan reflects:

- forecast participant intake and the support types required;
- coverage requirements (hours, locations, time of day);
- specialist capability requirements (autism, psychosocial disability, behaviour support, holiday programs);
- the Director (Compliance)'s view on Condition 2 staffing where sole-worker arrangements are required;
- attrition forecasts; and
- Director-approved budget.

7.2 Suitability for the NDIS sector

Selection assesses each candidate against the NDIS Code of Conduct expectations: respect for participant rights; honesty and integrity; competence; safety; and the protection of participants from violence, abuse and neglect. Selection methods include structured interview, scenario-based questions, and reference checks that specifically address suitability to work with people with disability (and, where relevant, with children).

7.3 Equity and anti-discrimination

Recruitment is non-discriminatory and complies with all applicable equity and anti-discrimination law. Decisions are based on the requirements of the role.

8. Pre-engagement checks

No worker commences delivering NDIS supports until Able to Thrive Personnel has verified, and Able to Thrive Pty Ltd has received evidence of, the following in respect of that worker:

- a current NDIS Worker Screening Check clearance;
- where the worker may deliver services to children, a current WWCC clearance;
- the worker's right to work in Australia;
- any role-specific qualifications (certificates, professional registrations, first aid, driving licence where driving is required);
- two reference checks, with at least one specifically addressing suitability for the sector and (where relevant) for working with children; and
- a signed Staff Code of Conduct and (where relevant) Code of Conduct for Working with Children.

Currency of clearances is monitored continuously by Able to Thrive Personnel. Any worker whose NDIS Worker Screening Check or WWCC is suspended, revoked or expired is

immediately stood down from delivering NDIS supports and remains stood down until the clearance is reinstated and current.

9. Induction and onboarding

Every new worker completes induction before delivering any service. Induction is delivered through the Able to Thrive online Onboarding Classroom and through scheduled in-person or video sessions with the HR Coordinator and Operations Manager and the Lead Compliance Officer. Induction covers, at a minimum:

- introduction to Able to Thrive — values, structure, service mix, brand;
- the NDIS Code of Conduct;
- the NDIS Practice Standards relevant to the worker's role;
- Able to Thrive's policies in their current operational form, including (without limitation) Incident Management, Suicide Prevention and Response, Conflict of Interest, Living Alone Risk Assessment (where the worker may be allocated to in-scope participants), Feedback Compliments and Complaints, Child Safety and Child Safe Environment (where the worker may be allocated to children's programs), Privacy and Confidentiality, and the Staff Code of Conduct;
- safeguarding (recognising elevated risk for people with disability, especially children with disability) and disclosure response;
- use of Brevity for case records, incident reports, complaints and other workflows;
- communication with participants, families, support coordinators and the Able to Thrive management team;
- manual handling, infection control, medication management (where applicable to the role), and basic first aid principles;
- Work Health and Safety; and
- worker wellbeing and the Employee Assistance Program.

Induction completion is recorded against the worker's file. No worker is allocated to a shift until induction completion is verified by the Lead Compliance Officer.

10. Training and development

- Refresher training in all core policies is delivered at least annually. Material changes to a policy trigger out-of-cycle refresher training.
- Role-specific training (for example, behaviour support practice, holiday program lead worker training, support coordination training) is delivered as required.
- External training (first aid renewal, medication training, sector-specific qualifications) is supported by Able to Thrive where it is necessary for role competency.
- Training records are maintained against each worker's file. The Lead Compliance Officer verifies training currency before any worker is allocated to a participant or program with specific training requirements.

11. Supervision and performance management

11.1 Supervision

Workers receive structured supervision appropriate to their role. Support workers are supervised by lead workers and by the HR Coordinator and Operations Manager. Where workers deliver services to participants who live alone (Condition 2 participants), supervision arrangements include in-home visits at the frequency set in the participant's Supervision and Monitoring Plan under P-1.31.

11.2 Performance management

Performance is managed through:

- clear position descriptions and expectations set at engagement;
- regular informal feedback from supervisors;
- structured performance review at least annually;
- participant feedback (collected under the Feedback, Compliments and Complaints Policy and the third-party satisfaction checks under P-1.31);
- observation during in-home supervision visits; and
- review of incidents, complaints and corrective actions.

Performance issues short of misconduct are addressed through coaching, additional supervision, training, and where required, a documented performance improvement plan with milestones and review dates.

11.3 Misconduct

Misconduct (including any breach of the NDIS Code of Conduct, the Staff Code of Conduct, or the law) is investigated promptly and fairly. The worker is given an opportunity to respond. Outcomes may include counselling, formal warning, retraining, suspension, or termination of engagement, depending on the severity. Serious misconduct (including any conduct that may amount to a Reportable Incident under the NDIS Act, reportable conduct under NSW law, or a criminal offence) is escalated to the Child Safety Officer or the Lead Compliance Officer as appropriate, and may result in immediate stand-down pending investigation.

12. Workplace health and safety

- Able to Thrive Pty Ltd and Able to Thrive Personnel each have concurrent duties under WHS law and consult, cooperate and coordinate in the discharge of those duties.
- Workers are provided with a safe workplace, including in the locations where services are delivered (which may include participants' homes, hired venues, public spaces and motor vehicles).
- Workers are trained in WHS, provided with required personal protective equipment where applicable, and supported to refuse work that they reasonably believe presents an imminent risk of serious harm.

- Workplace incidents affecting workers are managed under the Workplace Incident Management Policy. Where an incident affects both a participant and a worker, both the Incident Management Policy and the Workplace Incident Management Policy apply concurrently.

13. Leave, return to work and entitlements

- All leave entitlements (annual leave, personal/carer's leave, compassionate leave, long service leave, parental leave, community service leave) are administered by Able to Thrive Personnel in accordance with the Fair Work Act, the National Employment Standards and applicable awards.
- Workers returning from injury or illness are supported through a documented Return to Work Plan administered under the Return to Work Policy and in cooperation with the workers compensation insurer.
- Reasonable adjustments are made for workers with disability or other access needs, in compliance with anti-discrimination law.

14. Conduct and standards

Every worker complies with the NDIS Code of Conduct, the Staff Code of Conduct (P-1.26), and the Code of Conduct for Working with Children (where applicable). Specific operational standards apply through the Conflict of Interest Policy (P-1.03), the Privacy and Confidentiality Policy, and the relevant participant-facing policies.

Workers do not enter into personal financial arrangements with participants, do not accept commissions or significant gifts from suppliers or referrers, and do not engage in conduct that brings Able to Thrive into disrepute. Breach is treated under Section 11.3.

15. Grievances and disputes

Worker grievances and disputes are handled under the Disputes and Grievances Policy (P-1.27). Workers may raise grievances confidentially with their supervisor, the HR Coordinator and Operations Manager, the Lead Compliance Officer, or a Director, and are protected from retaliation for doing so.

16. Separation

- Workers may resign on the notice period set out in their employment contract.
- Termination by Able to Thrive Personnel occurs in accordance with employment law and follows procedural fairness. For misconduct, the process in Section 11.3 applies. For redundancy, consultation under the applicable award and Fair Work Act applies.
- On separation, the worker's NDIS Worker Screening Check and WWCC are updated in the records to reflect cessation. Access to Able to Thrive systems is removed. Final pay is processed within statutory timeframes.

- Where the separation arises from misconduct that may meet the threshold for an NDIS Reportable Incident or NSW reportable conduct, the relevant notifications are made under the Incident Management Policy and Child Safety Policy, regardless of the worker having left the organisation.

17. Key personnel notification

Changes in key personnel (Directors and senior managers responsible for executive decisions) are notified to the NDIS Commission as required by sections 13 and 13A of the NDIS Provider Registration and Practice Standards Rules. The Lead Compliance Officer maintains a record of current key personnel and is responsible for preparing notifications.

18. Records and privacy

- Personnel records are held in accordance with the Privacy and Confidentiality Policy and the Privacy Act 1988 (Cth).
- Records of clearances (NDIS Worker Screening, WWCC, right to work, qualifications) are retained for the period of the worker’s engagement and for not less than seven years after separation.
- Training, performance, supervision and disciplinary records are retained for the same period.
- Workers may access their own personal information on reasonable request.

19. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Final accountability for NDIS workforce compliance. Key personnel notifications. Sign-off on serious misconduct outcomes and any matter involving a child safety dimension. Oversight of the labour hire arrangement with Able to Thrive Personnel.
Director (Finance) — Dante Michael	Joint sign-off on workforce budget, remuneration structures, and any material change in the labour hire arrangement. Oversight of payroll, superannuation and workers compensation through Able to Thrive Personnel.
HR Coordinator and Operations Manager — Kriz	Owner of this Policy. Day-to-day administration of the workforce across both entities. Allocation and rostering. Induction coordination. Performance management coordination. Supervision arrangements. Return to work plans. Liaison with Able to Thrive Personnel on payroll,

	leave and workers compensation matters.
Lead Compliance Officer	Verification of pre-engagement screening evidence. Verification of training currency. Cleared-worker list for child programs. Compliance review of performance management of workers involved in incidents or complaints. Reporting on workforce compliance metrics to Directors.
Client Services and Acquisition — Akash	In-person Sydney touchpoint for workers and participants. Input into workforce planning based on intake forecasts.
Admin (Compliance and HR) — Mikha	Administrative support for personnel records, training records, clearance monitoring, induction logistics and Brevity workforce data.
All workers	Compliance with this Policy, the Staff Code of Conduct, and the NDIS Code of Conduct. Notification of any change in clearance status, qualifications or personal circumstances that may affect work. Participation in supervision and training. Honest engagement with performance management.

20. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on any of the following: material change in the Labour Hire Agreement between the entities; change in the NDIS Worker Screening framework, Fair Work or WHS law; an audit finding bearing on workforce management; or material change in the workforce model.

ABLE TO THRIVE PTY LTD

Policy P-1.26

STAFF CODE OF CONDUCT

Document control

Policy number	P-1.26
Policy title	Staff Code of Conduct
Version	2.0
Date issued	September 2026
Supersedes	Staff Code of Conduct Policy and Procedure (Section 1.26 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	HR Coordinator and Operations Manager
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	September 2027, or upon material change to the NDIS Code of Conduct, the NSW Child Safe Standards, or Able to Thrive's service mix
Related policies and documents	Human Resources Policy (P-1.23); Conflict of Interest Policy (P-1.03); Child Safety Policy (P-2.17); Child Safe Environment Policy (P-2.20); Code of Conduct for Working with Children (separate document); Disputes and Grievances Policy (P-1.27); Privacy and Confidentiality Policy (P-1.30); Social Media Policy; NDIS Code of Conduct; Acknowledgement Form (signed at engagement and annually)

1. Purpose

This Code sets out the standards of conduct expected of every Able to Thrive Pty Ltd (Able to Thrive) worker. It applies the legal obligations under the NDIS Code of Conduct to the specific context in which Able to Thrive operates, and adds the organisational expectations that go beyond the minimum legal requirements.

Every worker signs an acknowledgement of this Code at engagement and on each anniversary of engagement. Signed acknowledgements are filed against the worker's record.

2. Scope

This Code applies to:

- all employees of Able to Thrive Pty Ltd, including management and administrative staff;
- all support workers engaged through Able to Thrive Personnel Pty Ltd;
- all contractors and consultants engaged by either entity; and
- the Directors of both entities (the Directors comply with the same conduct standards expected of any worker).

A breach of this Code may amount to a breach of the NDIS Code of Conduct, a Reportable Incident, reportable conduct under NSW child safety law, or a criminal offence. Some matters covered by this Code are also covered by separate policies; this Code cross-references those policies.

3. Legislative and regulatory framework

- NDIS Code of Conduct, prescribed under the National Disability Insurance Scheme (Code of Conduct) Rules 2018.
- *National Disability Insurance Scheme Act 2013* (Cth).
- *Fair Work Act 2009* (Cth) and applicable modern awards.
- *Child Protection (Working with Children) Act 2012* (NSW), Children's Guardian Act 2019 (NSW) and the NSW Child Safe Standards.
- *Work Health and Safety Act 2011* (NSW).
- *Privacy Act 1988* (Cth) and the Australian Privacy Principles.
- *Crimes Act 1900* (NSW) and other applicable criminal law.

4. The NDIS Code of Conduct

Every worker complies with the NDIS Code of Conduct. The Code requires every worker delivering NDIS supports and services to:

- act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions;
- respect the privacy of people with disability;
- provide supports and services in a safe and competent manner, with care and skill;
- act with integrity, honesty and transparency;
- promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability;
- take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability; and

- take all reasonable steps to prevent and respond to sexual misconduct.

This Code applies the NDIS Code of Conduct to Able to Thrive's specific operations through the sections that follow.

5. Respect, dignity and choice

- Treat every participant as a person of dignity, with the right to make decisions about their own life.
- Use the language, communication aids and pronouns the participant prefers. Adjust to the participant's preferred mode of communication, not the other way around.
- Respect cultural, religious and linguistic identity. Make space for cultural practices that are important to the participant.
- Respect Aboriginal and Torres Strait Islander identity, connection to country, family and community.
- Respect LGBTQIA+ identity. Do not "out" a participant or worker to family or others without their informed consent.
- Do not impose your own personal views, beliefs or preferences on a participant.
- Support the participant's choice of provider, support coordinator and individual support worker, including where the participant chooses a provider other than Able to Thrive.

6. Safety and competence

- Provide supports within the scope of your training, qualifications and authorisations. Do not perform tasks you are not trained for.
- Maintain currency of NDIS Worker Screening, Working with Children Check (where applicable), first aid, driving licence and any role-specific qualifications. Immediately inform Able to Thrive Personnel and the Lead Compliance Officer of any change in your screening status.
- Follow the participant's NDIS plan, support plan, behaviour support plan (if any) and the Service Agreement. Where these are unclear or appear inconsistent with safety, escalate to a manager.
- Use only approved manual handling techniques. Use the equipment provided. Do not improvise where safety is at stake.
- Administer medication only in accordance with the Medication Management Policy and the prescriber's instructions.
- Recognise the early signs of behavioural escalation, sensory overload, or distress. De-escalate through verbal and supportive means. Do not use restrictive practices — Able to Thrive is not registered for them and they are not part of any role.
- Stop and seek help if you are unsure how to proceed safely.

7. Boundaries with participants

- Maintain professional boundaries at all times. The worker–participant relationship is a service relationship, not a personal friendship.
- Do not enter into a personal financial arrangement of any kind with a participant or a participant's family. Do not lend or borrow money. Do not sell goods or services to a participant outside the approved scope of supports.
- Do not develop a romantic, sexual or intimate relationship with a participant, or with the parent or carer of a participant in your care. If such a relationship existed before engagement, declare it under the Conflict of Interest Policy.
- Do not enter into private contact with a participant outside the service context. This includes private phone calls, text messages, personal social media, private meetings, or visits outside scheduled shifts.
- Do not exchange gifts above nominal value with a participant. Gifts above $50, or any commission from a third party, are not accepted. See Conflict of Interest Policy (P-1.03) for the gifts framework.
- Do not transport a participant in your personal vehicle outside an approved service arrangement.

8. Working with children

Where any aspect of the role involves children (under 18 years of age), the worker complies with the Child Safety Policy (P-2.17), the Child Safe Environment Policy (P-2.20), and the Code of Conduct for Working with Children (which is signed at engagement and annually). In particular, the worker:

- does not have private or unsupervised one-to-one contact with a child outside an approved service context;
- does not share personal contact details, social media connections or private correspondence with a child;
- does not transport a child in a personal vehicle outside an approved arrangement;
- does not photograph or video a child outside the approved photography protocol;
- does not use physical discipline, withdrawal of food or hydration, shaming, restrictive practice, or any practice not consistent with positive behaviour support; and
- responds to a disclosure by a child by listening, affirming, recording, and escalating to the Child Safety Officer.

9. Honesty and integrity

- Be honest in all communications with participants, families, support coordinators, regulators, colleagues and Able to Thrive management.
- Record what actually happened in shift notes, case notes, incident reports and complaints. Do not omit, embellish or alter records.

- Do not claim hours not worked. Do not invoice for supports not delivered. Do not record activity that did not occur.
- Disclose conflicts of interest under the Conflict of Interest Policy as soon as you become aware of them.
- Do not use your position to obtain a personal benefit. Do not solicit, accept or offer bribes or commissions.

10. Confidentiality and privacy

- Treat personal information about participants as a position of trust. Access only what you need for the task at hand. Share only with those who need it for the participant's care.
- Do not discuss a participant's circumstances outside the workplace.
- Do not record images, video or audio of a participant without consent and approval under the relevant policy. Do not share recordings on personal social media.
- Comply with the Privacy and Confidentiality Policy (P-1.30) and the Australian Privacy Principles.
- Report any actual or suspected privacy breach to the Lead Compliance Officer without delay.

11. Reporting concerns

- Promptly raise and act on concerns about matters that may impact the quality and safety of supports.
- Report incidents in Brevity within the timeframes set by the Incident Management Policy.
- Raise complaints (your own or those of a participant or third party) through the Feedback, Compliments and Complaints Policy.
- Do not retaliate against a colleague or participant who has raised a concern or complaint. Retaliation is itself a breach of this Code.
- If you observe another worker breaching this Code, escalate to your manager or to the Lead Compliance Officer. If you fear retaliation, you may raise the matter confidentially with the Director (Compliance) or with the NDIS Quality and Safeguards Commission.

12. Preventing violence, abuse, neglect and exploitation

- Recognise that people with disability — especially women, children and people with cognitive disability — face elevated risk of violence, abuse, neglect and exploitation. Treat the prevention and detection of harm as a continuing duty, not a one-time training point.
- Do not physically, emotionally, financially or sexually abuse a participant. Do not threaten, intimidate, isolate, demean, shame, neglect or exploit a participant.

- Do not commit, attempt or facilitate any sexual contact with a participant. This applies during and outside service delivery and applies whether the participant is an adult or a child.
- Recognise the indicators of abuse, neglect and exploitation in others — physical signs, behavioural signs, environmental signs, disclosures. Respond by listening, recording and escalating; do not investigate.
- Where the matter involves a child, mandatory reporting under NSW law and the Reportable Conduct Scheme may apply (Child Safety Policy P-2.17).

13. Preventing sexual misconduct

- Do not engage in any sexual conduct with a participant. This is the case regardless of the participant's age, the participant's expressed preferences, or any apparent consent. The power imbalance between worker and participant means that sexual conduct cannot be consensual in this context.
- Do not make sexual comments, jokes or innuendos in the presence of participants or colleagues.
- Do not display, share or expose participants or colleagues to sexual material, including pornography.
- Do not engage in grooming behaviour — building a relationship of trust with the intent of facilitating sexual contact later. Even where no later contact occurs, grooming is itself misconduct.
- Report any concern about sexual conduct (your own observation or a disclosure) to the Lead Compliance Officer or Director (Compliance) immediately.

14. Work health and safety

- Comply with WHS law and Able to Thrive's WHS Policy.
- Take reasonable care for your own health and safety, and for the health and safety of others who may be affected by your work.
- Use the personal protective equipment provided. Report any defect or shortage immediately.
- Report hazards, incidents and near-misses.
- Do not work under the influence of alcohol or non-prescribed drugs. Where prescribed medication may impair performance, declare it and seek advice.
- Refuse work that you reasonably believe presents an imminent risk of serious harm and inform a manager.

15. Personal conduct outside work

Workers retain a private life. However, certain conduct outside work may affect a worker's suitability to deliver NDIS supports. In particular:

- a criminal charge, conviction or finding (including for any offence involving violence, dishonesty, drugs, or sexual misconduct) must be disclosed to the Lead Compliance Officer without delay;
- any restraint or apprehended violence order issued in respect of the worker must be disclosed;
- conduct on personal social media that identifies the worker as an Able to Thrive worker and that is incompatible with the standards of this Code may amount to misconduct;
- secondary employment or outside interests are disclosed under Section 10 of the Human Resources Policy (P-1.23).

16. Drugs and alcohol

- Workers do not consume alcohol or take non-prescribed drugs during work hours or before a shift, where consumption may impair performance.
- Workers do not attend work under the influence of alcohol or any substance that may impair performance.
- Workers do not bring alcohol or non-prescribed drugs to the workplace or to service-delivery locations.
- Where lawful medication may impair performance (sedation, drowsiness), the worker informs their manager and adjustments are made.

17. Social media and public communications

- Do not identify yourself publicly as an Able to Thrive worker on personal social media in a manner that would be incompatible with this Code.
- Do not post, share or comment on participants on personal social media. Do not post photographs or video of participants in any context.
- Do not represent Able to Thrive’s position publicly without authority. Media inquiries are referred to the Directors.
- Comply with the Social Media Policy (when issued under the Policy Review Action Plan).

18. Following policies and directions

- Familiarise yourself with the Able to Thrive policies relevant to your role.
- Comply with lawful and reasonable directions from your manager and from Able to Thrive Pty Ltd in its capacity as the registered NDIS provider directing your work.
- Where a direction appears inconsistent with this Code, the NDIS Code of Conduct or the law, raise the matter immediately with your manager or with the Lead Compliance Officer. Workers are not required to follow directions that would be unlawful or would breach the NDIS Code of Conduct.

19. Breach of this Code

A breach of this Code is taken seriously. The response depends on the nature and seriousness of the breach. Possible responses include:

- coaching and additional training, for minor or first-time breaches not involving harm;
- formal warning, recorded in the worker's file;
- performance improvement plan with milestones and review;
- change in supervision arrangements;
- suspension pending investigation, where the breach is serious or may be a Reportable Incident or reportable conduct;
- termination of engagement, for serious or repeated breaches; and
- notification to the NDIS Commission, the NSW Office of the Children's Guardian, police, or other regulators where required by law.

The Disputes and Grievances Policy (P-1.27) sets out how breach investigations and outcomes are conducted fairly. Workers have the right to be heard and to be represented during any investigation.

20. Acknowledgement

Every worker signs the Acknowledgement Form at engagement and on each anniversary of engagement. The Acknowledgement records that the worker has read, understood, and agrees to comply with this Code. The signed Acknowledgement is filed in the worker's record by Able to Thrive Personnel Pty Ltd and verified by the Lead Compliance Officer before any allocation to service delivery.

21. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for the conduct standards across the workforce. Sign-off on outcomes of serious misconduct investigations. Liaison with NDIS Commission and other regulators on conduct matters.
Lead Compliance Officer	Verification of Acknowledgement Forms before service allocation. Coordination of training and refresher training. Conduct of investigations into breach. Reporting on conduct matters to Directors.
HR Coordinator and Operations Manager — Kriz	Owner of this Policy. Day-to-day operationalisation. Liaison with Able to Thrive Personnel on Acknowledgement filing. Performance management for minor and routine matters under this Code.

All workers	Compliance with this Code at all times. Signing of the Acknowledgement Form. Participation in training. Honest engagement with any investigation. Escalation of any concern about the conduct of others.

22. Review of this Code

This Code is reviewed at least annually, and out of cycle on a change in the NDIS Code of Conduct, the NSW Child Safe Standards, or following an audit or NDIS Commission finding bearing on workforce conduct.

ABLE TO THRIVE PTY LTD

Policy P-1.27

DISPUTES AND GRIEVANCES POLICY

Document control

Policy number	P-1.27
Policy title	Disputes and Grievances Policy
Version	2.0
Date issued	September 2026
Supersedes	Disputes and Grievances Policy and Procedure (Section 1.27 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	HR Coordinator and Operations Manager
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	September 2027, or upon material change to the Fair Work Act 2009 (Cth), the applicable modern award, anti-discrimination law, or the workforce structure
Related policies and documents	Human Resources Policy (P-1.23); Staff Code of Conduct (P-1.26); Feedback, Compliments and Complaints Policy (P-2.03); Privacy and Confidentiality Policy (P-1.30); Conflict of Interest Policy (P-1.03); Workplace Bullying and Harassment Procedure; Grievance Lodgement Form; Employee Assistance Program (EAP)

1. Purpose

This Policy sets out how disputes and grievances raised by Able to Thrive Pty Ltd (Able to Thrive) and Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel) workers are handled. It covers concerns about workplace conduct, conditions, decisions, or relationships between workers — not complaints made by participants or the public about services (those are handled under the Feedback, Compliments and Complaints Policy P-2.03).

2. Scope

This Policy applies to:

- all support workers engaged through Able to Thrive Personnel;
- all employees of Able to Thrive Pty Ltd;
- all contractors and consultants engaged by either entity; and
- the Directors in their capacity as parties to (or recipients of) a workplace dispute or grievance.

Concerns raised by participants, families, support coordinators or external parties are handled under the Feedback, Compliments and Complaints Policy (P-2.03). Where a matter involves both an external complaint and an internal workforce dispute, both policies apply in parallel.

3. Legislative and regulatory framework

- *Fair Work Act 2009* (Cth), in particular Part 6-1 (general protections) and Part 6-4B (anti-bullying jurisdiction).
- Applicable modern awards (typically the Social, Community, Home Care and Disability Services Industry Award).
- *Sex Discrimination Act 1984* (Cth), Anti-Discrimination Act 1977 (NSW), Disability Discrimination Act 1992 (Cth), Racial Discrimination Act 1975 (Cth), Age Discrimination Act 2004 (Cth) and other applicable anti-discrimination law.
- *Work Health and Safety Act 2011* (NSW) — psychosocial hazards.
- *Privacy Act 1988* (Cth) — confidential handling of information.

4. Definitions

- **Grievance** means a concern raised by a worker about a workplace matter — including conduct, decisions, conditions, treatment, working relationships, or breach of policy — for which the worker seeks resolution.
- **Dispute** means a disagreement between two or more workers, or between a worker and management, that has not been resolved through normal supervision.
- **Grievant** means the worker raising the grievance.
- **Respondent** means the worker, manager or party against whom the grievance is raised.
- **Bullying** has the meaning given by the Fair Work Act — repeated unreasonable behaviour by an individual towards a worker that creates a risk to health and safety.

5. Policy statement

Able to Thrive treats every grievance as a legitimate matter to be heard, considered fairly, and resolved without delay. We act with procedural fairness — both parties are heard, decisions are based on evidence, and decisions are explained. We protect the confidentiality

of those involved to the extent possible. We protect workers who raise concerns in good faith from any form of retaliation. We acknowledge that workplace conflict is part of normal working life, and that the test of an organisation is not whether grievances arise but how they are handled.

6. Principles

- **Fairness.** Both parties are given the opportunity to be heard. Decisions are based on the available evidence.
- **Timeliness.** Grievances are addressed promptly. Delay rarely improves outcomes.
- **Confidentiality.** Information about a grievance is shared only with those who need it to handle the matter.
- **Support.** Both parties may be accompanied by a support person of their choice during any meeting, and may access the Employee Assistance Program (EAP).
- **No retaliation.** A worker who raises a grievance in good faith does not experience adverse consequences as a result of doing so.
- **Proportionate response.** The response is proportionate to the matter. Minor matters are addressed informally; serious matters follow the formal process.

7. What this Policy covers

This Policy applies to workplace concerns including (but not limited to):

- conduct of another worker (incivility, disrespect, gossip);
- bullying or harassment;
- discrimination on the basis of any protected attribute (sex, gender identity, sexual orientation, race, religion, age, disability, carer responsibilities, political belief);
- a management decision the worker considers unreasonable (rostering, allocation, conditions);
- breach of the Staff Code of Conduct by another worker;
- a workplace relationship that has broken down;
- concerns about supervision or management;
- disagreement between workers about how a task is to be performed;
- any other matter affecting the worker's ability to do their work or their wellbeing at work.

Performance management of the grievant is not, in itself, grounds for a grievance under this Policy. Concerns about how performance management is being conducted (procedural fairness, accuracy of feedback) are within scope.

Conduct that may amount to serious misconduct or a Reportable Incident under the Incident Management Policy is escalated under that Policy in parallel.

8. Informal resolution (first step)

In most cases, workplace concerns are best resolved informally. The grievant is encouraged to:

- raise the matter directly with the other party, where it is safe and reasonable to do so;
- discuss the matter with their supervisor or with the HR Coordinator and Operations Manager;
- seek peer mediation where the matter is between two workers and both agree.

Informal resolution is not a precondition to lodging a formal grievance. A worker may proceed directly to the formal process at any time, including where direct discussion is not safe (for example, where the matter involves alleged bullying, harassment or discrimination, or where the respondent is in a position of power over the grievant).

9. Formal grievance process

9.1 Lodgement

A formal grievance is lodged using the Grievance Lodgement Form. The Form is submitted to the HR Coordinator and Operations Manager, the Lead Compliance Officer, or directly to the Director (Compliance). The grievant may also raise the grievance verbally; a written record is then prepared in consultation with the grievant.

The grievance should describe what occurred, when, where, who was involved, what the impact has been, and the outcome the grievant is seeking. The grievant may include any supporting material.

9.2 Acknowledgement

The grievance is acknowledged in writing to the grievant within two business days. The acknowledgement records what is being investigated, who will handle the matter, the expected timeframe, the right to a support person, the right to access EAP, and the protection from retaliation.

9.3 Selection of investigator

A grievance is investigated by a person not involved in the matter and at a level senior to those involved where possible. The default is:

- grievance against a peer or about workplace conditions: investigated by the HR Coordinator and Operations Manager;
- grievance involving the HR Coordinator and Operations Manager, or any matter of significant seriousness: investigated by the Lead Compliance Officer;
- grievance involving the Lead Compliance Officer: investigated by the Director (Compliance);
- grievance involving a Director: investigated by the other Director, with external advisory support if appropriate;

- grievance involving both Directors, or where external independence is required for credibility: investigated by an external HR or legal investigator engaged by the Board.

9.4 Investigation

The investigation includes:

- discussion with the grievant to understand the matter and the outcome sought;
- discussion with the respondent, who is informed of the substance of the grievance and given the opportunity to respond;
- discussion with any witness;
- review of relevant records (rosters, case notes, communications, prior records);
- consideration of context including the relevant policies; and
- formulation of findings and proposed resolution.

Both parties may be accompanied by a support person at any meeting. The support person may be a colleague, a union representative, a friend or family member. The support person provides moral support and may take notes but does not advocate.

9.5 Findings and outcome

The investigator records findings and proposed outcome in writing. Outcomes may include:

- the grievance is upheld and specific action is taken (apology, change in arrangement, change in behaviour, training, disciplinary action against the respondent);
- the grievance is partly upheld and partial action is taken;
- the grievance is not upheld and the matter is closed with reasons;
- mediation is arranged between the parties; or
- the matter is referred to another process (performance management, misconduct investigation, Incident Management, or external referral).

The grievant and the respondent are informed of the outcome in writing, with reasons. The outcome timeframe is twenty business days from acknowledgement, unless extended in writing with reasons.

10. Mediation

Mediation is offered where both parties agree and the matter is suitable. Mediation is conducted by:

- an internal mediator (the HR Coordinator and Operations Manager, the Lead Compliance Officer, or a senior worker not involved); or
- an external mediator (engaged by Able to Thrive) where independence is appropriate.

Mediation outcomes are recorded in writing and signed by both parties.

11. Internal review and escalation

A grievant or respondent dissatisfied with the outcome may request internal review within ten business days. Internal review is conducted by a person more senior than the original investigator (see the default escalation in Section 9.3). Internal review considers whether the investigation followed this Policy and whether the findings and outcome were reasonable on the evidence. The internal review outcome is provided in writing within fifteen business days of the request.

Internal review does not exclude the right to external escalation. A worker may at any time:

- apply to the Fair Work Commission for an anti-bullying order under Part 6-4B of the Fair Work Act, where the matter relates to bullying;
- make a complaint to the Australian Human Rights Commission or the NSW Anti-Discrimination Board where the matter involves discrimination;
- apply to the Fair Work Commission for a general protections claim where the matter involves adverse action;
- make a complaint to SafeWork NSW where the matter involves a WHS hazard;
- make a complaint to the NDIS Quality and Safeguards Commission where the matter involves a worker concern about the quality or safety of NDIS supports.

12. Bullying, harassment and discrimination

Able to Thrive does not tolerate workplace bullying, harassment or discrimination on any protected attribute. Allegations are taken seriously and investigated with care for both parties. The Workplace Bullying and Harassment Procedure (a separate operational document) sets out additional detail on definitions, indicators and supports. Findings of bullying, harassment or discrimination may result in disciplinary action up to and including termination.

13. Support for parties

- **Support person.** Both parties may be accompanied by a support person of their choice at any meeting under this Policy.
- **Employee Assistance Program.** Both parties may access the EAP for confidential external counselling. EAP usage is not disclosed to managers.
- **Adjustments.** Where the grievance affects the parties’ ability to continue working together, temporary adjustments to rostering, allocation, supervision arrangements, or other working arrangements are made.
- **Time off.** Where appropriate, time off (paid where consistent with the worker’s entitlements) may be agreed during the process.

14. Confidentiality

Information about a grievance is shared only with those who need it to handle the matter. Both parties are asked to keep the matter confidential and not to discuss it with colleagues outside the process (other than with their support person or with the EAP). Confidentiality does not prevent a worker from making an external complaint as described in Section 11. Confidentiality is not used to silence concerns about safety or unlawful conduct.

15. No retaliation

A worker who raises a grievance in good faith does not experience any adverse change in their employment as a consequence of raising it. Adverse changes include (but are not limited to) reduction in hours, removal from preferred shifts, exclusion from team activity, change in supervision arrangements that disadvantages the worker, threats, criticism beyond the bounds of normal supervision, or termination. Retaliation is itself a breach of this Policy and of the Staff Code of Conduct, and is treated as serious misconduct.

16. Records

- Grievance records are kept by the HR Coordinator and Operations Manager (operational record) and the Lead Compliance Officer (governance record) in confidential files separate from general personnel files.
- Records include the lodgement, acknowledgement, investigation notes, findings, outcome, and any internal review.
- Records are retained for not less than seven years from the date of closure.
- Records are not disclosed except as required by law, with the consent of the parties, or where necessary for the proper handling of the matter.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability. Sign-off on outcomes of grievances involving the Lead Compliance Officer or where matters escalate to Director level. Engagement of external investigators where independence requires it.
Lead Compliance Officer	Investigation of grievances involving the HR Coordinator and Operations Manager, or of significant seriousness. Quality review of grievance handling across the organisation. Reporting on themes and trends to the Directors.
HR Coordinator and Operations Manager —	Owner of this Policy. Receipt and acknowledgement of grievances. Investigation of routine grievances.

Kriz	Coordination of mediation. Maintenance of grievance records.
Supervisors and managers	Promotion of an environment in which grievances can be raised safely. Informal resolution where appropriate. Escalation to the HR Coordinator and Operations Manager where the matter cannot be resolved informally.
All workers	Raise concerns in good faith. Engage honestly and respectfully with any process under this Policy. Respect confidentiality.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in Fair Work, anti-discrimination or WHS law, an audit finding bearing on this Policy, or a matter that identifies a systemic gap.

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Policy P-1.29

INFORMATION MANAGEMENT POLICY

Document control

Policy number	P-1.29
Policy title	Information Management Policy
Version	2.0
Date issued	October 2026
Supersedes	Information Management Policy and Procedure (Section 1.29 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	October 2027, or on material change to information systems, retention requirements, or the policy framework
Related policies and documents	Privacy and Confidentiality Policy (P-1.30); Cyber Security and Acceptable Use Policy (P-1.34); Incident Management Policy (P-2.06); Conflict of Interest Policy (P-1.03); Governance Policy (P-1.01); Information Asset Register; Retention Schedule (Appendix to this Policy); Brevity system documentation; SharePoint document management

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) and Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel) create, capture, classify, store, secure, access, retain and dispose of information. It covers all categories of organisational information — participant records, workforce records, financial records, governance records, policies, audit reports, and operational data.

The Policy is distinct from but operates alongside the Privacy and Confidentiality Policy (P-1.30) (which addresses personal information specifically) and the Cyber Security and Acceptable Use Policy (P-1.34) (which addresses technical controls).

2. Scope

This Policy applies to:

- all information created, received or held by Able to Thrive or Able to Thrive Personnel, in any format (electronic, paper, audio, video);
- all workers, contractors and Directors of both entities; and
- all systems and locations in which information is held, including Brevity, Microsoft Outlook, Microsoft Teams, SharePoint, ClickUp, the website content management system, locally stored files, and any paper records at the head office.

3. Legislative and regulatory framework

- *Privacy Act 1988* (Cth) and the Australian Privacy Principles.
- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards (governance, operational management and quality management indicators).
- *Corporations Act 2001* (Cth) — financial records retention.
- *Income Tax Assessment Act 1936* (Cth) and other tax legislation — five-year retention for tax records.
- *Fair Work Act 2009* (Cth) — employee records retention.
- *State Records Act 1998* (NSW) where applicable to public-funded health information.
- *Children and Young Persons (Care and Protection) Act 1998* (NSW) — child safety record retention.

4. Definitions

- **Information** means any data, text, image, audio or video held by Able to Thrive in any format.
- **Record** means information created or received in the course of Able to Thrive's operations that has business, legal, regulatory or evidentiary value.
- **Controlled document** means a record that is version-controlled, owned, approved and reviewed under a defined schedule — for example, a policy, the Business Plan, a contract, or a register.
- **Information asset** means a defined collection of information (a system, a database, a register, or a document set) of business value.
- **Information Asset Register** means the consolidated register of information assets, maintained by the Lead Compliance Officer.
- **Classification** means the sensitivity level assigned to a record under Section 6, determining how it is handled.

5. Policy statement

Able to Thrive treats its information as a strategic asset. We capture what we need to operate, support participants, evidence compliance, and improve over time. We protect it against loss, unauthorised access, alteration and inappropriate disclosure. We retain it for the period required by law and by good practice, and we dispose of it securely when retention is no longer required.

6. Information classification

Records are classified to determine how they are handled. The classifications are:

Classification	Examples	Handling
Public	Marketing materials; published website content; information packs for participants prior to engagement.	No restriction on access. May be reproduced and shared externally.
Internal	Internal communications; meeting minutes that do not contain sensitive information; rosters at a high level; general training materials.	Accessible to all workers. Not shared externally without approval.
Confidential	Participant records; participant communications; worker personnel files; commercially sensitive information; Director meeting minutes containing sensitive matters.	Access on a need-to-know basis only. Stored in access-controlled systems. Not shared externally without authorisation.
Highly confidential	Sensitive information under the Privacy Act including health information; investigation records; reportable incident notifications; child safety records; legal correspondence.	Access strictly on a need-to-know basis. Stored in access-controlled systems with audit logging where available. Sharing requires the Lead Compliance Officer's authorisation. Multi-factor authentication required for systems holding this category.

Where a record contains information of more than one classification, the highest applicable classification applies to the whole record. Most participant-related records are at least Confidential; records containing health information, child safety information, or incident investigation material are Highly confidential.

7. Document control for controlled documents

Controlled documents (policies, Business Plan, contracts, registers, governance documents) are managed under the Document Control standard set out in the Policy Review Action Plan and the Governance Policy. Each controlled document has:

- a unique identifier (e.g. P-1.29, Risk Register, Labour Hire Agreement);

- a Document Control panel recording version, date issued, owner, qualified compliance lead, approver, and next scheduled review;
- Director endorsement before becoming operational;
- a defined review cycle and event-driven review triggers; and
- archival of superseded versions with a record of when and why they were superseded.

The Lead Compliance Officer maintains the master list of controlled documents and their current versions.

8. Records lifecycle

8.1 Creation and capture

Records are created in the system designated for their type:

- **Brevity** — participant records, case notes, incident reports, complaint records, support coordination notes, rosters, the Living Alone Register, the Continuous Improvement Register, the Conflict of Interest Register, the Gifts and Benefits Register, the Risk Register.
- **SharePoint (Microsoft 365)** — controlled documents (policies, Business Plan, contracts, governance documents), training materials, audit reports, financial records, key personnel records.
- **Outlook and Microsoft Teams** — internal communications, scheduled meetings, calendars, meeting minutes.
- **ClickUp** — project workflows, action items, internal task management.
- **Finance system** — accounts payable, accounts receivable, payroll (via Able to Thrive Personnel), GST and tax records.
- **Website CMS** — published content and participant-facing information packs.
- **Paper** — used only where a paper original is required (signed contracts, signed consent forms requiring original, statutory declarations). Paper records are scanned to the relevant electronic system as soon as practical and the original is held securely at the head office.

8.2 Naming and metadata

Records use consistent naming conventions to support retrieval. The minimum metadata for a controlled document is: title, version, date, owner. Other records carry the metadata required by their system (e.g. Brevity participant ID).

8.3 Access

Access to records is on a need-to-know basis. System administrators do not access records without a legitimate operational reason and where this is not part of normal usage, they record the reason. Multi-factor authentication is enabled on all systems holding Confidential or Highly Confidential records.

8.4 Modification

Records that have evidentiary value (incident reports, case notes, communications with regulators) are not modified after creation except by formal amendment recorded with the author, date, reason and original content preserved. Brevity's audit log is treated as the primary modification trail for participant records.

8.5 Retention

Records are retained for the period set out in the Retention Schedule (Appendix). Where multiple retention periods apply (for example, NDIS, Fair Work and tax), the longest applies. Records may be retained beyond the minimum where they remain in active use or where a legal hold applies.

8.6 Disposal

When the retention period expires and the record is no longer in active use, the record is securely disposed of. Electronic records are deleted from the primary system and from any backup beyond the backup retention period. Paper records are shredded. Disposal is logged.

9. Retention Schedule (key categories)

The minimum retention period for the principal categories of record held by Able to Thrive is set out below. The full schedule is maintained as an appendix and is reviewed annually.

Category	Minimum retention	Trigger
Participant records (case notes, incident reports, communications, Service Agreement)	**7 years**	After the participant ceases to receive services
Child-related records	**7 years or until the child turns 25 (whichever is later)**	After the child ceases to receive services
Worker personnel files (engagement records, performance, supervision)	**7 years**	After separation from engagement
Worker screening records (NDIS Worker Screening, WWCC)	**7 years**	After separation from engagement
Training records	**7 years**	After separation from engagement
Reportable Incident notifications and supporting evidence	**7 years**	After lodgement
Complaint records (Brevity and Complaints Register)	**7 years**	After closure

Risk Register, Continuous Improvement Register, Conflict of Interest Register, Gifts Register	**Life of the organisation; closed entries retained 7 years**	From closure of the entry
Financial records (tax, GST, payroll)	**5 years (minimum under tax law); 7 years under Corporations Act for accounting records**	From creation
Board minutes and governance records	**Life of the organisation**	From creation
Insurance certificates of currency	**7 years**	From expiry
Contracts and agreements	**7 years**	After expiry or termination

Where any record is, or may become, relevant to litigation, investigation, audit, or coronial process, a legal hold is applied and the record is preserved regardless of the minimum retention period. The Director (Compliance) authorises legal holds.

10. Backups and recoverability

- Critical electronic records are backed up on a regular schedule. Backups are tested for recoverability at least annually.
- Backups are held on infrastructure that meets equivalent security standards to the primary systems.
- Recovery time and recovery point objectives are documented for the principal systems (Brevity, SharePoint, finance system) in the Business Continuity Plan.
- Backups are themselves treated as records and subject to retention controls.

11. Third-party systems and cloud services

Most of Able to Thrive's information systems are cloud-hosted (Brevity, Microsoft 365, ClickUp). For each third-party system holding Confidential or Highly Confidential information, Able to Thrive:

- records the system in the Information Asset Register;
- reviews the vendor's data security posture (certifications, hosting location, encryption, access controls, breach notification);
- confirms the contractual arrangement provides appropriate protection (including breach notification to Able to Thrive, return or destruction of data on termination, and compliance with the Privacy Act);
- records the data categories held in the system and the classification; and
- reviews the arrangement annually.

12. Information Asset Register

The Information Asset Register is maintained by the Lead Compliance Officer. For each asset, the Register records:

- asset name and description;
- system or location where it is held;
- classification (Public / Internal / Confidential / Highly Confidential);
- owner;
- access list summary;
- retention period;
- backup arrangements;
- vendor (for third-party systems) and the date of the last vendor review;
- any associated risk recorded in the Risk Register; and
- next scheduled review.

The Register is reviewed annually and updated whenever a new asset is introduced or a material change in an existing asset occurs.

13. Information security incidents

Where an information security incident occurs — including loss, theft, unauthorised access, ransomware, accidental disclosure, or any near-miss — it is reported immediately to the Lead Compliance Officer. The Lead Compliance Officer applies the response framework in the Privacy and Confidentiality Policy (P-1.30) and the Cyber Security and Acceptable Use Policy (P-1.34). Where the incident is an eligible data breach under the Privacy Act, the Notifiable Data Breach process applies. Where the incident affects NDIS participant records, the Incident Management Policy applies in parallel.

14. Training

All workers complete training in this Policy at induction. Training covers classification, the use of the designated systems for each category of record, naming and metadata, the prohibition on modification of evidentiary records, and the requirement to report any information security incident or near-miss.

15. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for information management. Authorisation of legal holds. Sign-off on the annual review of the Retention Schedule. Sign-off on any change in third-party system holding Highly Confidential information.
Director (Finance and	Oversight of the technology platforms used to hold

Technology) — Dante Michael	information. Joint sign-off on cyber-related elements. Vendor engagement and review.
Lead Compliance Officer	Owner of this Policy. Maintenance of the master controlled-document list, the Information Asset Register and the Retention Schedule. Quality review of classification and handling. Annual review.
All workers	Classification of records appropriately. Storage in designated systems. Compliance with access and modification rules. Prompt reporting of any information security incident or near-miss.

16. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a material change in information systems, a change in retention obligations under law, or an audit finding bearing on information management.

ABLE TO THRIVE PTY LTD

Policy P-1.30

PRIVACY AND CONFIDENTIALITY POLICY

Document control

Policy number	P-1.30
Policy title	Privacy and Confidentiality Policy
Version	2.0
Date issued	October 2026
Supersedes	Privacy and Confidentiality Policy and Procedure (Section 1.30 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	October 2027, or upon material change to the Privacy Act 1988 (Cth), the Notifiable Data Breaches scheme, NDIS Practice Standards, or the organisation's information systems
Related policies and documents	Information Management Policy (P-1.29); Cyber Security and Acceptable Use Policy (P-1.34); Human Resources Policy (P-1.23); Incident Management Policy (P-2.06); Feedback, Compliments and Complaints Policy (P-2.03); Child Safety Policy (P-2.17); Conflict of Interest Policy (P-1.03); Brevity system documentation; NDIS Code of Conduct; Australian Privacy Principles guidelines

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) and Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel) collect, use, disclose, store, secure, access, correct and dispose of personal information. The Policy gives effect to the Privacy Act 1988 (Cth), the

Australian Privacy Principles (APPs), the Notifiable Data Breaches scheme, the NDIS Code of Conduct, and the NDIS Practice Standards relating to privacy and information management.

2. Scope

This Policy applies to:

- all personal information collected, held, used or disclosed by Able to Thrive or Able to Thrive Personnel in connection with their operations;
- information about participants (including health and disability information, plan information, and incident information);
- information about workers (including screening clearances, qualifications, performance records, and remuneration);
- information about contacts (referrers, suppliers, partners, complainants); and
- all workers, contractors and Directors of both entities.

3. Legislative and regulatory framework

- *Privacy Act 1988* (Cth) and the Australian Privacy Principles.
- Part IIIC of the Privacy Act (Notifiable Data Breaches scheme).
- *Health Records and Information Privacy Act 2002* (NSW) — health information.
- *Privacy and Personal Information Protection Act 1998* (NSW) where applicable.
- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards (privacy and information management indicators).
- *Children and Young Persons (Care and Protection) Act 1998* (NSW) — information sharing for child safety purposes.

4. Definitions

- **Personal information** has the meaning given by the Privacy Act 1988 (Cth) — information or an opinion about an identified individual, or an individual who is reasonably identifiable.
- **Sensitive information** is a category of personal information attracting additional protection under the Privacy Act and includes health information, information about disability, racial or ethnic origin, religious beliefs, sexual orientation and criminal record. Most participant information held by Able to Thrive is sensitive information.
- **Health information** has the meaning given by the Privacy Act and the Health Records and Information Privacy Act 2002 (NSW) and includes information about a person’s physical or mental health, disability, and the services they receive.
- **Eligible data breach** has the meaning given by Part IIIC of the Privacy Act and triggers the Notifiable Data Breaches notification obligation.

- **Brevity** means the case management system used by Able to Thrive to hold participant records, incident reports, complaints, schedules and workforce data.

5. Policy statement

Able to Thrive treats personal information as a position of trust. We collect only what we need, use it only for the purposes for which it was collected (and reasonably related purposes), keep it secure, and share it only where we have lawful authority. We respect participants' right to know what we hold about them, to correct it, and to make a complaint about how it is handled.

6. The Australian Privacy Principles in practice

Able to Thrive applies each of the thirteen Australian Privacy Principles as follows.

APP	Principle	How Able to Thrive applies it
1	**Open and transparent management of personal information**	This Policy is published on the Able to Thrive website and provided to participants at intake. The Lead Compliance Officer is the Privacy Officer for the organisation.
2	**Anonymity and pseudonymity**	Where practical, individuals dealing with Able to Thrive may do so anonymously or under a pseudonym. Most service-delivery situations require identification.
3	**Collection of solicited personal information**	We collect only personal information necessary for our functions or activities. Sensitive information is collected only with consent (or where collection is required or authorised by law).
4	**Dealing with unsolicited personal information**	Unsolicited personal information is assessed and either retained (if it could have been lawfully collected) or destroyed/de-identified.
5	**Notification of the collection of personal information**	At the point of collection, Able to Thrive notifies the individual of who is collecting the information, why, how it will be used, who it may be disclosed to, and how to access and correct it.
6	**Use or disclosure of personal information**	Personal information is used and disclosed only for the primary purpose for which it was collected, for related secondary purposes the individual would reasonably expect, or with consent, or where authorised by law.

7	**Direct marketing**	Personal information is not used for direct marketing of unrelated products. Where Able to Thrive communicates with participants about its services, the individual may opt out.
8	**Cross-border disclosure**	Where personal information would be disclosed to an overseas recipient (for example, where a worker is located overseas and accesses participant information remotely), Able to Thrive takes reasonable steps to ensure the overseas recipient does not breach the APPs in relation to that information.
9	**Government related identifiers**	NDIS numbers and other government identifiers are used only for the purposes permitted under the Privacy Act and the NDIS Act.
10	**Quality of personal information**	Able to Thrive takes reasonable steps to ensure information is accurate, up to date and complete, including by checking with the individual at plan review and on request.
11	**Security of personal information**	Able to Thrive takes reasonable steps to protect personal information from misuse, interference, loss, unauthorised access, modification and disclosure (see Section 8).
12	**Access to personal information**	Individuals may access their personal information on request. The process is described in Section 10.
13	**Correction of personal information**	Individuals may request correction of inaccurate, out-of-date, incomplete or misleading information. The process is described in Section 10.

7. Collection, use and disclosure

7.1 Information about participants

At intake, Able to Thrive collects from the participant (and, with consent, from their representatives, support coordinators, and treating clinicians) the personal and sensitive information needed to deliver supports safely and effectively. This typically includes contact details, NDIS plan information, health and disability information, communication and access needs, support history, and emergency contacts. Where the participant is a child, information is also collected from the parent/carer.

The information is used to deliver supports, plan services, manage incidents and complaints, report under the NDIS framework, and improve services. The information may be disclosed to:

- Able to Thrive workers who need it to deliver supports;
- Able to Thrive Personnel where workforce planning or supervision requires it;
- the participant's nominated representatives, family members and support coordinator (with consent);
- the participant's treating clinicians (with consent or where required for urgent safety);
- the NDIS Commission and the NDIA where required by law or regulation;
- emergency services where urgent safety requires it;
- child protection authorities where mandatory reporting or other legal obligations apply; and
- the Office of the Children's Guardian under the Reportable Conduct Scheme where applicable.

7.2 Information about workers

Information about workers (employment records, screening clearances, training, performance) is held by Able to Thrive Personnel as employer, and shared with Able to Thrive Pty Ltd to the extent necessary for direction, supervision and NDIS compliance. The flow of worker information between the entities is recorded in the Labour Hire Agreement and is treated as the use of personal information for related purposes within the corporate group.

7.3 Information about other parties

Personal information about referrers, suppliers, partners and complainants is collected, used and disclosed only for the purposes of the relevant relationship and for related purposes.

8. Security

Personal information is held in secure systems. The principal information system used to hold participant and workforce records is Brevity. Security measures include:

- access controls — only workers with a legitimate need to access an item of personal information are granted access;
- authentication — strong passwords or equivalent, with multi-factor authentication where reasonably practicable;
- encryption of data in transit and (for sensitive data stores) at rest;
- physical security at the head office at B103/548–568 Canterbury Rd, Campsie NSW 2194, including secure storage of any paper records and locked devices;
- endpoint protection on all devices used to access personal information;
- training of workers in information security at induction and annually;
- backups of critical data on a regular schedule; and

- vendor due diligence on third-party systems that hold or process personal information.

Further detail on technical controls is set out in the Cyber Security and Acceptable Use Policy (P-1.34).

9. Notifiable Data Breaches

Where Able to Thrive becomes aware of a data breach (or suspected breach) involving personal information, the Lead Compliance Officer is notified immediately. The Lead Compliance Officer:

- takes immediate steps to contain the breach;
- assesses the breach against the criteria for an eligible data breach under Part IIIC of the Privacy Act (unauthorised access, disclosure or loss of personal information, where serious harm to any individual is likely as a result);
- where the breach is an eligible data breach, ensures that a statement is prepared and notification given to the Office of the Australian Information Commissioner (OAIC) and to the affected individuals as soon as practicable, and in any event within the timeframes set by the Notifiable Data Breaches scheme;
- records the breach in the Incident Register and assesses whether NDIS Commission notification is also required;
- initiates a review of the controls that failed and records the corrective action in the Continuous Improvement Register; and
- briefs the Directors.

The Director (Compliance) signs off on each Notifiable Data Breach notification before submission.

10. Access and correction

A participant, worker or other individual may request access to their personal information held by Able to Thrive at any time. The request is made to the Lead Compliance Officer in writing (including by email). Able to Thrive responds within 30 days, providing access in a format reasonable in the circumstances.

Where the individual believes information is inaccurate, out of date, incomplete, irrelevant or misleading, they may request correction. Able to Thrive considers the request and either corrects the information or, where correction is declined, records the request and the reason and, where the individual requests, attaches a statement to the record.

Access may be declined only on the grounds permitted under the Privacy Act (for example, where access would have an unreasonable impact on the privacy of another person, or where the request is frivolous or vexatious). Where access is declined, the reason is given in writing.

11. Privacy in incident management and complaints

Personal information collected through incident management and complaint handling is used only for those purposes and for related purposes (including notification to regulators, investigation, and continuous improvement). Information is shared with the affected participant and other affected parties to the extent necessary and consistent with this Policy. Where information cannot be shared (for example, because doing so would disclose another person's personal information without consent), this is explained to the individual.

12. Privacy in child safety contexts

Information about children is collected with the consent of the parent/carer at intake and is treated with the additional protections appropriate to children. Where mandatory reporting or Reportable Conduct Scheme obligations require disclosure (Child Safety Policy P-2.17), the disclosure is made notwithstanding the absence of consent. Children's information is not used for marketing of any kind.

13. Retention and disposal

- Personal information is retained only for so long as it is needed for the purpose for which it was collected (and for any legal record-keeping period that applies).
- Participant records are retained for not less than seven years after the participant ceases to receive services from Able to Thrive.
- Worker records are retained for the period of engagement and not less than seven years after separation.
- Information collected for child-related services is retained for not less than seven years after the child ceases to receive services or turns 25 (whichever is later) where retention assists future safeguarding.
- When personal information is no longer required, it is securely destroyed or de-identified.

14. Complaints about privacy

An individual who believes Able to Thrive has breached its privacy obligations may make a complaint through the Feedback, Compliments and Complaints Policy (P-2.03). Privacy complaints are handled by the Lead Compliance Officer. Where the complainant is not satisfied with the outcome, they may complain to the Office of the Australian Information Commissioner (OAIC) on 1300 363 992 or through the OAIC website.

15. Training

All workers complete privacy training at induction and annually. Training covers the Australian Privacy Principles in practical terms, the use of Brevity, the rules on sharing

participant information with families and external parties, recognition of data breaches, and the worker's responsibility to escalate any concern to the Lead Compliance Officer.

16. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for privacy compliance. Sign-off on each Notifiable Data Breach notification. Final decision on contested access or correction requests. Briefing of Directors on material privacy matters.
Lead Compliance Officer (Privacy Officer)	Owner of this Policy and Privacy Officer for the organisation. Handling of access and correction requests. Containment, assessment and notification of data breaches. Privacy training records. Annual privacy compliance review reported to Directors.
Director (Finance and Technology) — Dante Michael	Sign-off on the technical controls and vendor arrangements supporting privacy. Joint sign-off on cyber-related elements of data breach response with the Director (Compliance).
HR Coordinator and Operations Manager — Kriz	Day-to-day handling of worker personal information in Able to Thrive Personnel. Liaison with the Lead Compliance Officer on any worker-related privacy matter. Oversight of remote-access arrangements.
All workers	Compliance with this Policy. Accessing only the personal information needed for the task at hand. Reporting any suspected privacy breach or near-miss immediately to the Lead Compliance Officer.

17. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a material change in the Privacy Act, the Notifiable Data Breaches scheme, the NDIS framework, or the organisation's information systems.

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Policy P-1.31

LIVING ALONE RISK ASSESSMENT AND SOLE SUPPORT WORKER POLICY

Document control

Policy number	P-1.31
Policy title	Living Alone Risk Assessment and Sole Support Worker Policy
Version	1.0
Date issued	May 2026
Supersedes	Nil — new policy issued to evidence ongoing compliance with Condition 2 of the Able to Thrive Pty Ltd NDIS registration (ID 4-IPX11F6)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to the Condition 2 obligations, the Practice Standards, or the way the organisation delivers personal support to participants who live alone
Related policies and documents	Incident Management Policy; Suicide Prevention and Response Policy; Service Agreement template (with Condition 2 clauses); Risk Register; Participant Files; Conditions of NDIS Registration; NDIS Code of Conduct

1. Purpose

This Policy establishes the system by which Able to Thrive Pty Ltd (Able to Thrive) assesses, documents, manages and monitors the risks associated with delivering personal support by a sole support worker to a participant who lives alone.

The Policy gives operational effect to Condition 2 of the conditions imposed on Able to Thrive's NDIS registration (ID 4-IPX11F6) under section 73G of the National Disability Insurance Scheme Act 2013 (Cth). Condition 2 is a binding condition of registration. Failure to comply may result in compliance or enforcement action by the NDIS Quality and Safeguards Commission, including suspension or revocation of registration.

The Policy is read together with Able to Thrive's Incident Management Policy, Suicide Prevention and Response Policy, Risk Management Policy, the Service Agreement template (which includes the clauses required by Condition 2), and the Living Alone Register maintained by the Lead Compliance Officer.

2. Scope

This Policy applies to every participant who:

- lives alone (that is, does not regularly share their primary residence with another person who provides them with ongoing care or companionship); and
- receives personal support funded under the NDIS from Able to Thrive that is delivered by the same individual support worker, where that worker is the sole provider of personal support to that participant for the relevant period.

This Policy applies to every member of Able to Thrive's workforce involved in the onboarding, allocation, supervision, compliance management or direct delivery of personal support to a participant who lives alone, including support workers engaged through Able to Thrive Personnel Pty Ltd.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth).
- Conditions of registration imposed on Able to Thrive under sections 73F, 73G, 73H and 209 of the NDIS Act, in particular Condition 2 (sole support worker, participants who live alone).
- National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018.
- National Disability Insurance Scheme (Code of Conduct) Rules 2018.
- NDIS Practice Standards and Quality Indicators.
- *Work Health and Safety Act 2011* (NSW) and regulations.

4. Definitions

In this Policy, the following terms have the meanings given by Condition 2 of the conditions of registration, with the same legal effect:

- **Appropriate** means appropriate having regard to the participant's risk factors.
- **Face-to-face communication or contact** means communication or contact in person and directly with the participant. It does not include online or virtual communication.

- **Participant** (for the purposes of this Policy) means a participant who lives alone.
- **Personal support** means the class of support referred to as assistance with daily personal activities in the NDIS Pricing Arrangements (registration group 0107).
- **Risk factors** are the factors listed in Section 5 of this Policy and any additional risk factors identified for a participant. The
- **Participant's risk factors** are the risk factors assessed under this Policy as existing in relation to that participant.
- **Service agreement** means the written service agreement (or proposed written service agreement) between Able to Thrive and the participant for the provision of personal support, which may also cover other supports.
- **Sole support worker**, in relation to a participant, means an individual who is the sole provider of personal support to the participant for the relevant period.
- **Support worker** means an individual engaged through Able to Thrive Personnel Pty Ltd who provides personal support to a participant on behalf of Able to Thrive.

5. Risk factors

The following are the risk factors specified by Condition 2. The presence of any one of these factors, alone or in combination with others, will trigger the supervision and monitoring requirements set out in Section 8 of this Policy.

- The participant is not receiving, from any other NDIS provider, supports or services that involve regular, face-to-face contact with the participant.
- One or more of the following applies:
    - the participant or the participant's plan indicates that the participant has limited or no regular, face-to-face contact with relatives, friends or other people with whom the participant is well-acquainted;
    - without the assistance of another person, the participant has limited or no physical mobility;
    - the participant uses equipment to enable them to be physically mobile or to facilitate their physical mobility;
    - without the assistance of another person, the participant has limited or no ability to communicate with others;
    - the participant uses equipment to enable or facilitate communication with others, including to enable or facilitate the use of a phone or other device.

In addition to the factors specified above, the assessor will consider any other factor that may materially affect the participant's capacity to engage in the community or to seek assistance, including (but not limited to) recent serious illness, recent loss of an informal support network, identified mental health risks (assessed in conjunction with the Suicide Prevention and Response Policy), and any cultural or language considerations relevant to access to assistance.

6. Policy statement

Able to Thrive does not permit personal support to be provided by a sole support worker to a participant until a Living Alone Risk Assessment has been completed in accordance with this Policy, a Service Agreement (or proposed Service Agreement) compliant with Section 7 of this Policy has been entered into (or, where reasonable efforts have been made to enter into it, has been provided to the participant), and any supervision and reporting arrangements required by Section 8 are in place.

Where Condition 2 first applied to an existing participant who was already receiving sole-worker personal support, Able to Thrive complied with the requirements of this Policy within 30 days of the date on which the condition took effect, in accordance with sub-clause 5 of Condition 2.

7. Procedure — pre-engagement risk assessment and service agreement

7.1 Trigger and timing

The Living Alone Risk Assessment is initiated whenever any of the following occurs:

- A prospective participant is identified at intake as living alone and is being onboarded to receive personal support from Able to Thrive.
- An existing participant's circumstances change such that they begin living alone (for example, following a change in household arrangements).
- An existing participant's service arrangement changes such that personal support will be delivered, for the relevant period, by a sole support worker.

In each case, the assessment is completed and the corresponding Service Agreement (or proposed Service Agreement) is in place before personal support is delivered by a sole support worker.

7.2 Who completes the assessment

The Living Alone Risk Assessment is completed by an Able to Thrive staff member with appropriate competency. By default, this is the Client Services and Acquisition lead (Akash) at the point of intake, with administrative support from the Compliance and HR Administrator (Mikha) and quality review by the Lead Compliance Officer (Massy). The Director Eyad Shadid, as qualified compliance lead, provides oversight and final endorsement of the assessment.

7.3 Required content of the assessment

Each Living Alone Risk Assessment documents the following:

- Participant identifiers, NDIS number, and the date of assessment.
- Whether the participant lives alone and the basis for that determination (including any review of the participant's plan).

- Whether personal support will be delivered by a sole support worker, and the expected pattern of that delivery.
- An express assessment against each of the risk factors listed in Section 5, indicating whether each factor is present, absent or uncertain, with a brief evidence note for each.
- Any additional risk factors identified, with evidence.
- A summary conclusion as to whether one or more risk factors exist in relation to the participant.
- The supervision and monitoring arrangements to be put in place in light of the assessment outcome (see Section 8).
- The name, role and signature of the staff member completing the assessment, and the date.
- Endorsement by the Lead Compliance Officer and (for cases involving identified risk factors) the Director (Compliance).

7.4 Sharing the assessment with the participant

A copy of the completed assessment is provided to the participant as soon as reasonably practicable after the assessment is completed. The copy is provided in a format accessible to the participant, including, where required, in plain English, large print, an Easy Read format, or with the assistance of an interpreter or supporter chosen by the participant.

7.5 Filing

A copy of the assessment is placed in the participant’s file in the Brevity case management system and recorded against the Living Alone Register described in Section 9.

7.6 Service Agreement requirements

Each Service Agreement (or proposed Service Agreement, where reasonable efforts have been made to enter into a Service Agreement and a copy has been provided to the participant) takes into account the participant’s risk factors and specifies, at a minimum, each of the following matters required by Condition 2:

- the rights and obligations of the participant and of Able to Thrive under the Service Agreement;
- the means by which the participant’s support worker is selected, including the participant’s role in that selection;
- a procedure that is used to review the implementation of the Service Agreement. The procedure provides for a person other than the support worker (the participant’s reviewer, who is by default the Lead Compliance Officer or a delegate) to check directly with the participant, at an appropriate frequency, on the participant’s level of satisfaction with the type, quality and frequency of the personal support being provided;
- the means by which Able to Thrive supervises and monitors the performance of the support worker, including (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 Able to Thrive communicates with the participant, including (as far as practicable) face-to-face communication with the participant in the participant's home at an appropriate frequency; and
- the means by which Able to Thrive engages 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.

8. Procedure — supervision and monitoring where risk factors exist

Where one or more risk factors are assessed as existing in relation to a participant, Able to Thrive implements a documented Supervision and Monitoring Plan (the Plan) that is appropriate having regard to the participant's risk factors. The Plan addresses, at a minimum, each of the matters set out below.

8.1 Plan content

- The frequency and method of in-home supervision visits by an Able to Thrive supervisor.
- The frequency and method of direct face-to-face communication with the participant by an Able to Thrive representative who is not the sole support worker.
- The frequency and content of reports to key personnel under Section 8.3.
- Identified triggers (incidents, missed shifts, complaints, changes in participant condition) that will cause supervision to escalate.
- The roles responsible for executing each element of the Plan.

8.2 Implementation

The Lead Compliance Officer is responsible for ensuring the Plan is implemented from the date the participant first receives sole-worker personal support. The HR Coordinator and Operations Manager (Kriz) ensures rostering supports the in-home supervision visit frequency. The Client Services and Acquisition lead (Akash) provides the in-person Sydney touchpoint where the Plan calls for a non-worker supervisor visit.

8.3 Reports to key personnel

Regular reports to Able to Thrive's key personnel are produced in respect of the care and skill with which personal support is being provided to each participant covered by this Policy. The regularity of reports is appropriate having regard to the participant's risk factors. The default minimum reporting frequencies are:

- Where one or more risk factors are present: monthly reports to the Directors.

- Where multiple risk factors are present, or where any risk factor concerns mobility or communication limitations as described in clauses (b)(ii)–(b)(v) of Condition 2: fortnightly reports to the Directors.
- Where an incident occurs in respect of the participant: an out-of-cycle report to the Directors within the timeframes set by the Incident Management Policy, in addition to the regular reporting cycle.

Reports are prepared by the Lead Compliance Officer and signed off by the Director (Compliance) before distribution.

8.4 Action on concerns

Where a report or other information identifies a concern in relation to the care or skill with which personal support is being provided, Able to Thrive takes appropriate action without unreasonable delay. Action may include direct supervisor engagement with the worker, retraining, additional supervision, replacement of the worker (without termination of the worker's employment with Able to Thrive Personnel Pty Ltd), referral of the matter through the Incident Management Policy, or escalation to the NDIS Commission where the matter meets the threshold for a Reportable Incident.

9. Living Alone Register

The Lead Compliance Officer maintains an up-to-date Living Alone Register. The Register records, for every participant to whom Able to Thrive allows personal support to be provided by a sole support worker:

- participant identifiers and NDIS number;
- the date the participant entered the scope of this Policy;
- a summary of the risk factors assessed as existing;
- the date of the most recent risk assessment and the date of the next scheduled review;
- the supervision and monitoring arrangements applying to the participant;
- the date of the most recent in-home supervision visit;
- the date of the most recent third-party satisfaction check (Section 7.6, third bullet); and
- any active incidents, complaints or corrective actions associated with the participant.

The Register is reviewed by the Director (Compliance) at each scheduled Director meeting and is available for inspection by the NDIS Quality Auditor or the NDIS Commission on request.

10. Ongoing monitoring, reassessment and updates

Each Living Alone Risk Assessment is reviewed and updated:

- at the participant's scheduled plan review;
- not less than once every twelve months from the date of the previous assessment;

- as soon as reasonably practicable after Able to Thrive becomes aware of any change in circumstances that may have a significant impact on the provision of personal support to the participant (including, but not limited to, change of address, change in household composition, change in support arrangements with other providers, significant changes in the participant's health or capacity, and any reportable incident); and
- on the participant's request.

Each update is documented as a new version of the assessment. A copy of the updated assessment is provided to the participant in an accessible format and placed in the participant's file and the Living Alone Register.

11. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Final endorsement of risk assessments where one or more risk factors are present. Sign-off on Supervision and Monitoring Plans. Review of Living Alone Register at each Director meeting. Accountability for compliance with Condition 2.
Lead Compliance Officer	Owner of this Policy. Quality review of every assessment. Maintenance of the Living Alone Register. Preparation of regular reports to key personnel. Coordination of corrective actions. Audit preparation in respect of Condition 2 compliance.
Client Services and Acquisition — Akash	Identification of in-scope participants at intake. Completion of the initial Living Alone Risk Assessment. Sydney-based in-person communication with the participant required by Section 7.6 where the Lead Compliance Officer is not the designated communicator.
HR Coordinator and Operations Manager — Kriz	Allocation of workers consistent with the assessment outcome and the Supervision and Monitoring Plan. Rostering of in-home supervision visits at the required frequency.
Admin (Compliance and HR) — Mikha	Administrative support for the assessment. Filing of the assessment in Brevity. Updating of the Living Alone Register. Tracking of review dates.
Support workers	Compliance with the Supervision and Monitoring Plan. Immediate notification to the Lead Compliance Officer of any change in the participant's circumstances or capacity that may affect risk. Compliance with the NDIS

	Code of Conduct.

12. Record keeping

Records created under this Policy are kept in accordance with the NDIS record-keeping requirements prescribed by the Provider Registration and Practice Standards Rules. At a minimum:

- Each Living Alone Risk Assessment is retained for not less than seven years from the date of the assessment.
- The Living Alone Register is retained for not less than seven years from the date of last entry.
- Service Agreements that include the clauses required by Section 7.6 are retained for not less than seven years from the date of termination of services to the participant.
- Supervision reports, in-home visit records, and third-party satisfaction check records are retained for not less than seven years.

13. Continuous improvement

Trends identified through the Living Alone Register, supervision reports, satisfaction checks, complaints and incidents inform Able to Thrive's Continuous Improvement Register. Material trends are reported by the Lead Compliance Officer to the Directors for consideration of policy, training or operational changes.

14. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in the conditions of registration imposed on Able to Thrive; a change in the NDIS Practice Standards or Code of Conduct that affects this Policy; an audit finding (internal or external) bearing on Condition 2 compliance; or a material change in the way Able to Thrive delivers personal support to participants who live alone.

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Policy P-1.32

BEHAVIOUR SUPPORT IMPLEMENTATION POLICY

Document control

Policy number	P-1.32
Policy title	Behaviour Support Implementation Policy
Version	1.0 (new policy)
Date issued	September 2026
Status	Issued in support of Able to Thrive's application to vary its NDIS registration to include Module 2a (Implementing Behaviour Support Plans). This Policy becomes operational on approval of the variation. Until that approval, Able to Thrive does not implement behaviour support plans involving regulated restrictive practices. The framework for positive behaviour support already in place across other policies (in particular the Child Safe Environment Policy and the Staff Code of Conduct) continues to apply.
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	Twelve months after the date of Module 2a approval, or upon material change to the NDIS Restrictive Practices framework, the relevant state authorisation arrangements, or the Quality and Safeguarding Framework
Related policies and documents	Incident Management Policy (P-2.06); Child Safety Policy (P-2.17); Child Safe Environment Policy (P-2.20); Suicide Prevention and Response Policy (P-2.21); Staff Code of Conduct (P-1.26); Human Resources Policy (P-1.23); Privacy and Confidentiality Policy (P-1.30); Risk Management Policy (P-1.09); NDIS Behaviour Support Rules; relevant NSW restrictive practices authorisation

	framework documentation

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) implements behaviour support plans (BSPs) developed for NDIS participants by registered behaviour support practitioners. It establishes the principles that guide implementation, the controls that govern the use of regulated restrictive practices (in the event Able to Thrive in future implements any), the reporting obligations to the NDIS Commission, and the roles of the people involved.

The Policy is issued in support of Able to Thrive's application to vary its NDIS registration to include Module 2a (Implementing Behaviour Support Plans).

2. Scope and operational status

On approval of Module 2a, this Policy applies to:

- every NDIS participant of Able to Thrive who has a behaviour support plan that Able to Thrive is engaged to implement;
- every Able to Thrive worker involved in delivering supports to such a participant; and
- every interaction in which the worker is required to apply the strategies set out in the participant's behaviour support plan.

Until Module 2a is approved, Able to Thrive does not implement behaviour support plans that include regulated restrictive practices. Positive behaviour support consistent with this Policy continues to be applied across all services in conjunction with the Child Safe Environment Policy, the Staff Code of Conduct and other policies. Where a participant has a behaviour support plan that includes regulated restrictive practices, Able to Thrive supports the participant to find an appropriately-registered provider for the elements of the plan involving regulated restrictive practices.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.
- NDIS Practice Standards and Quality Indicators, including the indicators relating to behaviour support and implementation of behaviour support plans.
- NSW restrictive practices authorisation framework administered by the NSW Ageing and Disability Commission and the relevant senior practitioner arrangements.
- *Mental Health Act 2007* (NSW) — where the participant is subject to a mental health order, the order is not displaced by this Policy.

4. Definitions

- **Behaviour support plan (BSP)** means a written plan developed for an NDIS participant by an NDIS-registered behaviour support practitioner. It is informed by a functional behaviour assessment, identifies strategies to support the participant, and (where relevant) sets out any regulated restrictive practices authorised under it.
- **Behaviour support practitioner** means a person registered with the NDIS Commission to provide specialist behaviour support services and to develop behaviour support plans.
- **Positive behaviour support** is an evidence-based, person-centred approach focused on understanding the function of behaviour and supporting the participant to develop skills, environments and relationships that meet their needs without restriction.
- **Regulated restrictive practice** has the meaning given by the NDIS Restrictive Practices Rules and includes seclusion; chemical, mechanical, physical and environmental restraint.
- **Unauthorised restrictive practice** means the use of a restrictive practice that is either not authorised by a behaviour support plan or used in a manner not in accordance with such a plan.
- **Fading plan** means the component of a behaviour support plan that documents how the use of a restrictive practice will be reduced and replaced over time with less restrictive supports.

5. Policy statement

Able to Thrive's approach to behaviour support is grounded in positive behaviour support and the human rights of every participant. Behaviour is communication. Our role is to understand what the participant is communicating, to address the underlying need, and to support the participant to develop skills, environments and relationships that meet their needs without restriction.

Regulated restrictive practices are used only where they are authorised in a behaviour support plan developed by a registered practitioner, only where they are the least restrictive option, only in accordance with the plan, only for so long as necessary, and only with a clear and active fading plan. Every use is reported.

Unauthorised restrictive practice is not used by Able to Thrive workers in any circumstance. Any unauthorised use is a Reportable Incident and is notified to the NDIS Commission under the Incident Management Policy.

6. Engagement of behaviour support practitioners

Where a participant requires a behaviour support plan, the following applies:

- the practitioner is selected by the participant (or the participant's nominee), with the support of the participant's support coordinator (whether internal or external to Able to Thrive) and the Lead Compliance Officer;
- the practitioner is registered with the NDIS Commission to develop behaviour support plans;
- Able to Thrive does not employ or engage the practitioner; the practitioner is independent. Where the participant requests it and the participant's plan funds it, the practitioner may be engaged directly by the participant;
- where Able to Thrive itself in future provides specialist behaviour support (Module 2), the engagement of that service is managed under the Conflict of Interest Policy, and the practitioner developing a plan is not the same individual involved in implementing it.

7. Receipt, review and induction on a behaviour support plan

When Able to Thrive receives a behaviour support plan for a participant we support:

- the Lead Compliance Officer reviews the plan for completeness, currency, and consistency with this Policy;
- the plan is filed in the participant's Brevity record and access is granted to all workers allocated to the participant;
- the workers allocated to the participant receive an induction on the plan from a senior worker or the practitioner (where available), covering the participant's individual context, the proactive strategies, the early intervention strategies, the reactive strategies, the indicators of escalation, and (where applicable) any restrictive practices and the fading plan;
- induction completion is recorded; and
- any worker not yet inducted on the plan is not allocated to the participant.

Where the plan is revised by the practitioner, the same induction process is repeated for the revised plan. The previous version is archived under the Information Management Policy.

8. Implementation — proactive and early intervention strategies

The majority of a behaviour support plan typically describes proactive and early intervention strategies that aim to prevent escalation. Able to Thrive workers implement these as the primary approach. They include:

- environmental adjustments (sensory, social, predictability, routine);
- communication supports;
- teaching and skill-building activities;
- relationship and trust building;
- recognition of the participant's individual triggers and early warning signs; and
- de-escalation techniques tailored to the participant.

Workers do not deviate from the plan's strategies. Where a worker observes that a strategy is not working or is producing an adverse effect, the matter is escalated to the Lead Compliance Officer and to the practitioner without delay.

9. Implementation — reactive strategies and the use of restrictive practices

9.1 The hierarchy of responses

In a moment of escalation, workers respond using the least restrictive effective response, in the following order:

- continue with proactive and early intervention strategies, including verbal de-escalation, choice, removal of trigger;
- apply the reactive strategies specifically described in the participant's behaviour support plan;
- where the plan authorises a regulated restrictive practice, use the practice only if the strategies above are ineffective and the situation otherwise meets the criteria in the plan; and
- contact emergency services where the situation exceeds the capacity of the worker and the strategies in the plan.

9.2 Conditions for the use of a regulated restrictive practice

A regulated restrictive practice is used only where ALL of the following are met:

- the practice is authorised under the participant's current behaviour support plan, developed by a registered practitioner;
- the practice is one Able to Thrive is registered to implement under Module 2a;
- any required state authorisation (where applicable) is current and on file;
- the practice is used in the precise manner described in the plan;
- the practice is used for the minimum time necessary;
- the worker has been inducted on the plan and trained in the technique;
- the use is recorded in real time (as soon as it is safe to do so) in Brevity, with a description of antecedents, the practice used, duration, the participant's response, and any follow-up; and
- the use is reported to the practitioner and to the NDIS Commission in accordance with Sections 12 and 13.

9.3 Prohibited practices

Able to Thrive workers do not, under any circumstance:

- use any restrictive practice not authorised by the participant's behaviour support plan;

- use physical discipline, withdrawal of food or hydration, shaming, humiliation, or any practice inconsistent with the participant's dignity;
- use any restrictive practice on a child (under 18 years of age) outside the strictest application of the framework, and never in any holiday program;
- use any restrictive practice as a punishment or consequence;
- use any restrictive practice as a substitute for adequate staffing, training or environment;
- continue to use a restrictive practice beyond what the plan authorises in terms of duration, frequency or type.

Use of any restrictive practice outside the framework is an unauthorised restrictive practice. It is a Reportable Incident and is treated as serious misconduct.

10. The fading plan and capacity building

Every behaviour support plan that authorises a regulated restrictive practice includes a fading plan describing how the use will be reduced and replaced with less restrictive supports over time. Implementation of the BSP includes implementation of the fading plan. Workers actively support the participant to build the skills and environment that make the restrictive practice unnecessary. Progress against the fading plan is recorded and reported to the practitioner.

11. Data collection, monitoring and review

- Every use of a restrictive practice is recorded in real time in Brevity (or as soon as it is safe to do so) with the data required by the NDIS Commission and the practitioner.
- Behaviour data (frequency, intensity, duration, triggers, response, outcome) is collected continuously to inform the practitioner's review of the plan.
- The Lead Compliance Officer reviews behaviour support records weekly during the first month after a plan is introduced, then monthly, to confirm fidelity to the plan and to identify any concern.
- Trends across participants are reviewed quarterly and reported to the Directors.

12. Reporting to the behaviour support practitioner

Able to Thrive reports to the participant's behaviour support practitioner:

- the data described in Section 11;
- progress and concerns observed in implementing the plan;
- any incident involving the participant, regardless of whether a restrictive practice was used;
- any matter relevant to the practitioner's scheduled review of the plan; and
- any concern about the fit or effectiveness of the plan.

Reports are provided at the frequency agreed with the practitioner, and at any other time material information arises. Where the practitioner needs to revise the plan as a result, Able to Thrive supports the revision process.

13. Reporting to the NDIS Commission

- Every use of a regulated restrictive practice is reported to the NDIS Commission monthly through the NDIS Commission Portal in the form and timing required.
- Any unauthorised use of a restrictive practice is a Reportable Incident and is notified to the NDIS Commission immediately (within 24 hours) under the Incident Management Policy, in addition to the monthly report.
- Use of a restrictive practice on a child, or use that results in serious injury, is treated as an immediate-notification matter.

The Director (Compliance) is the named key personnel responsible for the timeliness and accuracy of all reports to the Commission under this Policy. The Lead Compliance Officer prepares the reports under the Director’s sign-off.

14. Working with the participant, families and carers

- The participant is engaged in the development and review of their behaviour support plan to the maximum extent possible, in their preferred mode of communication.
- Family members, carers and other supporters identified by the participant are engaged where the participant chooses (or where, for a child, the parent/carer is necessarily engaged).
- The behaviour support plan and its rationale are explained to the participant and their family/carers in accessible language.
- The participant retains the right to express concerns about the plan or its implementation through the Feedback, Compliments and Complaints Policy.

15. Training

Workers allocated to a participant with a behaviour support plan complete:

- induction in this Policy at engagement;
- plan-specific induction in the participant’s individual plan before any allocation (Section 7);
- training in positive behaviour support, de-escalation, and (for workers implementing a plan with regulated restrictive practices) training in the specific techniques authorised in the plan;
- refresher training at least annually and after any material change to a participant’s plan.

Training records are maintained against each worker’s file and verified by the Lead Compliance Officer before allocation.

16. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Sign-off on every monthly Restrictive Practices report and on every immediate notification of unauthorised use. Final accountability for Module 2a registration compliance. Liaison with NDIS Commission and the relevant senior practitioner arrangements in NSW.
Lead Compliance Officer	Owner of this Policy. Receipt and quality review of each behaviour support plan. Coordination of plan-specific induction. Preparation of monthly reports and incident notifications. Weekly and monthly review of behaviour support records. Maintenance of training records.
Behaviour support practitioner (external)	Development and revision of the participant’s behaviour support plan, including any fading plan. Provision of advice to Able to Thrive on implementation. Independent oversight of plan fidelity.
Lead worker / senior worker for the participant	Induction of allocated workers on the participant’s plan. Day-to-day implementation. Immediate response to any deviation or escalation. Real-time recording. Liaison with the practitioner.
Allocated workers	Implementation of the participant’s plan with fidelity. Real-time recording. Escalation of any concern. Compliance with the Staff Code of Conduct and this Policy.
HR Coordinator and Operations Manager — Kriz	Allocation only of trained and inducted workers to participants with behaviour support plans. Rostering arrangements that support fidelity.

17. Review of this Policy

This Policy is reviewed twelve months after Module 2a approval, and at least annually thereafter. The Policy is also reviewed out of cycle on any of the following: a change in the NDIS Restrictive Practices framework, the Behaviour Support Rules or the Practice Standards; a material change in the relevant NSW restrictive practices authorisation framework; an audit or Commission finding bearing on this Policy; or an incident involving the use of a restrictive practice that identifies a systemic gap.

ABLE TO THRIVE PTY LTD

Policy P-1.33

SPECIALIST DISABILITY ACCOMMODATION POLICY

Document control

Policy number	P-1.33
Policy title	Specialist Disability Accommodation Policy
Version	1.0 (new policy)
Date issued	November 2026
Status	Issued in support of Able to Thrive's application to vary its NDIS registration to include Module 5 (Specialist Disability Accommodation). This Policy becomes operational on approval of the variation and on enrolment of one or more SDA dwellings. Short-term accommodation arrangements currently provided by Able to Thrive through platform-sourced rentals (Airbnb / Booking.com) are not SDA and are managed under separate Short-Term Accommodation operating procedures.
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	Twelve months after Module 5 approval, or upon material change to the NDIS Specialist Disability Accommodation framework, the SDA Design Standard, or the relevant residential tenancy law in NSW
Related policies and documents	Conflict of Interest Policy (P-1.03); Incident Management Policy (P-1.06); Living Alone Risk Assessment Policy (P-1.31); Behaviour Support Implementation Policy (P-1.32); Privacy and Confidentiality Policy (P-1.30); Risk Management Policy (P-1.09); NDIS SDA Rules; NDIS SDA Design Standard; NDIS SDA Pricing Arrangements; Residential Tenancies Act 2010 (NSW)

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) provides Specialist Disability Accommodation (SDA) to NDIS participants. It addresses dwelling enrolment, design and maintenance, tenant rights, the separation of housing from supports, vacancy management, transitions, and the management of the conflict of interest where Able to Thrive provides both SDA and the supports delivered in it.

2. Scope and operational status

On approval of Module 5, this Policy applies to:

- every SDA dwelling enrolled by Able to Thrive with the National Disability Insurance Agency (NDIA);
- every participant who occupies an Able to Thrive SDA dwelling as a tenant or resident;
- all Able to Thrive workers, managers and Directors involved in the operation, maintenance or oversight of SDA;
- all property managers, builders, maintenance contractors and other parties engaged by Able to Thrive in connection with an SDA dwelling.

Until Module 5 is approved and at least one dwelling is enrolled with the NDIA as SDA, Able to Thrive does not deliver SDA. Existing short-term accommodation provided through platform-sourced rentals (Airbnb, Booking.com) is not SDA and continues to be managed under the Short-Term Accommodation operating procedures, which are distinct from this Policy.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020 and the NDIS SDA Operational Guideline.
- NDIS SDA Design Standard.
- NDIS Practice Standards and Quality Indicators, including the indicators relating to SDA.
- *Residential Tenancies Act 2010* (NSW) and the Residential Tenancies Regulation 2019 (NSW).
- *Boarding Houses Act 2012* (NSW) where applicable.
- *Work Health and Safety Act 2011* (NSW) — duties as a person conducting a business or undertaking and as the person with management or control of a workplace.

4. Definitions

- **Specialist Disability Accommodation (SDA)** means housing designed and built to meet the SDA Design Standard for participants with extreme functional impairment or very high support needs, as funded under the NDIS.
- **Dwelling** means a single SDA premises enrolled with the NDIA.
- **SDA enrolment** means the registration of a dwelling with the NDIA as eligible to attract SDA payments on behalf of a participant.
- **Design category** means one of the SDA design categories: Improved Liveability, Fully Accessible, Robust, High Physical Support.
- **SIL provider** means the provider of Supported Independent Living (SIL) supports delivered in the dwelling. The SIL provider may or may not be Able to Thrive.
- **Resident** means the participant who occupies the dwelling as their home, whether under a residential tenancy agreement, an occupancy agreement, or another arrangement consistent with NSW law.

5. Policy statement

Able to Thrive provides SDA dwellings that are physically suitable for the residents who live in them, safe, well-maintained, and respectful of each resident's rights, dignity, autonomy and choice. We treat each resident as the tenant of a home, not as a service recipient subject to the institutional culture of an earlier era of disability accommodation. The relationship between Able to Thrive and the resident in respect of housing is a tenancy relationship, governed by the Residential Tenancies Act 2010 (NSW) and the resident's SDA arrangement.

6. Separation of housing from supports

A foundational principle of SDA is that housing and supports are separable. The resident's housing (SDA, provided under this Policy) is distinct from the supports the resident receives in the dwelling (such as SIL, provided under a separate arrangement). Where Able to Thrive provides both the SDA and the supports, the two relationships are kept distinct in the following ways:

- **Separate agreements.** The resident has a residential tenancy or occupancy agreement for the housing, and a separate Service Agreement for the supports.
- **Separate decision-making.** The resident may end the supports without ending the housing arrangement, and may end the housing arrangement without ending the supports (subject to the requirements of each separate agreement and applicable law).
- **Separate choice of provider.** The resident may choose any SIL provider (or other support provider) for the supports delivered in the dwelling. The resident is not required to use Able to Thrive's supports because they are in an Able to Thrive

dwelling. The Conflict of Interest Policy (P-1.03) applies, including the Alternatives Offered Log.

- **Separate management.** The Able to Thrive worker(s) managing the dwelling on the housing side do not also direct the day-to-day supports delivered to the resident.

7. Dwelling enrolment and design

- Each Able to Thrive SDA dwelling is enrolled with the NDIA prior to any participant taking occupancy as SDA. Enrolment includes the dwelling's design category, the building type (apartment, villa, house, group home), and the maximum number of residents.
- Each dwelling is constructed (or, where existing, modified) in accordance with the SDA Design Standard for its design category. Certification by an SDA Design Assessor is obtained before enrolment.
- Material modifications to the dwelling after enrolment are not made without prior notice to the NDIA, certification by an SDA Design Assessor where required, and where applicable the consent of the resident.
- A register of enrolled dwellings is maintained by the Lead Compliance Officer and includes the dwelling address, design category, building type, capacity, enrolment date, current residents (with date of occupancy), and the relevant certification documents.

8. Tenancy arrangements

- Each resident enters into a residential tenancy agreement or occupancy agreement appropriate to the dwelling and to the resident's circumstances, in accordance with the Residential Tenancies Act 2010 (NSW), the Boarding Houses Act 2012 (NSW) where applicable, and the NDIS SDA framework.
- The agreement is provided to the resident in advance, in an accessible format, and discussed with the resident before signing. The resident is supported (by the resident's chosen support coordinator, a family member, an advocate or another supporter chosen by the resident) to understand the agreement.
- Rent and contribution amounts are set in accordance with the NDIS SDA framework. Where the SDA payment is made directly to Able to Thrive by the NDIA on the resident's behalf, the resident's contribution is in addition. The financial arrangement is explained in plain language.
- Bond requirements (where applicable) are dealt with in accordance with NSW residential tenancy law.
- Residents are given the same rights to peaceful enjoyment of their home as any other tenant in NSW, including the right to entry by appointment and reasonable privacy from inspection.

9. Rights and respect of residents

Each resident has the right to:

- live in their home with dignity, autonomy and privacy;
- have visitors of their choice, at times of their choice, consistent with the rights of other residents;
- decide how their home is decorated and arranged, consistent with the structural and safety requirements of the dwelling;
- decide what activities take place in their home and when;
- keep pets, where the dwelling and tenancy arrangement permit;
- choose, change or refuse any support provider, including Able to Thrive;
- engage in intimate, romantic and sexual relationships of their choosing, consistent with their consent and capacity;
- exercise their cultural, religious, political and other beliefs in their home;
- be free from violence, abuse, neglect, exploitation and discrimination;
- raise concerns and make complaints through the Feedback, Compliments and Complaints Policy (P-2.03) and (in respect of the tenancy) through the NSW Civil and Administrative Tribunal (NCAT).

10. Maintenance and safety of the dwelling

- Each dwelling is maintained to the SDA Design Standard for its design category throughout its life as an SDA dwelling. A scheduled maintenance plan is established for each dwelling.
- Urgent repairs (matters affecting safety, security, or essential services) are responded to within 24 hours.
- Non-urgent repairs are scheduled with the resident at a mutually convenient time.
- Annual inspection by an SDA Design Assessor (or equivalent qualified person) is conducted to confirm continued compliance with the Design Standard.
- WHS controls relevant to the dwelling as a workplace for workers providing supports are maintained, including the operation of any lifting equipment, ceiling tracks, smoke alarms, accessible egress, and emergency procedures.
- Insurance for the dwelling (building and public liability appropriate to SDA) is maintained, with current certificates of currency held by the Lead Compliance Officer.

11. Vacancy management

- Where a dwelling has a vacancy, the vacancy is advertised through appropriate channels and through engagement with support coordinators (internal and external) and prospective participants.

- The selection of a new resident is based on the resident's SDA eligibility, the fit between the dwelling and the resident's needs, the resident's choice, and (where applicable) compatibility with any other residents of a shared dwelling.
- Selection decisions are documented. Where Able to Thrive is also the prospective SIL provider, the Conflict of Interest Policy applies — the participant's choice of housing is not made conditional on their choice of supports.
- Reasonable notice and respectful conduct apply to viewings, applications and offers.

12. Transitions — move-in and move-out

12.1 Move-in

- A move-in plan is developed with the new resident, the resident's support coordinator, and any other party identified by the resident.
- The plan covers the resident's individual support arrangements (which may be delivered by Able to Thrive as SIL provider, by another provider, or by a mix), the schedule of move-in, the resident's personal effects, any required modifications or adjustments to the dwelling, and the social and orientation supports for the new resident.
- Where the resident is moving from an existing arrangement (family home, group home, hospital, other), Able to Thrive engages with the prior context to support continuity of supports during transition.

12.2 Move-out

- A move-out plan is developed in advance of the resident's departure. The plan addresses the resident's destination, the supports needed during and after the move, the handover of personal effects, the conclusion of the tenancy or occupancy arrangement under NSW law, and the closure of the Service Agreement (where Able to Thrive is also the support provider).
- Move-out is not used to remove a resident for reasons related to the resident's support arrangement choice. Termination of the tenancy or occupancy agreement is only effected on grounds consistent with NSW residential tenancy law.

13. Incidents involving the dwelling or its operation

Incidents that occur in or in relation to an SDA dwelling are managed under the Incident Management Policy (P-2.06). Where the incident is a Reportable Incident under section 73Z of the NDIS Act, notification to the NDIS Commission is made within the prescribed timeframes. Where the incident involves a tenancy matter (rent arrears, breach by either party, end-of-tenancy disputes), the matter is also dealt with under the Residential Tenancies Act, with NCAT engagement where required.

14. Privacy and information

Personal information about residents is managed under the Privacy and Confidentiality Policy (P-1.30) and the Information Management Policy (P-1.29). Information held about a resident's tenancy is not shared with the resident's support providers without the resident's consent, and vice versa, except where consent is not required (for example, for urgent safety matters).

15. Conflict of interest

Where Able to Thrive provides both SDA and the supports delivered in the dwelling, the conflict of interest is managed through the controls in the Conflict of Interest Policy (P-1.03) and through the separations set out in Section 6 of this Policy. In particular:

- the resident is informed in writing at the commencement of the tenancy that they may choose any support provider, including a provider other than Able to Thrive;
- the resident is informed that they may end one arrangement (housing or supports) without ending the other, subject to the terms of each agreement and applicable law;
- the support coordinator (whether internal or external) supports the resident's independent decision-making on these matters;
- the participant's ongoing satisfaction is checked by a person other than the support worker on a periodic basis, under the procedure that applies to all dual-service relationships.

16. Working with the resident, families and supporters

- Communication with the resident is in the resident's preferred mode and language.
- Family members, friends and advocates identified by the resident are engaged in decisions about the housing where the resident chooses this. Resident decisions are not deferred to family without the resident's consent.
- Where a resident has a substitute decision-maker for relevant matters, the substitute decision-maker is engaged in accordance with the scope of their authority.

17. Training and workforce arrangements

Workers who interact with SDA residents in connection with the dwelling (property managers, maintenance staff, the Lead Compliance Officer in respect of SDA) complete training in:

- the SDA framework and this Policy;
- the rights of residents as tenants;
- the separation of housing from supports;
- respectful interactions with residents;
- the Conflict of Interest Policy;
- the Incident Management Policy as it applies to SDA; and

- WHS in residents' homes as workplaces.

18. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for SDA compliance. Sign-off on dwelling enrolment and any material change. Liaison with NDIA and NDIS Commission on SDA matters. Resolution of disputes between the housing function and the support function within Able to Thrive.
Director (Finance) — Dante Michael	Financial oversight of SDA, including payment flows from the NDIA, resident contributions, maintenance budget, and insurance. Capital decisions on dwelling acquisition or modification.
Lead Compliance Officer	Owner of this Policy. Maintenance of the dwelling register. Coordination of certification, inspection and maintenance. Liaison with the SDA Design Assessor. Sign-off on resident communications about housing rights. Annual compliance review.
Property manager or housing operations lead (to be appointed on Module 5 approval)	Day-to-day operation of SDA dwellings. Tenancy agreements. Vacancy management. Maintenance coordination. Resident communication on housing matters. Distinct from the support delivery team.

19. Review of this Policy

This Policy is reviewed twelve months after Module 5 approval, and at least annually thereafter. The Policy is also reviewed out of cycle on any of the following: a change in the NDIS SDA framework or Design Standard; a change in NSW residential tenancy law; an audit or Commission finding bearing on SDA; or a material change in Able to Thrive's SDA portfolio.

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Policy P-1.34

CYBER SECURITY AND ACCEPTABLE USE POLICY

Document control

Policy number	P-1.34
Policy title	Cyber Security and Acceptable Use Policy
Version	1.0 (new policy)
Date issued	November 2026
Supersedes	Nil — new policy. Provides the technical control framework referenced by the Privacy and Confidentiality Policy (P-1.30) and the Information Management Policy (P-1.29).
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Director (Finance and Technology) — joint sign-off on technical matters	Dante Michael
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	November 2027, or upon material change to the threat landscape, the Essential Eight Maturity Model, the systems used, or following any cyber incident
Related policies and documents	Privacy and Confidentiality Policy (P-1.30); Information Management Policy (P-1.29); Staff Code of Conduct (P-1.26); Incident Management Policy (P-2.06); Risk Management Policy (P-1.09); Information Asset Register; Brevity, Microsoft 365, ClickUp vendor agreements

1. Purpose

This Policy sets the technical and behavioural controls that protect Able to Thrive Pty Ltd (Able to Thrive) and Able to Thrive Personnel Pty Ltd (Able to Thrive Personnel) information and systems against unauthorised access, loss, alteration, disclosure or disruption. It is the technical companion to the Privacy and Confidentiality Policy (which addresses the legal handling of personal information) and the Information Management Policy (which addresses records lifecycle and classification).

The Policy also defines acceptable use of Able to Thrive systems and devices by workers, including remote access by overseas-based workers.

2. Scope

This Policy applies to:

- all workers, contractors, Directors and third parties with access to Able to Thrive systems or information;
- all devices used to access Able to Thrive information, whether issued by Able to Thrive or personally owned;
- all systems holding Able to Thrive information, including Brevity, Microsoft 365 (Outlook, Teams, SharePoint), ClickUp, the finance system, the website CMS, mobile devices, and any other system from time to time used; and
- all locations from which access is made, including the Campsie head office, participants' homes, remote-worker locations in Australia, and the locations of overseas-based remote workers.

3. Legislative and regulatory framework

- *Privacy Act 1988* (Cth) and the Australian Privacy Principles (in particular APP 11 — security of personal information).
- Part IIIC of the Privacy Act (Notifiable Data Breaches scheme).
- *Criminal Code Act 1995* (Cth) — offences relating to unauthorised access to computer systems.
- Australian Cyber Security Centre (ACSC) Essential Eight Maturity Model as a methodological reference.
- NDIS Practice Standards (information management indicators).

4. Definitions

- **System** means any electronic platform used by Able to Thrive to hold, process or transmit information.
- **Device** means a computer, laptop, tablet, mobile phone or other piece of hardware used to access a system.

- **Multi-factor authentication (MFA)** means an authentication method requiring two or more separate factors (something the user knows, something the user has, or something the user is).
- **Cyber incident** means any event affecting the confidentiality, integrity or availability of a system or the information it holds, including malware, ransomware, unauthorised access, phishing success, accidental disclosure, lost device, denial of service, or any precursor to such an event.
- **Acceptable use** means the standards in Section 12 governing how workers use Able to Thrive systems and devices.

5. Policy statement

Able to Thrive treats cyber security as a discipline integrated with privacy, information management and risk. We implement controls proportionate to the sensitivity of our information and the threat landscape. Workers are partners in security, not bystanders — most incidents involve human factors, and prevention depends on every worker being aware, careful and willing to report concerns. Cyber incidents are managed promptly through the Incident Management Policy and, where applicable, the Notifiable Data Breaches process.

6. Access controls

- **Unique accounts.** Every worker is provisioned with their own user account for each system they need. Accounts are not shared.
- **Least privilege.** Access is granted to the minimum set of records and functions a worker needs to do their job. Administrative privileges are restricted to the workers who require them.
- **Multi-factor authentication.** MFA is enabled on every system holding Confidential or Highly Confidential information and on remote access to any Able to Thrive system. Exceptions require Director (Finance and Technology) approval.
- **Strong passwords.** Passwords meet the current ACSC guidance: at least 14 characters, unique per service, stored in a reputable password manager. Workers do not write down passwords or share them.
- **Periodic review.** User access is reviewed at least quarterly to confirm currency. Accounts of workers who have separated, or whose role has changed materially, are adjusted promptly (Section 13).
- **Audit logging.** Where systems support audit logging (Brevity, Microsoft 365), logging is enabled and reviewed periodically for unusual activity.

7. Device security

- **Endpoint protection.** All devices used to access Able to Thrive systems run current operating systems with security updates installed within seven days of release, anti-malware protection, and disk encryption.

- **Screen lock.** Devices are configured to lock automatically after no more than ten minutes of inactivity. Workers lock their devices when stepping away.
- **Issued devices.** Where Able to Thrive issues a device, the device is enrolled in the organisation's management framework, configured with the required controls, and may be remotely wiped on loss or separation.
- **Personally-owned devices (BYOD).** Workers using personally-owned devices for work confirm in writing that the device meets the requirements (current OS, encryption, anti-malware, screen lock) and accept that Able to Thrive may require remote wipe of work data on separation or device loss.
- **Mobile devices.** Phones and tablets used for work require PIN or biometric unlock. Photographs of participant records or screens are not taken on personal devices.
- **Lost or stolen device.** The worker reports loss or theft to the Lead Compliance Officer within four hours of becoming aware. The Lead Compliance Officer initiates remote wipe and assesses whether a data breach has occurred.

8. Network and remote access

- Remote access to Able to Thrive systems is made through authenticated channels (cloud services with MFA; VPN or equivalent where required).
- Workers do not access Able to Thrive systems over open public Wi-Fi without an authenticated, encrypted connection. Tethering or trusted networks are preferred.
- Overseas-based workers (currently including HR Coordinator and Operations Manager Kriz, Finance Manager Alex, and Admin Mikha) access systems through the same authenticated channels and are subject to the same controls as locally-based workers. Cross-border disclosure is recorded against APP 8 under the Privacy and Confidentiality Policy.
- Remote access is logged where the system supports it. Unusual login patterns (impossible travel, multiple failed attempts, access from unfamiliar locations) are investigated by the Lead Compliance Officer and the technology lead.

9. Email, phishing and social engineering

- Workers exercise caution with every email or message. They do not click links or open attachments from unknown senders, and they verify any request to change banking details, transfer funds, share credentials, or release personal information through a separate trusted channel.
- Suspected phishing or social engineering messages are reported to the Lead Compliance Officer or the technology lead. Reports are encouraged even where the worker is unsure; no worker is criticised for raising a false alarm.
- Workers do not use personal email accounts to conduct Able to Thrive business or to transmit Able to Thrive information.
- Mailing rules that auto-forward Able to Thrive email to external addresses are not configured by individual workers without approval.

10. Cloud services and third-party systems

- Able to Thrive uses cloud-hosted systems for most categories of record. New cloud services or material changes to existing services are reviewed for security posture, contractual protections, hosting location, encryption, access controls and breach notification before adoption. This review is led by the Director (Finance and Technology) with the Lead Compliance Officer.
- The Information Asset Register (under the Information Management Policy) records each cloud service, its data categories, classification and review date.
- Vendor security incidents are taken as Able to Thrive incidents until the contrary is established. Cyber Incident Response (Section 14) is initiated.
- On termination of a vendor relationship, data is returned to Able to Thrive or destroyed by the vendor in accordance with the contract, and confirmation is obtained.

11. Backups, patching and resilience

- Critical records are backed up on a regular schedule appropriate to their criticality. Backups are tested for recoverability at least annually.
- Operating systems and applications are patched on a defined schedule. Security patches are applied within seven days of release; other patches at scheduled maintenance windows.
- Recovery time and recovery point objectives are documented in the Business Continuity Plan for the principal systems (Brevity, Microsoft 365, the finance system).
- Recovery is rehearsed periodically.

12. Acceptable use

12.1 General

- Able to Thrive systems and devices are provided for work purposes. Limited personal use is acceptable where it does not interfere with work, does not consume excessive resources, and does not breach any other policy.
- Workers do not use Able to Thrive systems to access, store, send or share unlawful content, including material that is sexually explicit, discriminatory, harassing, defamatory, or that infringes copyright.
- Workers do not install software on issued devices without approval. Approval is given by the technology lead.
- Workers do not bypass or attempt to bypass any security control.

12.2 Generative AI and external services

Generative AI tools and other external services that process information are useful but introduce risk. The following rules apply:

- Confidential or Highly Confidential information (including participant names, identifiers, plan information, health information, incident records, complaint records) is not entered into any public or consumer-grade generative AI tool (such as the public versions of ChatGPT, Gemini, Claude or similar).
- Where a generative AI service is approved by the Director (Finance and Technology) for use with sensitive information (typically because it is a contracted enterprise tier with appropriate data handling commitments), the conditions of use are recorded in the Information Asset Register.
- Outputs from generative AI tools are verified by the worker before use. Workers retain professional responsibility for the work product.

12.3 Social media

- Workers do not post participant information, photographs or video on personal social media (this is also a Staff Code of Conduct requirement).
- Workers do not present themselves on personal social media in a manner inconsistent with the Staff Code of Conduct.
- Public communication on behalf of Able to Thrive (media, sector commentary) is approved by the Directors.

13. Worker lifecycle — provisioning, change and separation

- **Provisioning.** New worker accounts are created with least-privilege access based on the role. Account creation is documented.
- **Change of role.** Where a worker's role changes, access is adjusted to match the new role. Old privileges are removed.
- **Separation.** On separation (resignation, termination, end of engagement), access is removed promptly. Issued devices are returned. Where personal devices were used (BYOD), Able to Thrive work data is wiped from the device. Confirmation of these steps is recorded in the worker's separation file.
- **Contractor and consultant access.** Time-limited, scoped to the engagement, and removed on conclusion.

14. Cyber incident response

Where a cyber incident occurs (or is suspected), the worker who becomes aware reports it to the Lead Compliance Officer immediately. The Lead Compliance Officer:

- **Contains** — disconnects affected devices, suspends compromised accounts, isolates the affected system or service to prevent further impact.
- **Assesses** — works with the technology lead and (where appropriate) external incident response support to understand the scope, the cause and the data involved.
- **Notifies** — assesses the matter against the Privacy and Confidentiality Policy (notifiable data breach), the Incident Management Policy (Reportable Incident affecting participant records), and applicable law. Notifications to the Office of the

Australian Information Commissioner, the NDIS Commission, the Australian Cyber Security Centre (where relevant), and affected individuals are made within the timeframes required.

- **Recovers** — restores affected systems and data, applies any patches or configuration changes required to prevent recurrence.
- **Learns** — records the incident in the Continuous Improvement Register with corrective actions, owners and due dates. Briefs the Directors.

The Director (Compliance) signs off on every external notification under this Policy. The Director (Finance and Technology) is the second signatory on technical aspects.

15. Training and awareness

All workers complete training in this Policy at induction. Training covers password hygiene, MFA, phishing recognition, device security, acceptable use, generative AI rules, and reporting expectations. Refresher training is delivered at least annually. The Lead Compliance Officer also runs periodic phishing simulations and awareness communications.

16. Monitoring and audit

- Audit logs are reviewed periodically by the technology lead with the Lead Compliance Officer.
- Access reviews are conducted quarterly (Section 6).
- Vulnerability scans on critical systems are conducted at least annually, or whenever there is a material change in the technology environment.
- An annual cyber security review is conducted by the Directors, assessing maturity against the Essential Eight or an equivalent framework, identifying gaps, and authorising the improvement program for the following year.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Sign-off on every external notification of a cyber incident. Liaison with regulators on cyber matters that affect participants. Sign-off on the annual cyber security review.
Director (Finance and Technology) — Dante Michael	Owner of technical control selection and implementation. Approval of new cloud services and material changes. Approval of any exception to MFA or other technical controls. Second signatory on cyber incident notifications.
Lead Compliance Officer	Owner of this Policy. Coordination of quarterly access

	reviews, vendor reviews, audit log reviews and the annual cyber security review. First responder for cyber incidents. Training records. Coordination of phishing simulations.
Technology lead (function within the Finance and Technology portfolio)	Day-to-day technical implementation of the controls in this Policy. Patch and update scheduling. Endpoint configuration. Incident technical response. Backup and recovery operations.
All workers	Compliance with the controls. Reporting of incidents, near-misses, suspicious messages, and lost devices. Participation in training. Accountable for the use of their accounts.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on any of the following: a material change in the threat landscape; a cyber incident affecting Able to Thrive; a change in the Essential Eight Maturity Model or equivalent guidance; a material change in the systems used; or an audit finding bearing on cyber security.

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Policy P-2.03

FEEDBACK, COMPLIMENTS AND COMPLAINTS POLICY

Document control

Policy number	P-2.03
Policy title	Feedback, Compliments and Complaints Policy
Version	2.0
Date issued	May 2026
Supersedes	Feedback, Compliments and Complaints Policy and Procedure (Section 2.3 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to the NDIS complaints management requirements, Practice Standards, or organisational structure
Related policies and documents	Incident Management Policy (P-2.06); Conflict of Interest Policy (P-1.03); Privacy and Confidentiality Policy; Brevity case management system; NDIS Code of Conduct; Complaints Register; Complaint Acknowledgement Letter template

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) seeks, receives, responds to and learns from feedback, compliments and complaints from participants, their families and representatives, support coordinators, workers, partners and the public.

The Policy gives effect to Able to Thrive's obligations under section 73W of the NDIS Act to implement and maintain a complaints management and resolution system, and to the

requirements prescribed under section 73X by the National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018.

2. Scope

This Policy applies to:

- all feedback, compliments and complaints received in connection with the supports delivered by Able to Thrive;
- all Able to Thrive workers, including support workers engaged through Able to Thrive Personnel Pty Ltd, employees, contractors and management; and
- all participants, families and representatives, support coordinators, partner organisations, suppliers, and members of the public who interact with Able to Thrive.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth), sections 73W and 73X.
- National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018.
- NDIS Code of Conduct.
- NDIS Practice Standards and Quality Indicators relating to feedback and complaints.
- *Privacy Act 1988* (Cth) and the Australian Privacy Principles.
- *Australian Consumer Law*, where applicable.

4. Definitions

- **Feedback** means any comment, suggestion or observation about Able to Thrive’s supports, services, operations or people.
- **Compliment** means an expression of satisfaction or appreciation in respect of Able to Thrive’s supports, services, operations or people.
- **Complaint** means an expression of dissatisfaction with a support, service, decision, action, omission or person, in respect of which a response or resolution is explicitly or implicitly expected.
- **Complainant** means a person who has raised a complaint, whether identified or anonymous, and whether or not they are the person directly affected.
- **Resolution** means the outcome of complaint handling, which may include explanation, apology, change in practice, financial remedy, training, disciplinary action, or other measures appropriate to the complaint.

5. Policy statement

Able to Thrive welcomes feedback, compliments and complaints. Complaints are treated as an important source of learning, not as a threat. Every participant has a right to make a complaint, in any form, about any aspect of the support they receive, and to do so without

fear of retaliation. Every complaint is acknowledged, taken seriously, and handled in accordance with this Policy.

Able to Thrive does not require complainants to use a particular form, channel or language. We adapt to the complainant's preferred mode of communication. Anonymous complaints are accepted and dealt with on the available information.

6. Principles

- **Accessibility.** Complaints may be made in any form and in any language. We provide interpreters, Easy Read materials, accessible formats and advocacy support on request.
- **Responsiveness.** Complaints are acknowledged promptly and resolved as quickly as the circumstances allow.
- **Procedural fairness.** All parties to a complaint are given an opportunity to be heard. Decisions are based on evidence and explained in writing.
- **No retaliation.** Complainants do not experience any adverse change in the supports they receive as a consequence of making a complaint.
- **Privacy.** Personal information is handled in accordance with the Privacy and Confidentiality Policy. Information is shared only with those who need it to handle the complaint.
- **Choice of channel.** Complainants may complain directly to Able to Thrive, to the NDIS Quality and Safeguards Commission, or to both. We support either choice.
- **Continuous improvement.** Themes and patterns identified through complaints feed into the Continuous Improvement Register.

7. Channels for making a complaint

A complaint may be made to Able to Thrive through any of the following channels:

- **Direct to any Able to Thrive worker** — verbally, in writing, or in any other accessible form. The worker is responsible for recording the complaint and escalating it under Section 8.
- **Phone** — 1300 095 012.
- **Email** — accounts@abletothrive.com.au or such other complaints email address as Able to Thrive may publish from time to time.
- **Post** — Lead Compliance Officer, Able to Thrive Pty Ltd, B103/548–568 Canterbury Rd, Campsie NSW 2194.
- **In person** — at the Able to Thrive head office in Campsie, by appointment or otherwise.
- **Website** — through the feedback and complaints form at www.abletothrive.com.au.

A complaint may also be made through a participant's support coordinator, family member, advocate or other representative on the participant's behalf. With the participant's consent, that representative is the point of contact during the resolution process.

Complainants are also informed that they may make a complaint directly to the NDIS Quality and Safeguards Commission at 1800 035 544, on the Commission's online complaint form, or by post to PO Box 210, Penrith NSW 2751. Making a complaint to the NDIS Commission does not prevent a complaint also being made to Able to Thrive (or vice versa).

8. Complaint handling procedure

8.1 Receipt and acknowledgement

On receipt of a complaint, the worker or manager who receives it records the complaint in the Brevity case management system within the same shift or business day. The Lead Compliance Officer is automatically notified through Brevity workflow.

The complaint is acknowledged in writing to the complainant within one business day of receipt. The acknowledgement:

- confirms receipt of the complaint;
- records the substance of the complaint as Able to Thrive understands it;
- names the person handling the complaint and provides their contact details;
- explains the steps that will be taken;
- explains the expected timeframe; and
- reminds the complainant of their right to also complain to the NDIS Commission and provides the Commission's contact details.

Where the complaint is made anonymously, an acknowledgement is filed on the Brevity record but is not sent to the complainant.

8.2 Initial triage and classification

Within two business days of receipt, the Lead Compliance Officer classifies the complaint as one of:

- **Low complexity** — typically resolvable through explanation or immediate corrective action within seven business days.
- **Medium complexity** — requiring some investigation and resolvable within twenty business days.
- **High complexity** — involving allegations of significant harm, abuse, neglect, or a possible breach of the NDIS Code of Conduct, requiring detailed investigation. High-complexity complaints are also reviewed against the Incident Management Policy and may need to be notified to the NDIS Commission under the Reportable Incidents framework.

The complainant is informed of the classification and the expected timeframe.

8.3 Investigation and resolution

The complaint is investigated by the Lead Compliance Officer. Where the complaint involves the Lead Compliance Officer, the Director (Compliance) appoints another investigator (internal or external). The investigation includes:

- review of records relating to the matter (participant file, incident reports, communications);
- discussion with the complainant to clarify the substance and the outcome sought;
- discussion with any worker, manager or external party involved;
- analysis of any systemic factors;
- formulation of findings and proposed resolution; and
- review of the proposed resolution with the Director (Compliance) before finalisation, for medium- and high-complexity complaints.

8.4 Outcome and communication

The outcome is communicated to the complainant in writing within the applicable timeframe. The written outcome:

- explains what Able to Thrive found;
- states the resolution (which may include explanation, apology, change in practice, refund or financial remedy where appropriate, training, disciplinary action, or other measures);
- confirms the steps to be taken and by when;
- describes the participant's right to seek internal review under Section 9; and
- reminds the complainant of the right to escalate to the NDIS Commission.

8.5 Implementation and closure

Agreed actions are tracked through to completion. The complaint is closed in Brevity only when the complainant has been informed of the outcome and any agreed actions have been completed (or, for ongoing actions, are recorded in the Continuous Improvement Register).

9. Internal review

A complainant who is dissatisfied with the outcome of their complaint may request internal review. Internal review is conducted by a person who was not involved in the original handling of the complaint. By default, internal review is conducted by the Director (Compliance) — or, where the Director was involved in the original handling, by the other Director.

Internal review focuses on:

- whether the original handling followed this Policy;
- whether the findings were supported by the evidence; and
- whether the resolution was appropriate in the circumstances.

The outcome of internal review is communicated to the complainant in writing within fifteen business days of the request. Internal review does not exclude or replace the complainant's right to complain to the NDIS Commission.

10. Linkage with other policies

- **Incident Management Policy** — complaints alleging harm, abuse or neglect are also handled as incidents and may be Reportable Incidents.
- **Conflict of Interest Policy** — complaints about the management of conflicts of interest are handled under this Policy with input from the Lead Compliance Officer's conflict-of-interest oversight role.
- **Disputes and Grievances Policy** — internal disputes between workers are handled under that Policy. Where a worker raises a complaint about the supports being provided to a participant, this Policy applies.
- **Privacy and Confidentiality Policy** — personal information collected through complaint handling is managed under that Policy.

11. Feedback and compliments

Feedback and compliments are recorded in Brevity and acknowledged. Compliments concerning a particular worker are passed to that worker and to their manager. Themes from feedback are reviewed quarterly by the Lead Compliance Officer and reported to the Directors. Where feedback identifies an opportunity for improvement, the matter is recorded in the Continuous Improvement Register with an owner and a due date.

12. Anonymous and third-party complaints

Anonymous complaints are accepted. Able to Thrive investigates them on the available information and records the outcome in the Brevity register. The complainant is not contactable about the outcome but the matter is acted on internally.

Third-party complaints (made by a person other than the participant directly affected) are accepted. Where the participant directly affected can be identified and has not consented to the complaint being made, Able to Thrive considers the complaint on the available information while protecting the participant's rights and privacy.

13. Protection from retaliation

Making a complaint does not affect the supports a participant receives from Able to Thrive. Workers who handle complaints are required to engage with complainants in the same professional manner as before the complaint. Any conduct that could amount to retaliation against a complainant — whether by reducing supports, changing arrangements adversely, or treating the complainant differently — is itself a breach of this Policy and may lead to disciplinary action up to and including termination.

14. Record keeping

- Complaints, feedback and compliments are recorded in Brevity at the time of receipt.

- A Complaints Register is maintained by the Lead Compliance Officer, summarising complaints received, classifications, outcomes, timeframes, and any escalations to the NDIS Commission.
- Complaint records are retained for not less than seven years from the date the complaint is closed.
- Records are managed in accordance with the Privacy and Confidentiality Policy.

15. Reporting and continuous improvement

The Lead Compliance Officer reports on complaints handling at each scheduled Director meeting, including:

- the number of complaints received in the period and a comparison to prior periods;
- classifications, timeframes met, and any breaches of timeframe;
- themes and trends;
- actions taken and outcomes for the period; and
- any matter escalated to the NDIS Commission or another regulator.

Themes identified through complaints are fed into the Continuous Improvement Register and inform updates to policies, procedures and training. The Lead Compliance Officer presents an annual Complaints Summary to the Directors as part of the Annual Compliance Report.

16. Training and awareness

All workers complete training in this Policy at induction. Training covers:

- the participant's right to complain;
- how to recognise a complaint, including complaints that are not framed as such;
- what to do when a complaint is raised — recording in Brevity, escalation, and protection from retaliation;
- how to support participants to make a complaint if they wish; and
- the role of the NDIS Commission.

Refresher training is delivered at least annually. Information for participants about the complaints process is provided at intake and is also available on the Able to Thrive website and at the head office reception.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Qualified compliance lead. Sign-off on the resolution of medium- and high-complexity complaints. Conduct of internal reviews (where not original handler). Annual Complaints Summary to the Board.

Lead Compliance Officer	Owner of this Policy. Classification, investigation and resolution of complaints. Maintenance of the Complaints Register. Quarterly reporting to the Directors. Coordination with the NDIS Commission where matters are escalated.
Client Services and Acquisition — Akash	In-person Sydney handling of complaints raised face-to-face. Liaison with participants and external Support Coordinators during the resolution process.
HR Coordinator and Operations Manager — Kriz	Engagement with workers named in complaints, separation of complaint handling from performance management, and any rostering adjustments required during a complaint.
All workers	Recognition and recording of complaints, escalation to the Lead Compliance Officer, professional and non-retaliatory engagement with complainants, and participation in investigation as required.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in the NDIS complaints management rules; a complaint that identifies a systemic gap in this Policy; or a material change in the way Able to Thrive operates.

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Policy P-2.06

INCIDENT MANAGEMENT POLICY

Document control

Policy number	P-2.06
Policy title	Incident Management Policy
Version	2.0
Date issued	May 2026
Supersedes	Incident Management Policy and Procedure (Section 2.6 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to the NDIS Reportable Incidents Rules, the Practice Standards, or the way Able to Thrive operates its incident management system
Related policies and documents	Suicide Prevention and Response Policy (P-2.21); Living Alone Risk Assessment Policy (P-1.31); Feedback, Compliments and Complaints Policy (P-2.03); Child Safety Policy; Risk Management Policy; Workplace Incident Management Policy; Privacy and Confidentiality Policy; Brevity incident management system; NDIS Code of Conduct

1. Purpose

This Policy establishes Able to Thrive Pty Ltd's (Able to Thrive) incident management system. It sets out how incidents are identified, reported, classified, investigated, resolved, and used to improve the quality of supports delivered to participants.

The Policy gives effect to Able to Thrive's obligation under section 73Y of the NDIS Act to implement and maintain an incident management system, and to its obligations under

section 73Z and the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 in respect of Reportable Incidents.

2. Scope

This Policy applies to:

- all Able to Thrive workers, including support workers engaged through Able to Thrive Personnel Pty Ltd, employees, contractors and management;
- every incident occurring in connection with the delivery of NDIS supports to a participant by Able to Thrive, including in the participant's home, in the community, at STA accommodation, at school holiday programs, and during any other service delivery;
- incidents that occur outside service delivery but that come to Able to Thrive's attention and may affect a participant's safety, wellbeing or supports.

Workplace incidents affecting Able to Thrive workers (including injuries, near-misses and WHS matters) are managed under the Workplace Incident Management Policy. Both policies apply where an incident affects both a participant and a worker.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth), sections 73Y and 73Z.
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.
- NDIS Code of Conduct.
- NDIS Practice Standards and Quality Indicators, including the indicators relating to incident management.
- *Children and Young Persons (Care and Protection) Act 1998* (NSW) — mandatory reporting where the participant is a child.
- *Coroners Act 2009* (NSW) — coronial reporting in the event of a death.
- *Work Health and Safety Act 2011* (NSW).

4. Definitions

- **Incident** means any of: an acute event or change in circumstances affecting a participant's safety, wellbeing or supports; a near-miss event; an event affecting Able to Thrive's ability to deliver services to a participant; or an alleged or actual breach of the NDIS Code of Conduct by an Able to Thrive worker.
- **Reportable Incident** has the meaning given by section 73Z of the NDIS Act and the Reportable Incidents Rules. The categories are listed in Section 6.2 of this Policy.
- **Immediate notification** means a notification submitted to the NDIS Commission within 24 hours after Able to Thrive becomes aware of the incident.
- **5-day notification** means a written report submitted to the NDIS Commission within five business days after Able to Thrive becomes aware of the incident.

- **Key personnel** means the Directors and any senior managers responsible for executive decisions, as notified to the NDIS Commission under sections 13 and 13A of the Provider Registration and Practice Standards Rules.

5. Policy statement

Able to Thrive maintains an incident management system designed to identify and respond to incidents promptly, to protect participants from harm, to support workers, to meet the organisation's legal and regulatory obligations, and to learn systemically from what occurs.

Every worker has a duty to report incidents and a right to do so without fear of retaliation. Every incident is taken seriously, recorded in Brevity, and reviewed by management. Reportable Incidents are notified to the NDIS Commission within the timeframes set by the Reportable Incidents Rules.

6. Categories of incidents

6.1 Internal incidents

Internal incidents include any incident managed under this Policy that does not meet the threshold for a Reportable Incident. Examples include: minor injuries to participants not requiring medical treatment; medication administration errors that did not cause harm; behavioural incidents not involving alleged abuse or neglect; service-delivery failures (missed shifts, equipment failures, transport disruptions); and near-misses.

Internal incidents are recorded, reviewed and used for continuous improvement. They may, on further information, be reclassified as Reportable Incidents (see Section 10.3).

6.2 Reportable Incidents

The following categories of incidents are Reportable Incidents under section 73Z of the NDIS Act and the Reportable Incidents Rules. Where an incident in any of these categories has occurred, or is alleged to have occurred, in connection with the provision of supports or services by Able to Thrive, it is notified to the NDIS Commission in accordance with Section 11.

- **(a) Death** — the death of a person with disability.
- **(b) Serious injury** — serious injury of a person with disability. Serious injury includes injury requiring inpatient medical treatment, fractures, burns, deep wounds, and injury requiring resuscitation or causing loss of consciousness.
- **(c) Abuse or neglect** — abuse or neglect of a person with disability. This includes physical, emotional or psychological abuse; financial abuse; and neglect of basic needs.
- **(d) Unlawful sexual or physical contact or assault** — unlawful sexual or physical contact with, or assault of, a person with disability (excluding contact with, or impact on, the person that is trivial or negligible).

- **(e) Sexual misconduct** — sexual misconduct committed against, or in the presence of, a person with disability, including grooming for sexual activity.
- **(f) Use of a restrictive practice** — use of a restrictive practice in relation to a person with disability that is either not authorised under a behaviour support plan or used in a manner not in accordance with such a plan. Able to Thrive is not currently registered for restrictive practices; any use of a restrictive practice in connection with our supports would be Reportable.

7. Identification and immediate response

7.1 Immediate priorities

At the point of an incident, the worker's immediate priorities are, in order:

- the safety of the participant;
- the safety of any other person at the scene, including the worker;
- contacting emergency services (000) where required;
- preserving the scene if the incident may be subject to investigation by police or other authorities;
- notifying Able to Thrive management; and
- documenting what occurred.

7.2 Specialist policies

Where the incident relates to suicidal ideation, an attempt at self-harm, or a participant death by suicide, the Suicide Prevention and Response Policy (P-2.21) applies. Where the incident involves a participant who lives alone and receives sole-worker personal support, the Living Alone Risk Assessment Policy (P-1.31) is also engaged for review. Where the incident involves a child, the Child Safety Policy applies.

7.3 After-hours response

Outside business hours, the worker contacts the after-hours response line. The escalation pathway is documented and not dependent on any single person:

- In-person Sydney response — Akash, Client Services and Acquisition.
- Director on-call for serious matters — Eyad Shadid, Director (Compliance).
- Remote coordination across time zones — Kriz, HR Coordinator and Operations Manager.

For any incident that may be a Reportable Incident, the worker contacts the Director (Compliance) immediately without delay, irrespective of time of day.

8. Worker reporting procedure

8.1 When to report

Workers report every incident regardless of perceived severity. Timeframes:

- **Immediate verbal notification to a manager** — for any incident involving actual or suspected harm, any incident that may be a Reportable Incident, and any matter requiring urgent management attention.
- **Brevity incident report submitted** within the same shift, and in any event no later than the end of the next business day after the incident.

8.2 What the report must include

- participant identifiers and NDIS number;
- date, time and location of the incident;
- the worker's description of what occurred, including direct quotes from the participant where possible;
- any injuries observed and any first aid or medical attention provided;
- immediate actions taken (including emergency services if contacted);
- persons notified and at what time;
- any witnesses and their contact details;
- photographs of the scene or injury where relevant and permitted by the participant; and
- the worker's name, role and signature.

The Brevity incident report is the primary record. Verbal accounts and supplementary notes are added to the Brevity record by the worker or by the manager who took the verbal report.

9. Management response

9.1 Initial triage

On receipt of an incident report, the assigned manager (in business hours, the Lead Compliance Officer; out of business hours, the on-call Director or delegate) triages the incident within four business hours and:

- confirms participant safety;
- confirms that immediate actions required at the scene have been taken;
- makes an initial assessment of whether the incident may be a Reportable Incident; and
- determines whether further information is required and, if so, who will obtain it and by when.

9.2 Classification

Within 24 hours of the incident report being submitted (or within four hours where the matter may be a Reportable Incident), the Lead Compliance Officer classifies the incident as one of:

- an Internal Incident (managed under this Policy without external notification);
- a Reportable Incident (Section 11 applies);
- a Workplace Incident (the Workplace Incident Management Policy applies in parallel); or
- a Complaint (the Feedback, Compliments and Complaints Policy applies in parallel).

A single matter may engage more than one category; in that case, all applicable policies are followed concurrently.

9.3 Reclassification

Where further information becomes available that changes the nature of the incident, the classification is revised by the Lead Compliance Officer and the change is recorded in the Brevity record. Where reclassification results in the incident becoming a Reportable Incident, the notification to the NDIS Commission is made within 24 hours of the reclassification.

10. Reportable Incident notification to the NDIS Commission

10.1 Immediate notification (within 24 hours)

For every Reportable Incident, Able to Thrive submits an immediate notification to the NDIS Commission through the NDIS Commission Portal within 24 hours after becoming aware of the incident. The Director (Compliance) is the named key personnel responsible for ensuring the notification is made within time. The Lead Compliance Officer prepares the notification.

The immediate notification includes the information required by the Reportable Incidents Rules, including but not limited to: the nature of the incident; the time, date and place; the persons involved; immediate actions taken; and the proposed further actions.

10.2 5-day notification

Within five business days of becoming aware of the Reportable Incident, Able to Thrive submits a written report to the NDIS Commission containing the matters required by the Reportable Incidents Rules, including the further information gathered since the immediate notification and the steps taken to support and protect the affected participant.

10.3 Death of a participant

The death of any person with disability who was receiving NDIS supports from Able to Thrive is notified to the NDIS Commission immediately on becoming aware of the death, regardless of cause and regardless of whether the death occurred during service delivery. The Coronial obligations under the Coroners Act 2009 (NSW) are addressed concurrently. The Director (Compliance) is the single point of liaison with police, the coroner and the NDIS Commission. No records are altered or destroyed.

10.4 Further information

Able to Thrive cooperates with the NDIS Commission in the investigation of any Reportable Incident, including by providing further information within the timeframes specified, making workers available for interview, and providing documents on request.

11. Investigation

11.1 When to investigate

Every Reportable Incident is investigated. Internal Incidents are investigated where there is evidence of a systemic issue, a pattern of similar incidents, or a possible breach of the NDIS Code of Conduct.

11.2 Who investigates

Investigations are conducted by the Lead Compliance Officer, or by an external investigator engaged by Able to Thrive where the matter is serious or where independence requires it (including any incident where the Lead Compliance Officer was involved). The investigator is independent of the workers and managers directly involved in the incident.

11.3 Investigation method

- review of the Brevity record, any supplementary documents and any contextual records (participant file, behaviour support plan, recent incident history);
- interviews with the participant (where appropriate, with consent, and with a support person), workers, witnesses, and any external parties;
- review of relevant policies and procedures;
- analysis of any systemic factors (training, supervision, resourcing, policy clarity); and
- formulation of findings and recommendations.

11.4 Findings and recommendations

Findings and recommendations are documented in an Investigation Report. The Report is reviewed by the Director (Compliance) and, for Reportable Incidents, provided to the NDIS Commission as part of the 5-day notification or subsequent reporting. Recommendations are tracked through the Continuous Improvement Register.

12. Participant and family involvement

The participant affected by an incident, and the participant's representative or family where the participant consents (or where consent is not required because of the nature and seriousness of the matter), are:

- informed about the incident, the actions taken, and the outcomes;
- given the opportunity to be heard during the investigation;

- informed of their right to make a complaint through the Feedback, Compliments and Complaints Policy and to escalate any concern to the NDIS Commission directly;
- offered any further support that may be appropriate, including additional services, referrals, or changes to their supports; and
- provided with information in an accessible format.

13. Worker support

Workers involved in incidents are supported by Able to Thrive through:

- debrief with management within 24 hours for serious or distressing incidents;
- access to confidential external counselling through the Employee Assistance Program;
- time off as appropriate, agreed with the HR Coordinator and Operations Manager;
- separation of investigation from performance management: workers are clearly informed whether a discussion is part of an investigation, a performance discussion, or both; and
- protection from retaliation for reporting an incident in good faith.

14. Corrective action and continuous improvement

Corrective actions arising from incidents and investigations are recorded in the Continuous Improvement Register with named owners, due dates and progress notes. The Register is reviewed at each scheduled Director meeting. Trends across multiple incidents are reviewed quarterly by the Lead Compliance Officer and reported to the Directors. Material trends inform updates to this Policy, related policies, training and supervision arrangements.

15. Record keeping

- Brevity incident records are retained for not less than seven years from the date of the incident.
- Investigation Reports and supporting evidence are retained for not less than seven years from the date the investigation is closed.
- Reportable Incident notifications and supporting correspondence with the NDIS Commission are retained for not less than seven years from the date of submission.
- No records are altered or destroyed where the matter is, or may be, the subject of any ongoing investigation, coronial process, or proceedings.

16. Training

All workers complete training in this Policy as part of induction before delivering any service. Training covers:

- the categories of incidents (including the Reportable Incident categories) and how to recognise them;

- the worker reporting procedure, with practical exercises in using Brevity;
- the after-hours escalation pathway;
- the linkage to the Suicide Prevention, Living Alone and Child Safety policies; and
- the worker's right to report without retaliation.

Refresher training is delivered at least annually and after any material change to this Policy or to the Reportable Incidents Rules. Training completion is recorded against each worker's file.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Director on-call for serious incidents. Sign-off on all Reportable Incident notifications to the NDIS Commission. Liaison with police, coroner, NDIS Commission and external investigators. Final decision-making on classification disputes and on engagement of external investigators.
Lead Compliance Officer	Owner of this Policy. Triage and classification of incidents. Preparation of Reportable Incident notifications under Director sign-off. Investigation lead for most matters. Maintenance of the Continuous Improvement Register entries arising from incidents. Quarterly trend reporting to the Directors.
Client Services and Acquisition — Akash	In-person Sydney on-call response. First-response support to workers at the scene where access is feasible. Liaison with participants and families during and after incidents. Coordination of follow-up contact.
HR Coordinator and Operations Manager — Kriz	Remote coordination across time zones. Roster adjustments, worker reassignment and supervision arrangements arising from incidents. Liaison with workers regarding time off, EAP access and debrief.
Admin (Compliance and HR) — Mikha	Administrative support for incident records. Maintenance of the Brevity workflow. Tracking of notification timeframes. Filing of correspondence with the NDIS Commission.
All workers	Immediate response priorities under Section 7. Worker reporting procedure under Section 8. Honest engagement with investigations. Compliance with corrective actions.

18. Audit and monitoring

- The Lead Compliance Officer monitors compliance with this Policy continuously and reports a summary at each scheduled Director meeting.
- A quarterly internal audit reviews a sample of incident records, classification decisions, notification timeliness and corrective action completion.
- An annual external review may be commissioned by the Directors where warranted.
- NDIS Commission audit findings and recommendations are recorded against this Policy and tracked through the Continuous Improvement Register.

19. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in the NDIS Reportable Incidents Rules; an audit or NDIS Commission finding bearing on this Policy; a Reportable Incident that identifies a systemic gap; or a material change in Able to Thrive’s service mix.

ABLE TO THRIVE PTY LTD

Policy P-2.07

MEDICATION MANAGEMENT POLICY

Document control

Policy number	P-2.07
Policy title	Medication Management Policy
Version	2.0
Date issued	May 2026
Supersedes	Medication Management Policy and Procedure (Policy and Procedure Manual V3, issued 1 May 2023)
NDIS Practice Standard	Core Module Division 4 — Provision of Supports Environment, Outcome 4.3 Management of Medication
Bundled support	Medication management (registered under Able to Thrive's NDIS registration ID 4-IPX11F6)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or on material change to the NDIS Practice Standards, NSW Poisons and Therapeutic Goods law, or the organisation's medication-management practice
Related policies and documents	Incident Management Policy (P-2.06); Suicide Prevention and Response Policy (P-2.21); Child Safety Policy (P-2.17); Behaviour Support Implementation Policy (P-1.32); Privacy and Confidentiality Policy (P-1.30); Staff Code of Conduct (P-1.26); Medication Administration Record (MAR); Medication Incident Report; Medication Management Training Records; PRN Medication Protocol

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) supports participants with their medication needs in a manner that is safe, lawful, person-centred, and consistent with the NDIS Practice Standards (Outcome 4.3, Management of Medication). It addresses worker scope of practice, authorisation, storage, administration, documentation, errors, disposal, and training.

The Policy applies whether the participant self-administers with assistance, has medication administered by a worker, or has medication managed through a dose administration aid prepared by a pharmacy.

2. Scope

This Policy applies to:

- every participant who receives any level of medication-related support from Able to Thrive, including (but not limited to) prompting, supervision, dose administration aid management, oral administration, topical application, eye/ear/nose drops, inhaler/nebuliser support, subcutaneous injection where authorised, and PRN administration;
- all Able to Thrive workers involved in supporting medication, regardless of setting (in-home, community, STA, school holiday programs);
- all settings in which Able to Thrive supports medication, including the participant's home, hired venues, vehicles during transport, and the head office where medication may be temporarily held; and
- management of any medication-related incident, error or near-miss.

This Policy does not apply to over-the-counter products purchased by the participant for their own use without a treatment context (for example, paracetamol for an occasional headache used at the participant's own initiative), provided no worker is involved in the choice or administration of the product.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards, Outcome 4.3 Management of Medication, and the associated quality indicators.
- *Poisons and Therapeutic Goods Act 1966* (NSW) and the Poisons and Therapeutic Goods Regulation 2008 (NSW).
- *Therapeutic Goods Act 1989* (Cth).
- *Work Health and Safety Act 2011* (NSW) and the WHS Regulation 2017 (NSW).
- *Drug Misuse and Trafficking Act 1985* (NSW) (in relation to Schedule 8 medications).
- *Privacy Act 1988* (Cth) — handling of health information.

4. Definitions

- **Medication** means any substance prescribed, recommended or self-selected for treating, preventing or managing a health condition, including prescription medications, over-the-counter medications, complementary and alternative medicines, and supplements.
- **Scheduled medication** means medication classified under the Poisons Standard. Schedule 4 (S4) medications are prescription-only. Schedule 8 (S8) medications are controlled drugs with additional storage and recording requirements.
- **Dose administration aid (DAA)** means a pharmacy-prepared medication container (for example, a Webster-pak™ blister pack) that organises a participant's medications by day and time.
- **Medication Administration Record (MAR)** means the record (paper or electronic, typically held in Brevity) of every medication administered, prompted or otherwise supported, and every refusal or missed dose, in relation to a participant.
- **PRN medication (pro re nata)** means a medication prescribed to be administered "as needed" rather than on a fixed schedule.
- **Prompting** means reminding or assisting a participant to take their own medication that they self-administer. The participant retains control over taking the medication.
- **Administration** means physically giving the medication to the participant (placing in the mouth, applying topically, administering drops, etc.).
- **The six rights of medication** means: the right participant, the right medication, the right dose, the right route, the right time, and the right documentation.

5. Policy statement

Able to Thrive supports participants to take their medications safely, with respect for their autonomy and dignity. Workers operate within their training and authorisation; they do not perform medication tasks they are not trained for. The six rights of medication are checked every time. Every dose, every prompt, every refusal and every missed dose is documented. Every medication incident is reported and reviewed.

6. Scope of practice for support workers

Able to Thrive workers do not prescribe medication, change a dose, change a route, change a time, or substitute one medication for another. The role of the worker is to support the medication regimen prescribed by the participant's treating practitioner. The scope of activity workers may undertake, in order of increasing complexity, is:

Activity	Description and worker requirement
Self-medication (no support)	The participant manages their own medication entirely. Workers do not handle medications. No worker activity is required.

Prompting	The worker reminds the participant that a dose is due. The participant retrieves, opens and takes the medication independently. The worker records that the prompt was given and the participant took the medication.
Supervision	The worker is present while the participant retrieves and takes the medication. The worker checks against the MAR. The worker does not administer.
DAA support	The worker presents a pharmacy-prepared DAA (Webster-pak or similar) to the participant, who removes and takes the dose. The worker checks against the DAA label and the MAR.
Direct administration	The worker physically administers the medication (oral, topical, drops, inhaler). The worker holds a current Medication Management training certificate, has been deemed competent by the Lead Compliance Officer, and follows the procedure in Section 8.
PRN administration	Administration of a "as needed" medication, following the participant-specific PRN protocol developed by the prescriber (Section 9). Workers do not initiate PRN medication without a documented PRN protocol.
Invasive procedures (injection, enteral feeding-tube medications, etc.)	Considered High Intensity Daily Personal Activities (Module 1). Able to Thrive is not currently registered for Module 1 and does not undertake these activities. Where a participant requires this support, the participant is referred to a Module 1-registered provider.

7. Authorisation and the medication regimen

A worker administers (or otherwise supports) medication only where ALL of the following are in place:

- the medication is prescribed (where the medication is a Schedule 4 or Schedule 8 medication) by an appropriately qualified medical or nurse practitioner;
- the current prescription or treatment plan is documented in the participant's Brevity record;
- the current MAR template for the participant is in place, listing all medications, dose, route, time, and the prescriber;
- the participant (or the participant's substitute decision-maker where authorised) has consented to the worker supporting medication;
- the worker is trained and authorised for the level of activity required (Section 6).

Where a participant's medication is provided in a pharmacy-prepared DAA, the DAA serves as the prescriber's instruction. Where medications are not in a DAA, the original pharmacy-labelled container is used; medications are never decanted into unmarked containers.

8. Administration procedure

Every administration of medication follows the six rights:

- **Right participant** — identify the participant by name and (where multiple participants are in the setting) a second identifier such as photograph in the participant file.
- **Right medication** — check the medication against the MAR. Check the pharmacy label or DAA label.
- **Right dose** — confirm the dose matches the MAR.
- **Right route** — confirm the route (oral, topical, drops, inhaler) matches the MAR.
- **Right time** — confirm the dose is due. Doses are administered within 30 minutes either side of the scheduled time unless the prescriber's instruction is different.
- **Right documentation** — record the administration in the MAR immediately after, with the worker's name and signature, the date and time, and any observation.

Workers do not administer to a participant other than the participant for whom the medication is prescribed. Workers do not administer a medication they cannot identify from its label and the MAR. If anything does not match, the worker stops, does not administer, and escalates to a senior worker or the Lead Compliance Officer.

9. PRN medication

PRN medications are administered only where:

- the medication is prescribed by an appropriately qualified practitioner with a clear indication (the symptom or circumstance under which the medication is to be administered);
- a participant-specific PRN protocol is in place, documenting the indication, the dose, the maximum frequency, the minimum interval between doses, the maximum daily dose, the expected response, and the action to take if there is no response or an adverse response;
- the worker has assessed that the indication is present;
- the administration is documented in the MAR immediately, including the indication observed, the dose, the time, and the participant's response within 30 minutes; and
- every PRN administration is reported to the Lead Compliance Officer at the end of the shift.

Workers do not administer a PRN medication on the basis of behaviour alone where the medication is intended for behavioural effect. Use of medication to manage behaviour falls within the framework of Chemical Restraint and is governed by the Behaviour Support Implementation Policy (P-1.32). Able to Thrive does not implement chemical restraint until

and unless Module 2a is approved and the participant has an authorising behaviour support plan.

10. Refusal, missed doses and errors

10.1 Refusal

A participant has the right to refuse medication. The worker:

- respects the refusal, does not insist or coerce, and does not deceive the participant about what is being administered;
- records the refusal in the MAR with the time, the medication and the participant's stated reason (if given);
- escalates to the Lead Compliance Officer or on-call manager where the refusal involves a critical medication, where the refusal is unusual for the participant, or where the worker has any concern; and
- the Lead Compliance Officer notifies the participant's prescriber where required and updates the support plan if a pattern of refusal emerges.

10.2 Missed doses

Where a dose has been missed (the worker forgot, the participant was unavailable, or for any other reason), the worker records the missed dose in the MAR, escalates to the Lead Compliance Officer, and the Lead Compliance Officer obtains advice from the participant's prescriber or pharmacist where required. Missed doses are reviewed as medication incidents under Section 11.

10.3 Errors

A medication error includes any of: administering the wrong medication; administering the wrong dose; administering at the wrong time outside the 30-minute window; administering to the wrong participant; failing to administer; administering by the wrong route; failing to record an administration. Every error, including a near-miss caught before harm, is treated as a medication incident under Section 11.

11. Medication incidents

Every medication incident is reported in Brevity as an Incident under the Incident Management Policy (P-2.06). The report includes:

- what occurred (the six rights breach or other description);
- the medication and dose involved;
- the participant's observed response;
- the immediate actions taken (including any contact with prescriber, pharmacist, Poisons Information Centre on 13 11 26, or emergency services);
- the persons notified; and

- any further follow-up required.

Where the error has caused, or could reasonably be expected to cause, serious injury, the incident may be a Reportable Incident under the NDIS Act and is notified to the NDIS Commission under the Incident Management Policy within 24 hours. The Director (Compliance) signs off on all notifications.

Medication incidents are reviewed by the Lead Compliance Officer to identify systemic causes. Trends are reported to the Directors and recorded in the Continuous Improvement Register.

12. Storage of medication

- Participant medications are stored in the participant's home in a location agreed with the participant — typically in original pharmacy containers or DAAs, in a cool, dry place, out of reach of children where applicable, and at the temperature specified by the manufacturer.
- Medications requiring refrigeration are stored in a refrigerator at the temperature range specified.
- Schedule 8 (controlled) medications are stored in a locked container in the participant's home accessible only to the participant or to authorised workers. Where Able to Thrive workers hold the key, the key is secured in a manner that is auditable.
- Medications are not transferred between participants. Medications are not stockpiled by workers; they remain in the participant's possession.
- Worker bags do not carry participant medications between locations (other than where the participant is travelling and the worker is supporting that movement, in which case the medications travel in their pharmacy containers in a sealed bag).

13. Schedule 8 controlled medications

- Schedule 8 medications require additional documentation. For each S8 medication, a register is maintained recording every dose administered, the date and time, the worker who administered, and the quantity remaining.
- Discrepancies in S8 quantities are reported immediately to the Lead Compliance Officer, who investigates and (where loss or diversion is suspected) notifies the Director (Compliance) and, where required by law, the police.
- S8 medications are stored separately from other medications, in a locked container or location.

14. Disposal of medication

- Workers do not dispose of participant medications without authorisation. Expired, ceased or unwanted medications are returned to a pharmacy under the Return Unwanted Medicines (RUM) program. The participant or the participant's representative authorises return.

- Liquid spills and contaminated dose forms are disposed of in accordance with the Management of Waste Policy (P-2.09).
- Sharps from medication administration (where applicable) are disposed of in approved sharps containers in accordance with the Management of Waste Policy.

15. Training and competence

Workers who administer medication, or who provide DAA support beyond simple prompting, complete:

- a recognised Medication Management training program at induction;
- participant-specific induction on each participant's medication regimen, including any PRN protocol, before allocation;
- competency assessment by the Lead Compliance Officer or a delegate before independent practice; and
- refresher training annually, and after any material change to a participant's regimen or to this Policy.

Training and competency records are held against each worker's file and verified by the Lead Compliance Officer before allocation to a participant requiring medication support.

16. Records and documentation

- The MAR is the primary record of medication activity. It is current, complete, and signed at the time of administration (not at the end of the shift).
- PRN administrations are recorded in the MAR with the indication and response.
- S8 register entries are made at the time of administration.
- Medication incident records, training records and competency assessments are held in accordance with the Privacy and Confidentiality Policy (P-1.30) and the Information Management Policy (P-1.29).
- Records are retained for not less than seven years from the date the participant ceases to receive services.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for medication management compliance. Sign-off on Reportable Incident notifications for medication matters. Liaison with NDIS Commission on medication-related concerns.
Lead Compliance Officer	Owner of this Policy. Verification of training and competency. Review of medication incidents. Liaison with prescribers and pharmacists. Maintenance of MAR

	templates. Periodic audit of S8 registers. Trend reporting to Directors.
Lead worker / senior worker for the participant	Induction of allocated workers on the participant's medication regimen. First-response to any medication incident. Liaison with the participant's prescribing team where required.
Allocated workers	Practice within scope and training. Application of the six rights. Real-time MAR documentation. Reporting of refusals, missed doses, errors and incidents.
HR Coordinator and Operations Manager — Kriz	Allocation only of trained and competency-assessed workers to medication-related tasks.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in NDIS Practice Standard 4.3, NSW poisons law, a Reportable Incident bearing on medication, or a material change in the organisation's medication practice.

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Policy P-2.08

MEALTIME MANAGEMENT POLICY

Document control

Policy number	P-2.08
Policy title	Mealtime Management Policy
Version	1.0 (new policy)
Date issued	May 2026
Supersedes	Nil — new policy. Addresses the NDIS Practice Standard introduced in the November 2021 amendments to the Quality Indicators Guidelines.
NDIS Practice Standard	Core Module Division 4 — Provision of Supports Environment, Outcome 4.4 Mealtime Management
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or on material change to the NDIS Practice Standards, NSW food safety law, or the participant cohort's mealtime support needs
Related policies and documents	Incident Management Policy (P-2.06); Medication Management Policy (P-2.07); Living Alone Risk Assessment Policy (P-1.31); Child Safety Policy (P-2.17); Privacy and Confidentiality Policy (P-1.30); Staff Code of Conduct (P-1.26); Mealtime Management Plan template; Choking Response procedure; First Aid procedure; IDDSI Framework reference materials

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) supports participants who require assistance with mealtimes. It addresses identification of mealtime support needs, the preparation and delivery of meals to the texture and consistency prescribed by the participant's clinical team, positioning during meals, environmental considerations, response to choking and aspiration, worker training and the documentation expected.

The Policy gives effect to NDIS Practice Standard Outcome 4.4 (Mealtime Management), introduced in the November 2021 amendments to the NDIS Quality Indicators Guidelines.

2. Scope

This Policy applies to:

- every participant supported by Able to Thrive who has been identified as requiring assistance with mealtimes, including (but not limited to) participants with dysphagia, participants who require texture-modified diets, participants who require physical assistance to eat or drink, participants who require prompting or supervision at mealtimes for choking risk, and participants with feeding-related disability;
- all settings in which Able to Thrive supports mealtimes, including the participant's home, community-based settings, short-term accommodation, and school holiday programs;
- all workers involved in supporting any aspect of mealtimes, from meal preparation through to clearing away;
- the operational interface between Able to Thrive and the participant's clinical team (speech pathologist, dietitian, occupational therapist, GP) where applicable.

Severe dysphagia management (where a participant's dysphagia is severe and the support is delivered as a High Intensity Daily Personal Activity) falls under Module 1 of the NDIS Practice Standards. Able to Thrive is not currently registered for Module 1. Where a participant requires severe dysphagia support, the participant is referred to a Module 1-registered provider for that element of support.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards, Outcome 4.4 Mealtime Management, and the associated quality indicators.
- *Food Act 2003* (NSW) and the Food Standards Code (Australia New Zealand Food Standards Code) — food handling and food safety.
- *Work Health and Safety Act 2011* (NSW) — duties of workers and the PCBU in food handling and meal preparation.
- IDDSI (International Dysphagia Diet Standardisation Initiative) Framework — the international descriptor framework used by speech pathologists and dietitians to specify food and drink textures for participants with dysphagia.

4. Definitions

- **Mealtime support** means any assistance provided to a participant in relation to meals, including preparation, prompting, supervision, physical assistance to eat or drink, and post-meal observation.
- **Dysphagia** means difficulty swallowing. Dysphagia can affect the safety and adequacy of eating and drinking and is a leading cause of choking and aspiration pneumonia in people with disability.
- **Aspiration** means the entry of food, drink or other material into the airway. Silent aspiration occurs without obvious coughing or distress and can lead to aspiration pneumonia.
- **IDDSI Framework** means the eight-level descriptor system (Levels 0–7 for drinks and foods) used to communicate texture and consistency requirements. Common levels include Level 7 Regular, Level 6 Soft and Bite-Sized, Level 5 Minced and Moist, Level 4 Pureed, Level 3 Liquidised/Moderately Thick, Level 2 Mildly Thick, Level 1 Slightly Thick, Level 0 Thin.
- **Mealtime Management Plan** (MMP) means a written, individualised plan for a participant with mealtime support needs, developed by (or with input from) the participant's relevant clinician (typically a speech pathologist or dietitian).
- **Texture-modified diet** means a diet prepared to a specified IDDSI level or other clinician-specified texture in response to a participant's clinical need.

5. Policy statement

Mealtimes are at once a daily necessity and an experience that contributes to a participant's dignity, identity, social connection and quality of life. Able to Thrive supports mealtimes safely, in accordance with each participant's individual plan, and in a manner that respects their preferences. Where a participant has a Mealtime Management Plan, every worker who supports that participant's meals knows the plan, follows it, and reports against it.

6. Identification of mealtime support needs

Mealtime support needs are identified at intake and reviewed regularly. Identification considers:

- information from the participant's referrer, NDIS plan, support coordinator, family and treating clinicians;
- the participant's self-report of any difficulty with eating, drinking, choking, coughing during meals, weight loss, repeated chest infections, or food refusal;
- observation of the participant's eating and drinking during early support sessions;
- history of dysphagia, gastrointestinal conditions, neurological conditions, or developmental conditions that may affect mealtimes; and
- the participant's cultural, religious and personal food preferences.

Where any indicator of mealtime support need is present, the matter is escalated to the Lead Compliance Officer, who arranges for the participant's clinical team (speech pathologist and/or dietitian) to be engaged for assessment. Where Able to Thrive is not the participant's direct route to the clinical team (for example, where engagement is through the support coordinator), Able to Thrive supports the connection.

7. Mealtime Management Plans

Each participant identified as requiring mealtime support has a written Mealtime Management Plan (MMP). The MMP is developed by, or with input from, the participant's relevant clinician (typically a speech pathologist for dysphagia or swallowing concerns, a dietitian for nutritional concerns, an occupational therapist for positioning and adaptive equipment). The MMP describes:

- the participant's mealtime needs and risks (including the relevant IDDSI level for foods and drinks where applicable);
- the texture-modified diet or other dietary requirements;
- the preparation specifications, including any thickener or adaptive method;
- feeding strategies (pacing, bite size, positioning, prompting);
- the environment for mealtimes (seating, lighting, distraction levels);
- adaptive equipment (modified cutlery, plate guards, cups, straws — and the contraindications for use of any of these, especially straws where contraindicated for dysphagia);
- signs of difficulty to watch for (coughing, choking, residue, fatigue, refusal, change in voice quality after swallowing);
- the response to difficulty (positions, support strategies, escalation);
- the supplementation or hydration strategy where applicable;
- the review schedule.

The MMP is filed in the participant's Brevity record and access is granted to all workers allocated to the participant.

8. Induction of workers on a participant's MMP

Before any worker is allocated to a participant with an MMP:

- the worker is inducted on the specific MMP by a lead worker or the Lead Compliance Officer;
- the worker can describe the participant's IDDSI level (where applicable), the preparation requirements, the feeding strategies, the signs of difficulty, and the response to difficulty;
- induction completion is recorded;
- a worker not yet inducted on the MMP is not allocated to the participant for mealtime support, even if otherwise allocated to the participant for other supports.

Where the MMP is revised by the clinician, the induction is repeated for the revised plan. The previous version is archived under the Information Management Policy.

9. Meal preparation and delivery

9.1 Preparation

- Meals are prepared to the texture and consistency specified in the participant's MMP. For participants with an IDDSI level, every component of the meal is checked against the IDDSI testing methods (for example, the fork drip test for thickened liquids, the fork pressure test for soft foods).
- Thickeners (where required for fluids) are mixed in accordance with the manufacturer's instructions to achieve the prescribed IDDSI level. Workers do not estimate thickener quantities by eye.
- Food temperatures are checked before serving. Hot foods are below the temperature that would cause a burn; cold foods are at safe-for-eating temperatures.
- Food safety practices comply with the Food Standards Code: hand hygiene before preparation; clean preparation surfaces and equipment; separation of raw and cooked foods; appropriate refrigeration; cooking to safe internal temperatures; safe storage of leftovers.
- Allergen and dietary restriction information is confirmed against the participant's record before every meal. Allergies, intolerances, religious dietary requirements (e.g. halal, kosher), cultural preferences and stated dislikes are respected.

9.2 Environment and positioning

- Seating, table height, lighting and distraction levels are arranged in accordance with the MMP. For participants with dysphagia or aspiration risk, an upright seated position (typically 90 degrees) is maintained during and after the meal for the period specified in the MMP.
- Workers minimise distractions during the meal where the MMP requires this. Television, conversations that distract, or rushing are avoided where they affect safety.
- The pace of feeding follows the participant's lead. The participant's mouth is empty before the next bite or sip is offered.

9.3 Adaptive equipment

Adaptive equipment specified in the MMP is used. Equipment not specified in the MMP (in particular straws, which can be contraindicated for some participants with dysphagia) is not used until the clinician has authorised it.

10. Recognising and responding to mealtime difficulty

10.1 Signs to watch for

- coughing or throat-clearing during or after eating or drinking;
- a gurgly or wet voice quality after swallowing;
- food or fluid remaining visibly in the mouth (residue);
- drooling, leakage or food falling from the mouth;
- change in colour (pallor, cyanosis) or distress;
- refusal of food, fatigue mid-meal, or unusually slow eating;
- any indication of pain or discomfort with swallowing.

10.2 Response to difficulty short of choking

- pause the meal;
- reposition the participant in accordance with the MMP;
- offer water or a thickened sip (consistent with the IDDSI level);
- observe for clearing of the difficulty;
- do not resume until the participant is settled and the MMP's indicators of safe swallowing have returned;
- record the event in Brevity at the end of the meal and notify the lead worker and the Lead Compliance Officer.

10.3 Choking

Choking is a medical emergency. The worker:

- encourages the participant to cough if able;
- if coughing is not effective, applies first aid for choking in accordance with current Australian Resuscitation Council guidance (back blows and abdominal thrusts as appropriate to the participant's age and circumstances);
- calls Triple Zero (000) immediately, requesting an ambulance;
- continues first aid until the obstruction clears or paramedics arrive;
- on resolution, records the event in detail in Brevity and notifies the Lead Compliance Officer immediately.

A choking event is an Incident under the Incident Management Policy and may be a Reportable Incident under section 73Z of the NDIS Act if serious injury or death occurs. The Director (Compliance) signs off on any notification to the NDIS Commission.

10.4 Suspected aspiration

Where a worker suspects aspiration (visible entry of food or fluid into the airway, or signs of silent aspiration such as recurrent chest infection in the participant's history), the worker records the observation in Brevity and notifies the Lead Compliance Officer. The Lead Compliance Officer escalates to the participant's clinician for review of the MMP. Repeated

chest infections in a participant supported under this Policy are reviewed as a possible indicator of aspiration.

11. Monitoring and documentation

- Every mealtime support session is recorded in Brevity at the end of the shift, including what was offered, what was consumed, any difficulties, any deviation from the MMP, and any observation of concern.
- Food and fluid intake is recorded where the MMP requires monitoring (typically where there is concern about nutrition or hydration).
- Body weight is recorded at the frequency specified in the MMP. Unexpected weight loss or gain is flagged to the Lead Compliance Officer and to the participant's clinician.
- Trends in mealtime concerns across participants are reviewed quarterly by the Lead Compliance Officer and reported to the Directors.

12. Multidisciplinary coordination

Able to Thrive supports the participant's clinical team to maintain currency of the MMP. Where the participant's presentation changes (recurrent chest infection, weight loss, increased difficulty), Able to Thrive notifies the clinician with the consent of the participant (or the participant's decision-maker) and supports the clinician's review. Where the clinician revises the MMP, Able to Thrive's workers are inducted on the revised plan before further mealtime support is provided (Section 8).

13. Training and competence

Workers supporting mealtimes complete:

- induction in this Policy at engagement;
- participant-specific induction on each MMP before allocation (Section 8);
- food safety training appropriate to the role (basic food handling for all workers; food safety supervisor accreditation for workers preparing meals in higher-risk contexts such as school holiday programs or STA);
- first aid training including current certification in choking response (annual renewal); and
- refresher training in this Policy at least annually, and after any material change to a participant's MMP.

Training and competency records are held against each worker's file and verified by the Lead Compliance Officer before allocation.

14. Cultural, religious and personal preferences

Food and mealtimes carry cultural, religious and personal meaning. Able to Thrive workers respect each participant's preferences and identity. Halal, kosher, vegetarian, vegan and other dietary practices are followed. Where a participant has a cultural or religious practice around mealtime conduct (saying grace, hand washing rituals, particular utensils), this is supported. Workers do not impose their own dietary views on participants.

15. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for mealtime management compliance. Sign-off on Reportable Incident notifications for mealtime-related matters. Liaison with NDIS Commission where required.
Lead Compliance Officer	Owner of this Policy. Identification of participants requiring an MMP and coordination of clinical engagement. Verification of training and competency. Review of mealtime incidents. Liaison with clinicians on plan revisions. Trend reporting.
Speech pathologist / dietitian / OT (external)	Development and revision of the participant's MMP. Provision of guidance to Able to Thrive on implementation. Periodic review of plan effectiveness.
Lead worker / senior worker for the participant	Induction of allocated workers on the participant's MMP. First-response to mealtime difficulties. Liaison with the clinician where required.
Allocated workers	Implementation of the MMP with fidelity. Real-time documentation. Recognition and response to mealtime difficulty. Compliance with food safety and first aid expectations.
HR Coordinator and Operations Manager — Kriz	Allocation only of trained and competency-assessed workers to participants with MMPs.

16. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in NDIS Practice Standard 4.4, NSW food safety law, the IDDSI Framework, or a Reportable Incident or material event bearing on mealtime management.

ABLE TO THRIVE PTY LTD

Policy P-2.09

MANAGEMENT OF WASTE POLICY

Document control

Policy number	P-2.09
Policy title	Management of Waste Policy
Version	2.0
Date issued	May 2026
Supersedes	Waste Management Policy and Procedure (Policy and Procedure Manual V3, issued 1 May 2023)
NDIS Practice Standard	Core Module Division 4 — Provision of Supports Environment, Outcome 4.5 Management of Waste
Bundled support	Hazardous waste disposal (registered under Able to Thrive's NDIS registration ID 4-IPX11F6)
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or on material change to the NDIS Practice Standards, NSW EPA waste classification, WHS law, or the organisation's service mix
Related policies and documents	Incident Management Policy (P-2.06); Medication Management Policy (P-2.07); Privacy and Confidentiality Policy (P-1.30); Staff Code of Conduct (P-1.26); WHS Policy; Infection Control Policy; PPE procedure; Spill Response procedure; Hazardous Waste Contractor Agreement

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) manages waste generated in the course of providing supports to NDIS participants, in a manner that is safe for participants, workers and the community, and consistent with NSW environmental and health protection laws.

The Policy gives effect to NDIS Practice Standard Outcome 4.5 (Management of Waste) and supports Able to Thrive's registration for hazardous waste disposal as a bundled support.

2. Scope

This Policy applies to:

- all waste generated in the course of supports delivered by Able to Thrive, including waste generated in participants' homes during personal care, waste from school holiday programs, waste from STA stays, and any general or hazardous waste at the head office;
- all Able to Thrive workers involved in any aspect of waste handling, segregation, storage or disposal;
- all locations where Able to Thrive delivers services or holds waste pending disposal;
- the engagement and management of licensed waste contractors for any waste stream that cannot be disposed of through ordinary council waste collection.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards, Outcome 4.5 Management of Waste, and the associated quality indicators.
- *Protection of the Environment Operations Act 1997* (NSW) and the Protection of the Environment Operations (Waste) Regulation 2014 (NSW) — administered by the NSW Environment Protection Authority (EPA).
- NSW EPA Waste Classification Guidelines.
- *Work Health and Safety Act 2011* (NSW) and the WHS Regulation 2017 (NSW) — duties relating to handling of hazardous substances and PPE.
- *Public Health Act 2010* (NSW) — handling of clinical and related waste.

4. Definitions

- **General waste** means everyday waste that does not contain hazardous, clinical, infectious or sharps material. It is disposed of through ordinary council collection.
- **Clinical waste** means waste contaminated with body substances (blood, urine, faeces, vomit, wound exudate) where the contamination is sufficient to present an infection risk. Examples include heavily soiled wound dressings, used incontinence products where heavily soiled with blood, and gloves visibly contaminated with blood.

Lightly soiled materials (most used incontinence pads, most dressings without visible blood) are general waste under NSW EPA guidelines.

- **Sharps** means any item with the potential to penetrate skin and transmit infection — needles, lancets, syringes with attached needles, broken glass contaminated with body substances, and scalpel blades.
- **Hazardous waste** means waste that is classified as hazardous under the NSW EPA Waste Classification Guidelines, including chemicals, asbestos, batteries, mercury-containing items, and certain medical waste streams. Hazardous waste requires a licensed waste contractor for collection and disposal.
- **Hazardous waste disposal** as a bundled support means the disposal, on behalf of a participant, of hazardous waste generated by the participant's supports (for example, continence products in clinical-waste quantities, or other waste streams classified as hazardous under NSW law).
- **Personal protective equipment (PPE)** means gloves, masks, eye protection, gowns and other equipment provided to workers to protect against hazards including contamination by waste.

5. Policy statement

Able to Thrive segregates, stores and disposes of waste in a manner that is safe, lawful and respectful. Waste is segregated at the point of generation. Workers use the personal protective equipment provided. Hazardous waste is disposed of through licensed contractors with appropriate documentation. Waste handling is dignified — handling personal care waste is part of supporting a participant's dignity, and workers conduct themselves accordingly.

6. Waste streams

The principal waste streams arising from Able to Thrive's supports are:

Waste stream	Examples	Disposal pathway
General waste	Food packaging, paper towels, general office waste, lightly soiled gloves with no visible blood, lightly soiled incontinence pads (most cases).	Council general waste collection at the participant's residence or at the head office.
Recyclable waste	Paper, cardboard, glass, plastic containers, aluminium cans.	Council recycling collection at the participant's residence or at the head office.
Clinical waste	Heavily blood-stained dressings, materials contaminated with body	Yellow clinical waste bag, sealed, collected by a licensed clinical waste contractor on the agreed

	fluids in quantities presenting an infection risk.	schedule.
Sharps	Needles (including subcutaneous and insulin), lancets, scalpel blades, broken glass contaminated with body substance.	Approved yellow sharps container (puncture-resistant, AS/NZS 4031 or AS/NZS 4261 compliant). Collected by a licensed sharps waste contractor.
Pharmaceutical waste	Expired, ceased or unwanted medications.	Returned to a community pharmacy under the Return Unwanted Medicines (RUM) program. Workers do not dispose of medications in general waste or down sinks/toilets.
Hazardous waste (other)	Chemicals (cleaning products in unusual quantity), batteries, fluorescent tubes, mercury-containing thermometers, certain disinfectants, identified hazardous substances.	Licensed hazardous waste contractor under the EPA framework. Workers do not co-mingle hazardous waste with general waste.

7. Segregation at the point of generation

Waste is segregated as it is generated. Workers do not co-mingle waste streams. In particular:

- sharps are placed directly into the sharps container at the moment of use; sharps are never placed into general waste, recycling, or clinical waste bags;
- clinical waste is placed into yellow clinical waste bags; general waste is placed into general waste bags;
- pharmaceutical waste is held separately for return to pharmacy;
- hazardous waste is held separately for collection by the licensed contractor.

Where the worker is uncertain about the correct stream for a particular item, the worker treats the item as the more cautious stream (clinical rather than general; hazardous rather than clinical) and escalates to the Lead Compliance Officer for guidance.

8. Personal protective equipment

- Disposable gloves are worn whenever a worker handles waste of any kind beyond ordinary general waste.
- Gloves are changed between tasks; gloves used for personal care of one participant are not reused for another participant or another task.

- Where there is splash risk (handling clinical waste, dealing with a spill), eye protection and disposable aprons or gowns are worn.
- Masks are worn where infection risk is indicated.
- PPE is removed and disposed of as the appropriate waste stream (typically general waste unless visibly contaminated to a clinical level), and hand hygiene is performed immediately after removal.
- Workers report any PPE shortage to the lead worker and the Lead Compliance Officer immediately; workers do not work without the PPE the task requires.

9. Hand hygiene and infection prevention

- Hand hygiene is performed before and after every personal care task involving waste, before food handling, after removing PPE, after using the toilet, and at any other time hands may have become contaminated.
- Soap and water are preferred where hands are visibly soiled. Alcohol-based hand rub is used where soap and water are not available and hands are not visibly soiled.
- The Infection Control Policy provides additional detail. This Policy and that Policy operate together in respect of body-fluid exposures and outbreak response.

10. Sharps handling

- Sharps containers comply with AS/NZS 4031 (single-use, household) or AS/NZS 4261 (re-usable, healthcare facility) as appropriate.
- Containers are sealed when they reach the fill line, not before and not after.
- Workers do not recap, bend or break used needles.
- Sharps containers in participants' homes are stored out of reach of children and visitors.
- In the event of a needlestick or sharps injury, the worker washes the wound under running water, applies first aid, reports the injury to the lead worker and the Lead Compliance Officer immediately, and follows up with medical assessment in accordance with the WHS Policy and the Workplace Incident Management Policy.

11. Spills and contamination response

Where a spill of body substance or hazardous material occurs (in a participant's home, in STA, at the head office, in a vehicle), the worker:

- protects the immediate area and other people present;
- dons appropriate PPE before approach (gloves, eye protection, apron, mask as required);
- contains the spill (absorbent materials, kitty litter, or commercial spill kits for larger spills) without spreading;
- removes the bulk of the spill into the appropriate waste stream (clinical waste for body substances; hazardous waste contractor for chemical spills);

- cleans the area with detergent and water; for body fluids, follows with a disinfectant appropriate to the surface;
- disposes of PPE and cleaning materials in the appropriate stream;
- performs hand hygiene; and
- records the spill in Brevity as an Incident under the Incident Management Policy.

Where the spill involves a large quantity of hazardous material, a chemical that cannot be safely cleaned by the worker, or any spill that exceeds the worker's training or PPE, the worker withdraws the area, contains entry, and calls emergency services where required.

12. Storage of waste pending disposal

- Waste held pending disposal is stored in a manner that prevents access by participants (especially children), workers other than the relevant worker, pests, and weather. Containers are clearly labelled.
- Sharps containers are stored upright, sealed when full, and not stored beyond the fill line.
- Clinical waste bags awaiting collection are stored in a sealed bin in a clearly marked location.
- Hazardous waste awaiting contractor collection is stored in containers approved for the substance, in a location that meets the contractor's requirements.
- Storage durations are kept to the minimum practical. Clinical waste and pharmaceutical waste do not remain on site beyond reasonable timeframes pending collection or return.

13. Hazardous waste contractor arrangements

- Hazardous waste, clinical waste and sharps are collected by licensed contractors. Able to Thrive holds a current waste services agreement with at least one licensed contractor for each relevant stream.
- The contractor's licence and authorisation are verified at engagement and on each renewal. Copies are held by the Lead Compliance Officer.
- Each collection is documented with a waste tracking note or consignment note as required by the EPA framework. Tracking documents are retained for not less than five years.
- Where waste is generated at a participant's home in quantities that warrant collection (typically where the participant has been assessed as requiring the hazardous waste disposal bundled support), Able to Thrive coordinates contractor collection from the participant's residence.
- Worker observations of any contractor non-conformance (missed collections, damaged containers, breach of consignment requirements) are reported to the Lead Compliance Officer for follow-up.

14. Participant dignity in waste handling

Personal care waste — particularly continence-care waste — is part of supporting the participant. Workers handle this discreetly and without commentary that diminishes the participant's dignity. The participant's preferences about timing, location and conduct of personal care are respected. Waste is not displayed, photographed or discussed beyond what is necessary for clinical reasons.

15. Training

Workers complete training in this Policy at induction. Training covers:

- waste streams and segregation;
- PPE use and removal;
- hand hygiene;
- sharps handling and the response to a sharps injury;
- spill response;
- infection prevention; and
- the dignity expectations under Section 14.

Refresher training is delivered at least annually and after any material change to this Policy or to contractor arrangements. Training records are held against each worker's file.

16. Records

- Waste tracking and consignment notes are retained for not less than five years.
- Contractor licences and certificates of currency are held by the Lead Compliance Officer.
- Spill incidents and sharps injuries are recorded in Brevity under the Incident Management Policy.
- Training records are maintained as part of each worker's personnel file.

17. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for waste management compliance. Sign-off on hazardous waste contractor engagement. Liaison with NSW EPA or other regulators on any waste-related matter.
Lead Compliance Officer	Owner of this Policy. Verification of contractor licences. Maintenance of waste tracking records. Audit of segregation practice. Training records. Review of spill and sharps-injury incidents. Trend reporting.

HR Coordinator and Operations Manager — Kriz	PPE availability and supply chain. Allocation of trained workers to tasks involving waste handling.
Lead worker / senior worker for the participant	First response to spills and sharps injuries. Induction of allocated workers on the participant-specific waste arrangements.
Allocated workers	Waste segregation. PPE use. Hand hygiene. Sharps handling. Spill response. Incident reporting. Dignity in personal care waste handling.
Licensed waste contractor	Collection, transport and disposal of clinical, sharps and hazardous waste in accordance with EPA-licensed scope. Provision of waste tracking documentation. Notification of any non-conformance.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in NDIS Practice Standard 4.5, NSW EPA waste classification, WHS law, or a Reportable Incident or material event bearing on waste management.

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Policy P-2.15

SUPPORT COORDINATION POLICY

Document control

Policy number	P-2.15
Policy title	Support Coordination Policy
Version	2.0
Date issued	November 2026
Supersedes	Support Coordination Policy and Procedure (Section 2.15 of the Policy and Procedure Manual V3, issued 1 May 2023)
Registration group	0106 — Assistance in Coordinating or Managing Life Stages, Transitions and Supports
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	November 2027, or upon material change to the NDIS framework for support coordination, the Conflict of Interest Policy, or the service mix
Related policies and documents	Conflict of Interest Policy (P-1.03); Privacy and Confidentiality Policy (P-1.30); Incident Management Policy (P-2.06); Feedback, Compliments and Complaints Policy (P-2.03); Living Alone Risk Assessment Policy (P-1.31); Suicide Prevention and Response Policy (P-2.21); Child Safety Policy (P-2.17); Staff Code of Conduct (P-1.26); Alternatives Offered Log; Service Agreement template; NDIS Practice Standards for Support Coordination

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) delivers support coordination to NDIS participants under registration group 0106. It addresses the principles of the service, the scope of activities, the management of the conflict of interest arising from also providing direct services, documentation requirements, communication with other providers and the NDIA, and the integration with other Able to Thrive policies.

2. Scope

This Policy applies to:

- all support coordination services delivered by Able to Thrive under registration group 0106;
- all support coordinators employed or engaged by Able to Thrive;
- all participants in receipt of support coordination from Able to Thrive, whether or not the participant also receives direct services from Able to Thrive; and
- the relationship between Able to Thrive support coordinators and other Able to Thrive workers, other NDIS providers, and the NDIA.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards and Quality Indicators, including the indicators relating to support coordination.
- NDIS Pricing Arrangements and Price Limits in respect of registration group 0106.
- NDIS Provider Registration and Practice Standards Rules.

4. Definitions

- **Support coordination** is the support funded under the NDIS that helps a participant to understand and use their plan, choose and engage providers, build capacity to direct their own life, and resolve service issues.
- **Support Connection (Level 1)** is the lowest level of coordination, focused on building the participant's ability to connect with providers and the broader community.
- **Support Coordination (Level 2)** is coordination involving a higher level of engagement to build the participant's capacity to maintain a resilient network of supports.
- **Specialist Support Coordination (Level 3)** is delivered by qualified specialists and reserved for participants whose situations are more complex and require a specialist approach.
- **Plan** means the participant's NDIS plan as approved by the NDIA.
- **Alternatives Offered Log** has the meaning given by the Conflict of Interest Policy (P-1.03) and records the alternative providers considered for each recommendation.

5. Policy statement

Able to Thrive delivers support coordination in a manner that puts the participant's choice and control at the centre. Support coordinators present participants with options, not directions. Recommendations are made on the basis of fit with the participant's goals and plan, not on the basis of any commercial interest of Able to Thrive. The fact that Able to Thrive also provides direct services is disclosed and managed under the Conflict of Interest Policy.

6. Levels of support coordination offered

Able to Thrive is registered to provide support coordination under registration group 0106. Within that registration, Able to Thrive delivers:

- **Support Connection (Level 1)** — focused on practical assistance to access providers and community resources.
- **Support Coordination (Level 2)** — building participant capacity to direct supports across providers and across plan categories.

Specialist Support Coordination (Level 3) is not currently delivered by Able to Thrive. Where a participant's plan funds Specialist Support Coordination, the participant is referred to a Specialist Support Coordinator who meets the requirements for that level.

7. Service principles

- **Choice and control.** Participants choose their providers, supports and arrangements. The support coordinator informs and supports the participant's choices.
- **Independence of advice.** The support coordinator's advice is independent of any commercial interest of Able to Thrive. The conflict of interest controls in Section 8 apply.
- **Capacity building.** The service builds the participant's capacity to direct their own life over time. Dependence on the support coordinator is not the goal.
- **Cultural responsiveness.** The support coordinator respects the participant's cultural identity and adapts engagement accordingly. For Aboriginal and Torres Strait Islander participants, the coordinator engages with Aboriginal-controlled organisations and community supports where the participant chooses this.
- **Accessibility.** Communication is in the participant's preferred mode and language. Plain English, Easy Read, communication aids and interpreters are offered.
- **Privacy.** Personal and sensitive information is handled under the Privacy and Confidentiality Policy.

8. Managing the conflict of interest

Able to Thrive is registered as a provider of both direct services and support coordination. This creates a structural conflict of interest that is managed through the controls in Section 6 of the Conflict of Interest Policy (P-1.03). Each support coordinator:

- **Provides the written disclosure** to every participant at the commencement of support coordination, in an accessible format, explaining the dual role and the participant's right to choose any provider for direct supports.
- **Includes the Conflict of Interest clause** in the Service Agreement for any participant who is also (or may become) a recipient of Able to Thrive's direct services.
- **Maintains the Alternatives Offered Log** for every recommendation involving a direct support, recording the support type proposed, the alternative providers considered, the basis for selection, and the participant's preference.
- **Is not paid on direct-service utilisation** by their participants. Their employment terms record the separation of incentives.
- **Is reviewed quarterly** by the Lead Compliance Officer as to compliance with the above.

Where a participant prefers to use an Able to Thrive direct service, that preference is honoured. What the controls prevent is the support coordinator steering the participant toward Able to Thrive without offering or considering alternatives.

9. Intake and engagement

Support coordination engagement starts when:

- the participant has an approved NDIS plan that funds support coordination at the relevant level;
- Able to Thrive has the capacity to deliver the level required; and
- the participant chooses Able to Thrive as their support coordinator.

At intake, the support coordinator:

- introduces themselves, the service, the level of coordination, and the participant's rights;
- provides the Conflict of Interest written disclosure (Section 8);
- discusses the participant's goals, preferences, current supports and history;
- reviews the participant's plan in detail;
- establishes the communication preferences (mode, frequency, accessibility needs);
- identifies any safeguarding considerations including (where applicable) the application of the Living Alone Risk Assessment Policy, the Child Safety Policy, or any matter relevant to suicide risk;
- proposes a working plan for the first three months; and
- enters the Service Agreement.

10. Service activities

Support coordination is delivered through the following activities, scaled to the level funded in the plan:

- **Plan understanding and translation** — helping the participant understand what their plan funds, the language of the plan, and how to use it.
- **Provider selection and engagement** — supporting the participant to identify, choose and engage providers across all the supports they need. The Alternatives Offered Log is maintained where any direct service from Able to Thrive is among the options.
- **Service Agreements with other providers** — assisting the participant to enter Service Agreements with other providers and to understand the obligations on each side.
- **Service issue resolution** — assisting the participant to address service quality concerns with their providers, including making complaints under the relevant provider's complaint process and/or to the NDIS Commission.
- **Capacity building** — actively building the participant's ability to direct their own supports over time, including by explaining processes, accompanying the participant in early meetings, and progressively reducing the coordinator's involvement as the participant's capability grows.
- **Network resilience** — supporting the participant to maintain a diversified support network so that loss of any single provider does not destabilise the plan.
- **Crisis assistance** — supporting the participant during crisis, including escalating to relevant supports and emergency services where required. Crisis assistance does not replace clinical crisis services.
- **Plan utilisation tracking** — monitoring the use of plan funds across categories and flagging concerns to the participant in time to act.
- **Preparation for plan review** — assisting the participant to prepare for the NDIA plan review, including by gathering progress evidence and documenting unmet needs.
- **Reporting** — preparing the support coordination report required by the NDIA at intervals specified in the plan.

11. Documentation and case notes

- Every interaction with the participant, every contact with another provider on the participant's behalf, and every recommendation or decision is recorded as a case note in Brevity within the same shift.
- Case notes describe what occurred factually (who, what, when, where), without subjective interpretation; the participant's preferences and decisions are recorded in the participant's own words where possible.
- The Service Agreement, the participant's current plan, the Conflict of Interest disclosure, and any consent forms are filed in the participant's Brevity record.

- Entries in the Alternatives Offered Log (Section 8) are made at the time of each recommendation.
- Records are managed under the Privacy and Confidentiality Policy and the Information Management Policy.

12. Working with other providers

- Communication with other providers is on a need-to-know basis and only with the participant's consent (or where consent is not required, for example for urgent safety matters or as authorised by law).
- Where Able to Thrive is also providing direct services to the participant through another part of the organisation, the support coordinator engages with the direct service team at arm's length, applying the same standards as for an external provider.
- Where the participant is dissatisfied with a provider, the support coordinator supports the participant to raise concerns through that provider's complaint process. The support coordinator does not act as the participant's representative without consent.
- Where the support coordinator identifies a safeguarding concern about another provider (including any indicator of abuse, neglect or exploitation), the matter is escalated to the Lead Compliance Officer and, where the threshold applies, to the NDIS Commission directly.

13. Crisis response

Where the participant is in crisis or at imminent risk, the support coordinator applies the Suicide Prevention and Response Policy (P-2.21) (where suicide risk is present), the Child Safety Policy (P-2.17) (where the participant is a child), and the Incident Management Policy (P-2.06). The support coordinator contacts emergency services where required and notifies the Lead Compliance Officer. Where the participant lives alone, the Living Alone Risk Assessment Policy (P-1.31) is also engaged.

14. Service reports to the NDIA

Support coordination reports to the NDIA are prepared in accordance with the format and timing specified in the participant's plan. Reports are prepared in plain language, focus on participant goals and outcomes, and are shared with the participant before lodgement. The Lead Compliance Officer maintains a register of reports prepared and lodged.

15. Service exit

Support coordination ends when the plan funding for support coordination is exhausted, when the participant chooses another support coordinator, when the participant's circumstances no longer require coordination, or when Able to Thrive determines (with appropriate notice) that it cannot continue to provide the service. On exit:

- a handover summary is prepared and provided to the participant and (with the participant's consent) to the incoming support coordinator;
- the participant's record is finalised in Brevity;
- outstanding service issues are documented and handed over; and
- the participant is given the option to provide feedback through the Feedback, Compliments and Complaints Policy.

16. Training and competence

Support coordinators hold the qualifications and experience required for the level of coordination they deliver. Induction training covers this Policy, the Conflict of Interest Policy (with emphasis on Section 6 controls), the Privacy and Confidentiality Policy, the participant-facing policies (Living Alone, Suicide Prevention, Child Safety), and the Brevity workflows. Annual refresher training is delivered. Coordinators meet with the Lead Compliance Officer for supervision at least monthly.

17. Incidents and complaints

Incidents involving support coordination — whether observed by the coordinator about a participant or a provider, or arising in the coordinator's own conduct — are managed under the Incident Management Policy. Complaints are handled under the Feedback, Compliments and Complaints Policy. Themes identified through incidents or complaints are recorded in the Continuous Improvement Register.

18. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Final accountability for support coordination practice. Sign-off on serious matters, including any concern about a support coordinator's conduct or any safeguarding escalation arising from coordination work.
Lead Compliance Officer	Owner of this Policy. Quarterly review of Conflict of Interest controls across the coordination team. Supervision of coordinators. Training records. Maintenance of Alternatives Offered Log oversight. Register of NDIA reports.
Support coordinators	Delivery of coordination services in accordance with this Policy and the Conflict of Interest Policy. Written disclosure to participants. Maintenance of the Alternatives Offered Log. Case notes and documentation. Escalation of safeguarding concerns.

Client Services and Acquisition — Akash	In-person liaison in Sydney where required. Coordination between direct services and support coordination teams within Able to Thrive at arm's length.

19. Review of this Policy

This Policy is reviewed at least annually, and out of cycle on a change in the NDIS framework for support coordination, the Conflict of Interest Policy, or the service mix.

ABLE TO THRIVE PTY LTD

Policy P-2.17

CHILD SAFETY POLICY

Document control

Policy number	P-2.17
Policy title	Child Safety Policy
Version	2.0
Date issued	May 2026
Supersedes	Child Safety Policy and Procedure (Section 2.17 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Child Safety Officer	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to the NSW Child Safe Standards, the Reportable Conduct Scheme, mandatory reporting law, or Able to Thrive's delivery of services to children
Related policies and documents	Child Safe Environment Policy (P-2.20); Incident Management Policy (P-2.06); Suicide Prevention and Response Policy (P-2.21); Feedback, Compliments and Complaints Policy (P-2.03); Code of Conduct for Working with Children; WWCC and NDIS Worker Screening Records; Pre-program Risk Assessment template; Holiday Program Procedures; NDIS Code of Conduct

1. Purpose

This Policy sets out Able to Thrive Pty Ltd's (Able to Thrive) commitment to the safety, wellbeing and inclusion of children, and the obligations of every worker, manager, Director and contractor in delivering that commitment. The Policy applies the NSW Child Safe Standards and the requirements of the NDIS Code of Conduct and Practice Standards to Able to Thrive's specific service mix, which includes school holiday programs for children with autism.

The Policy reflects Able to Thrive's belief that all children have a right to feel safe and to be safe in our care, that child safety is everyone's responsibility, and that there is no acceptable level of child abuse or harm.

2. Scope

This Policy applies to:

- all Able to Thrive workers (including employees, support workers engaged through Able to Thrive Personnel Pty Ltd, contractors and management);
- all services delivered by Able to Thrive to children under the age of 18, including (but not limited to) school holiday programs, in-home supports, community access supports, transport, and support coordination;
- all premises and environments in which services to children are delivered, whether owned by Able to Thrive, hired for the purpose, or otherwise used; and
- all online interactions and digital communications between Able to Thrive workers and children.

3. Legislative and regulatory framework

- *Children and Young Persons (Care and Protection) Act 1998* (NSW) — mandatory reporting and child protection.
- *Child Protection (Working with Children) Act 2012* (NSW) — Working with Children Check.
- *Children's Guardian Act 2019* (NSW) — Child Safe Scheme, Reportable Conduct Scheme, and the Office of the Children's Guardian.
- NSW Child Safe Standards (10 standards) issued by the Office of the Children's Guardian.
- *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS Code of Conduct.
- NDIS Practice Standards, including the indicators relating to child-related supports.
- NDIS Worker Screening requirements.

4. Definitions

- **Child** means a person under the age of 18.
- **Child abuse** means any act or omission that causes a child harm, including physical abuse, emotional or psychological abuse, sexual abuse, neglect, and exposure to family violence.
- **Child Safety Officer** means the senior Able to Thrive officer designated to lead child safety practice, receive concerns, and discharge reporting obligations. The Child Safety Officer is Eyad Shadid, Director (Compliance).
- **Reportable conduct** has the meaning given by the Children's Guardian Act 2019 (NSW) and includes (in summary) a sexual offence or sexual misconduct against, with or in the presence of a child; a serious physical assault of a child; ill-treatment or

neglect of a child; behaviour causing significant emotional or psychological harm to a child; and an offence under section 43B or section 316A of the Crimes Act 1900 (NSW).

- **Risk of significant harm** has the meaning given by the Children and Young Persons (Care and Protection) Act 1998 (NSW).
- **WWCC** means a Working with Children Check clearance issued under the Child Protection (Working with Children) Act 2012 (NSW).

5. Commitment to child safety

Able to Thrive is committed to the safety, wellbeing and inclusion of every child in our care. We:

- treat the safety of children as a non-negotiable priority that overrides commercial, operational and personal considerations;
- listen to and respect children, and take their concerns seriously;
- ensure that every person working with children is suitable and properly supported;
- actively prevent harm by designing supports and environments to minimise risk;
- respond promptly and appropriately to any allegation, suspicion or disclosure of harm;
- uphold the cultural safety of Aboriginal and Torres Strait Islander children and the cultural and religious safety of children from diverse backgrounds;
- uphold the safety of children with disability, recognising that they may face elevated risk of harm; and
- continuously review and improve our child safe practice.

6. Alignment with the NSW Child Safe Standards

Able to Thrive implements the NSW Child Safe Standards through this Policy, the Child Safe Environment Policy (P-2.20), our Code of Conduct for Working with Children, and our operational procedures. The ten Standards and how we implement them are summarised below.

No.	Standard	How Able to Thrive implements it
1	Child safety is embedded in organisational leadership, governance and culture.	Child Safety Officer at Director level. Quarterly child safety reporting to the Directors. Child safety reflected in strategic priorities and risk register.
2	Children participate in decisions affecting them and are taken seriously.	Holiday program design includes child voice. Daily check-ins with children. Children’s feedback recorded and acted on. Age-appropriate complaints channel.

3	Families and communities are informed and involved.	Parents/carers informed of all programs, supervision, and any incidents. Parent contact required at intake and during programs. Open-door policy for queries.
4	Equity is upheld and diverse needs are respected.	Tailored supports for children with autism. Cultural safety practices for Aboriginal and Torres Strait Islander children. Communication aids, interpreters and Easy Read where required.
5	People working with children are suitable and supported.	NDIS Worker Screening Check and WWCC verified before any worker is supplied. Code of Conduct for Working with Children signed at engagement. Supervision and training. See Section 7.
6	Processes to respond to complaints of child abuse are child focused.	Complaints channel accessible to children (verbal, visual, written, via parent or third party). Disclosures handled by trained workers and escalated to the Child Safety Officer.
7	Staff are equipped with the knowledge, skills and awareness.	Induction training in this Policy, the Code of Conduct, mandatory reporting, Reportable Conduct, and disability-specific safeguarding. Annual refresher.
8	Physical and online environments minimise opportunity for harm.	Pre-program risk assessments. Supervision ratios. Toileting and personal care protocols. Photography and digital protocols. Online safety standards. See Child Safe Environment Policy P-2.20.
9	Implementation of the Child Safe Standards is regularly reviewed.	Annual review of this Policy. Quarterly child safety reporting to Directors. Continuous Improvement Register entries arising from any concern or incident.
10	Policies and procedures document how the organisation is child safe.	This Policy and the Child Safe Environment Policy. Code of Conduct for Working with Children. Pre-program Risk Assessment template. Holiday Program Procedures. Incident Management linkage.

7. Worker suitability and support

7.1 Pre-engagement checks

Before any worker is supplied to deliver services to children, Able to Thrive Personnel Pty Ltd verifies and holds evidence of, and Able to Thrive Pty Ltd confirms it has received evidence of:

- a current NDIS Worker Screening Check clearance;
- a current Working with Children Check (WWCC) clearance;
- the worker's right to work in Australia;
- two reference checks, of which at least one specifically addresses suitability for working with children; and
- any role-specific qualifications (first aid, anaphylaxis training, etc. as appropriate to the program).

Workers are not allocated to programs involving children until the above checks are verified. The Lead Compliance Officer maintains a current list of workers cleared to work with children.

7.2 Currency

The Provider monitors the currency of NDIS Worker Screening and WWCC clearances and immediately stands down any worker whose clearance is suspended, revoked or expired.

7.3 Code of Conduct for Working with Children

At engagement and again annually, every worker who may deliver services to children signs the Code of Conduct for Working with Children. The Code prohibits:

- any form of physical, emotional, sexual or psychological abuse;
- private or unsupervised one-to-one contact with a child outside an approved service context;
- sharing of personal contact details, social media connections or private correspondence with a child;
- photography or video of children outside the approved photography protocol (see Child Safe Environment Policy);
- transporting a child in a personal vehicle without prior management approval;
- use of physical discipline or any restrictive practice; and
- discriminatory, demeaning or shaming language.

Breach of the Code is treated as a serious matter, may amount to reportable conduct, and may lead to disciplinary action including termination.

7.4 Supervision and support

Workers delivering services to children are supervised by an experienced lead worker or by Able to Thrive management. Supervision arrangements are documented in the Pre-program

Risk Assessment. Workers are supported with debrief opportunities after each program, access to the Employee Assistance Program, and structured access to senior staff for guidance.

8. Children’s participation

Children’s voices shape how Able to Thrive supports them. We:

- introduce ourselves and the program to children in age-appropriate language;
- seek children’s preferences and feedback throughout each program;
- explain to children what to do if they don’t feel safe or if something is wrong, in age-appropriate language;
- listen to children when they raise concerns and take action where required, without dismissing or minimising;
- provide a child-friendly summary of how to raise a concern (visual or written, depending on the child’s needs); and
- record children’s feedback at the program level and feed it into program design and continuous improvement.

9. Family, community and cultural safety

- **Family involvement.** Parents/carers are informed of the program structure, supervision arrangements, the named lead worker, and how to contact Able to Thrive during the program. Parents/carers consent to participation and to specific elements (photography, transport, etc.) at intake.
- **Aboriginal and Torres Strait Islander children.** We acknowledge the strength and resilience of Aboriginal and Torres Strait Islander children and families. We respect cultural identity, connection to country, family and community. Where appropriate and possible, we engage with Aboriginal-controlled organisations and community supports.
- **Children from culturally and linguistically diverse backgrounds.** We support cultural and religious identity, including dietary requirements, observance of religious practice, and use of interpreters or Easy Read materials where required.
- **Children with disability.** We recognise that children with disability may face elevated risk of harm. Our practice explicitly addresses communication access, the use of communication aids, and the involvement of family or chosen supports in safeguarding the child.
- **LGBTQIA+ children.** We respect children’s identities. We do not "out" a child to family or others without the child’s informed consent, and we support inclusion.

10. Recognising and responding to child abuse

10.1 Recognising

Indicators of possible abuse or harm may include physical signs (unexplained injuries, malnourishment, unusual marks), behavioural signs (withdrawal, regression, fear, sexualised behaviour inappropriate to age, self-harm), and environmental signs (disclosure by the child, inconsistent accounts, family circumstances). Workers do not investigate. Workers observe, document and report.

10.2 Responding to a disclosure

Where a child discloses harm:

- listen calmly, do not press for detail, and do not promise confidentiality;
- affirm the child for telling and assure the child they are not in trouble;
- record the child's words as accurately as possible, in the child's own language where possible;
- do not question the child further or seek detail beyond what the child has volunteered; and
- escalate to the Child Safety Officer immediately, and submit a Brevity incident report by the end of the shift.

11. Mandatory reporting

Where any Able to Thrive worker forms a reasonable belief that a child is at risk of significant harm, the matter is escalated immediately to the Child Safety Officer. The Child Safety Officer assesses the matter and ensures a report is made to the NSW Child Protection Helpline on 132 111 within the timeframes required by the Children and Young Persons (Care and Protection) Act 1998 (NSW).

The internal escalation does not replace a worker's personal mandatory reporting obligation where it applies. Workers who are themselves mandatory reporters under NSW law fulfil their own reporting obligation in addition to internal escalation. Reports to the NSW Child Protection Helpline are recorded in the Brevity child safety record.

12. Reportable Conduct Scheme

Able to Thrive is subject to the NSW Reportable Conduct Scheme administered by the Office of the Children's Guardian. Any allegation, report or suspicion of reportable conduct by an Able to Thrive worker (whether the conduct allegedly occurred during work or otherwise) is:

- escalated to the Child Safety Officer immediately;
- reported by the Child Safety Officer to the Office of the Children's Guardian within 7 business days of becoming aware, in accordance with the Children's Guardian Act 2019 (NSW);

- investigated by Able to Thrive (or by an external investigator where independence requires it) in cooperation with the Office of the Children's Guardian;
- notified to the NDIS Commission under the Reportable Incidents framework where the threshold for an NDIS Reportable Incident is also met; and
- handled with the worker stood down from any contact with children pending the outcome of the investigation, where the nature of the allegation warrants it.

The findings of the investigation are reported to the Office of the Children's Guardian as required by the Scheme.

13. Complaints and concerns from children

A child, a parent or carer, or any other person may raise a concern about child safety at Able to Thrive through any of the channels in the Feedback, Compliments and Complaints Policy. In addition:

- children are given an age-appropriate summary of how to raise a concern at the start of every program;
- children may raise a concern with any worker, the lead worker, the Child Safety Officer, or with their parent/carer who can then contact Able to Thrive;
- a child's concern is taken seriously, recorded, and escalated to the Child Safety Officer the same day; and
- a child who has raised a concern is supported and is not subject to any adverse change in their supports as a result of raising it.

14. Training

All workers complete training in this Policy, the Code of Conduct for Working with Children, mandatory reporting, the Reportable Conduct Scheme, and disability-specific safeguarding (recognising elevated risk for children with disability) before they may deliver any service involving children. Lead workers complete additional training in supervision, responding to disclosures, and risk management in program settings.

Refresher training is delivered annually. Training completion is recorded against each worker's file and is verified by the Lead Compliance Officer before any worker is allocated to a child-related program.

15. Roles and responsibilities

Role	Responsibility under this Policy
Child Safety Officer — Eyad Shadid	Designated senior accountability for child safety. Receipt of all child safety escalations. Sign-off on reports to the NSW Child Protection Helpline and the Office of the Children's Guardian. Liaison with regulators and external agencies. Quarterly child safety reporting

	to the Board.
Lead Compliance Officer	Owner of this Policy. Verification of worker WWCC and NDIS Worker Screening before allocation to child programs. Maintenance of the cleared-worker list. Coordination of pre-program risk assessments. Training records. Continuous Improvement Register entries arising from child safety matters.
Lead workers (holiday programs)	Operational supervision of workers and children during programs. Daily check-in with children. First response to any concern. Escalation to the Child Safety Officer.
All workers in child programs	Compliance with the Code of Conduct for Working with Children. Recognition of and response to disclosures. Recording in Brevity. Participation in mandatory training.
All workers (general)	Escalation of any concern about a child's safety to the Child Safety Officer, regardless of whether the worker is allocated to a child program. Compliance with mandatory reporting obligations where they apply.

16. Record keeping

- Child safety records, including pre-program risk assessments, child voice records, incident reports, mandatory reports, and Reportable Conduct notifications, are retained for not less than seven years from the date of the record, or longer if required by law.
- Worker clearance records (WWCC, NDIS Worker Screening) are retained for the period of the worker's engagement plus seven years.
- Training records are retained for the period of the worker's engagement plus seven years.
- Records are managed in accordance with the Privacy and Confidentiality Policy.

17. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in NSW child safety law (including the Child Safe Standards or the Reportable Conduct Scheme); a change in mandatory reporting law; an audit or regulator finding bearing on this Policy; an incident under this Policy that identifies a systemic gap; or a material change in Able to Thrive's delivery of services to children.

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Policy P-2.20

CHILD SAFE ENVIRONMENT POLICY

Document control

Policy number	P-2.20
Policy title	Child Safe Environment Policy
Version	2.0
Date issued	May 2026
Supersedes	Child Safe Environment Policy and Procedure (Section 2.20 of the Policy and Procedure Manual V3, issued 1 May 2023)
Policy owner	Lead Compliance Officer
Child Safety Officer	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to NSW child safety law, or to the structure of Able to Thrive's holiday programs or other services for children
Related policies and documents	Child Safety Policy (P-2.17); Incident Management Policy (P-2.06); Code of Conduct for Working with Children; Pre-program Risk Assessment template; Holiday Program Procedures; Photography and Digital Recording Consent Form; Parent/Carer Consent Form; Privacy and Confidentiality Policy

1. Purpose

This Policy sets out the operational standards that make Able to Thrive's services to children safe. It addresses physical environments, supervision, transport, personal care, photography, online interactions, behaviour support and emergency procedures. The Policy is read together with the Child Safety Policy (P-2.17), which sets out the broader child safety framework.

2. Scope

This Policy applies to:

- Able to Thrive's school holiday programs for children with autism;
- in-home and community-based supports delivered by Able to Thrive to a participant under the age of 18;
- any transport of children by Able to Thrive workers;
- any online or digital interaction between an Able to Thrive worker and a child; and
- any environment in which Able to Thrive services are delivered to children, including hired venues, public spaces, the participant's home, and online platforms.

3. Legislative and regulatory framework

- *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- *Children's Guardian Act 2019* (NSW) — Child Safe Standards.
- *Work Health and Safety Act 2011* (NSW).
- *Privacy Act 1988* (Cth) — photography and digital records of children.
- *Road Transport Act 2013* (NSW) and the Road Transport (Driver Licensing) Regulation 2017 (NSW) — driver licensing and child restraints.
- NDIS Code of Conduct and Practice Standards.

4. Pre-program risk assessment

Before each holiday program, and before any new service to a child commences, a Pre-program Risk Assessment is completed by the lead worker with sign-off by the Lead Compliance Officer (and, for higher-risk programs, by the Child Safety Officer). The Assessment covers:

- the venue and physical environment, including accessibility, supervision sight-lines, exits, fire safety, hazards, secure entries, and bathroom/changing areas;
- the activities planned, with a risk profile for each activity (including any specific risks for children with autism — sensory overload, transitions, water, traffic, etc.);
- the individual support needs of each child, as recorded in their NDIS plan and behaviour support plan (if any);
- the supervision ratio required, with named workers and contingencies;
- transport arrangements, including child restraints, driver clearances and routes;
- toileting and personal care arrangements;
- communication arrangements with parents/carers;
- emergency procedures specific to the venue and the cohort;
- first aid arrangements and identified medical needs (allergies, medications, anaphylaxis); and
- child-friendly communication of safety information.

The Assessment is filed in the Brevity program record before the program commences. The program does not commence until the Assessment is signed off.

5. Supervision ratios

Supervision ratios are determined for each program by reference to the children's individual support needs and the activity profile. The baseline organisational minimum is:

- one worker for every three children for group activities involving children with autism, where children have lower individual support needs;
- one worker for every two children for activities involving children with higher individual support needs or where the activity carries elevated risk (water-based, off-site excursions, transport between locations);
- one worker per child where the child's NDIS plan or behaviour support plan indicates one-to-one support is required;
- an additional lead worker, above the operational ratio, present for any group activity involving four or more children.

A worker is never alone with a child outside the supervision of at least one other adult, except where one-to-one support is the agreed model with the parent/carer and the child's plan, and where this is documented in the Pre-program Risk Assessment. Where one-to-one support is delivered, supervision arrangements such as check-ins, location tracking, and accessible meeting points are documented.

6. Venue and physical environment

- Venues are inspected before booking and recorded with safety information (exits, fire equipment, first aid station, accessible bathroom, hazards).
- Bathrooms have a clearly defined supervision arrangement that protects both the child's privacy and the worker's safeguarding position (workers do not enter a bathroom with a child unaccompanied except for documented personal care needs — see Section 8).
- Sight-lines are maintained between supervising workers; "blind spots" are identified and supervised by an additional worker.
- Sensory considerations are addressed for children with autism (lighting, noise, ability to retreat to a quiet space).
- Entry and exit points are secured and supervised during programs.

7. Transport

- Transport of children is conducted by workers who hold a current Australian driver's licence and current motor vehicle insurance, verified by Able to Thrive Personnel Pty Ltd.

- Children are transported with appropriate child restraints as required by the Road Transport (Driver Licensing) Regulation 2017 (NSW), with the type of restraint determined by the child's age and the parent/carer's instructions.
- A worker is not alone in a vehicle with a child unless this arrangement is the agreed model, documented in the Pre-program Risk Assessment, and consented to by the parent/carer. Where this occurs, the route is logged, the worker checks in with management at the start and end of the trip, and travel is direct from origin to destination.
- Workers do not transport children in personal vehicles outside an approved program context.
- Vehicles used to transport children are roadworthy and contain a first aid kit.

8. Toileting and personal care

Toileting and personal care for children are delivered with respect for the child's dignity, privacy, autonomy and safety. The following standards apply:

- where a child can manage their own toileting independently, the worker waits outside, in proximity, and the child knows how to call for help;
- where a child requires assistance with toileting or personal care, the assistance is delivered by a worker of the gender preferred by the child and parent/carer, and (where the arrangement involves any prolonged or sensitive contact) with a second worker in proximity (in the immediate area, available to assist or witness);
- personal care arrangements are documented in the child's service record and consented to in writing by the parent/carer at intake;
- photography and video are prohibited in bathroom and changing areas, irrespective of the photography consent given for other contexts; and
- any incident or near-miss involving toileting or personal care is recorded in Brevity and reviewed by the Lead Compliance Officer.

9. Photography, video and digital recording

- No photograph, video or recording of a child is taken, shared or stored by an Able to Thrive worker without the prior written consent of the parent/carer, recorded on the Photography and Digital Recording Consent Form at intake. Consent specifies the purposes (e.g. program records, family photos, marketing).
- Photographs and videos are taken only on Able to Thrive-issued devices (where these have been provided) or, where personal devices are used in the absence of an issued device, are immediately transferred to the Able to Thrive system and deleted from the personal device.
- Workers do not share photographs or video of children on personal social media. Sharing on Able to Thrive's social media is only with specific written parental consent and only with images that do not identify the child by full name or location.

- Bathroom, changing, sleep and personal-care contexts are excluded from photography under any circumstances.
- Storage and retention of photographs follow the Privacy and Confidentiality Policy.

10. Online and digital communications

- Workers do not communicate with children through personal phone numbers, personal email, personal social media accounts, or personal messaging applications.
- All necessary digital communication concerning a child is conducted through Able to Thrive systems, with the parent/carer copied in where age-appropriate.
- Workers do not connect with children on social media. Existing connections (e.g. a worker who knew the child before engagement) are disclosed at engagement and managed under the Conflict of Interest Policy.
- Online activities delivered as part of a program (e.g. video calls, online sessions during illness or travel) are recorded in the program plan, conducted from a neutral background, and (where reasonably practical) supervised by a second adult.

11. Behaviour support and group dynamics

- Able to Thrive workers do not use any restrictive practice, physical discipline, withdrawal of food or hydration, shaming, or any other practice not consistent with positive behaviour support.
- Where a child has a behaviour support plan, workers follow it. Where a child does not have a behaviour support plan and is exhibiting behaviour of concern, workers use the de-escalation techniques covered in training and seek input from the lead worker or Child Safety Officer.
- Group activities are structured to minimise triggers for children with autism, with built-in transitions, quiet spaces, and choice.
- Children are not separated from the group as a "consequence". Where a child needs time apart for self-regulation, they are accompanied to a supervised quiet space.
- Bullying or peer harm between children is responded to promptly by workers, with appropriate involvement of parents/carers.

12. Communication with parents/carers

- Parents/carers are given a program briefing before the program starts, covering supervision arrangements, the named lead worker, the venue, the contact number, and the procedures for any incident.
- Parents/carers are reachable for the duration of any program their child attends. Emergency contacts are recorded for each child.
- Parents/carers are informed promptly of any incident affecting their child, regardless of severity.

- A daily program note is shared with each parent/carer summarising their child's participation and any matters they may need to know.

13. Medical, allergies and medication

- Medical needs, allergies, medications and emergency action plans (e.g. anaphylaxis, asthma, epilepsy) are recorded at intake and updated as needed.
- Medications are administered in accordance with the Medication Management Policy and the prescriber's instructions, with parental consent.
- At least one worker present at each program holds a current first aid certificate. For programs where any child has anaphylaxis or asthma management requirements, a worker with the relevant training is present.
- A first aid kit is at the program venue at all times.

14. Emergencies

- Pre-program briefings include the venue's emergency procedures and evacuation routes. Workers walk these before the program begins.
- Workers use child-appropriate language in emergencies and stay with their assigned children at all times.
- Parents/carers are contacted as soon as practicable in the event of any emergency affecting their child.
- Emergency contacts for each child are accessible to all workers throughout the program.
- Any emergency is recorded in Brevity and reviewed under the Incident Management Policy.

15. Excursions

- Excursions outside the primary program venue require a separate Excursion Risk Assessment, signed off by the Lead Compliance Officer.
- Parents/carers consent to excursions in advance, with specific information about destination, transport, supervision and timing.
- Supervision ratios on excursions are no less than the in-venue baseline, and are tightened for higher-risk environments (water, crowds, traffic).
- A roll is taken at each transition (boarding transport, arriving at the destination, returning to transport, returning to the venue), and any discrepancy is responded to immediately.

16. Roles and responsibilities

Role	Responsibility under this Policy

Child Safety Officer — Eyad Shadid	Sign-off on Pre-program Risk Assessments for higher-risk programs and any one-to-one transport arrangements. Final accountability for child safety practice across all child-related services. Escalation point for any safety concern.
Lead Compliance Officer	Owner of this Policy. Sign-off on Pre-program Risk Assessments. Verification of consent forms (photography, transport, personal care, medical). Maintenance of the cleared-worker list. Continuous Improvement Register entries.
Lead workers (holiday programs)	Preparation of the Pre-program Risk Assessment. Operational supervision during programs. Daily program notes to parents/carers. Immediate response to incidents. End-of-day debrief with workers.
Workers in child programs	Compliance with the operational standards in this Policy. Use of Able to Thrive systems for any digital interaction. Reporting of incidents and concerns. Active supervision and engagement with children.
HR Coordinator and Operations Manager — Kriz	Rostering and allocation of cleared workers to child programs at the required ratios. Coordination of training. Coordination of EAP and worker support after distressing incidents.

17. Record keeping

- Pre-program Risk Assessments are retained for not less than seven years from the date of the program.
- Consent forms (photography, transport, personal care, medical) are retained for the period of the child's engagement plus seven years.
- Daily program notes and incident records are retained for the period required under the Incident Management Policy.
- Photographs and recordings are retained only for the purposes for which consent was given and are deleted when the purpose is met or consent is withdrawn.

18. Review of this Policy

This Policy is reviewed at least annually, and out of cycle whenever any of the following occurs: a change in NSW child safety law or NDIS Practice Standards; an incident under this Policy or the Child Safety Policy that identifies a systemic gap; a material change in the structure of Able to Thrive's holiday programs or other child-related services; or feedback from children, parents/carers or workers that indicates a gap.

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Policy P-2.21

SUICIDE PREVENTION AND RESPONSE POLICY

Document control

Policy number	P-2.21
Policy title	Suicide Prevention and Response Policy
Version	2.0
Date issued	May 2026
Supersedes	Suicide Prevention and Response Policy (undated) and Management Policy and Procedure (Suicide Prevention Incidents) (undated), both consolidated and updated in this version
Policy owner	Lead Compliance Officer
Qualified compliance lead	Eyad Shadid, Director (Compliance, HR, Operations & Client Experience)
Approved by	Eyad Shadid and Dante Michael, Directors (joint approval)
Next scheduled review	May 2027, or upon material change to NDIS reportable incident requirements, the Practice Standards, or the participant cohort served
Background	This Policy was originally developed following the death of a participant by suicide. The development of the Policy and the training of all staff in its application were recorded in the Continuous Improvement Register as the systemic response to that event. This Version 2.0 consolidates and strengthens the original framework.
Related policies and documents	Incident Management Policy; Living Alone Risk Assessment and Sole Support Worker Policy; Risk Management Policy; Child Safety Policy; Privacy and Confidentiality Policy; Brevity incident reporting system; NDIS Code of Conduct

1. Purpose

This Policy sets out how Able to Thrive Pty Ltd (Able to Thrive) identifies and responds to suicide risk in participants, escalates concerns, supports the participant and the responding worker, and meets its incident reporting and notification obligations under the NDIS.

Participant safety is the primary priority. Every situation is assessed individually, every concern is escalated, and every incident is documented and reviewed.

2. Scope

This Policy applies to:

- all Able to Thrive workers, including employees, support workers engaged through Able to Thrive Personnel Pty Ltd, contractors and management;
- any interaction with an Able to Thrive participant (adult or child) in any service setting; and
- any participant who expresses suicidal ideation, has a history of self-harm or attempted suicide, or whom a worker reasonably suspects is at risk of suicide or serious self-harm.

3. Legislative and regulatory framework

- *National Disability Insurance Scheme Act 2013* (Cth), in particular sections 73Y and 73Z and the reportable incidents framework.
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.
- NDIS Code of Conduct.
- NDIS Practice Standards and Quality Indicators.
- *Children and Young Persons (Care and Protection) Act 1998* (NSW) — mandatory reporting obligations in respect of children.
- *Coroners Act 2009* (NSW) — coronial reporting obligations following a death.
- *Work Health and Safety Act 2011* (NSW) — duties to workers responding to a participant in crisis.

4. Definitions

- **Suicidal ideation** means thoughts about suicide, including planning to end one's life or expressing a desire to do so.
- **Suicide attempt** means an action taken by a person with the intent of ending their life that does not result in death.
- **Self-harm** means deliberate injury to oneself. Self-harm may occur independently of suicidal intent but is treated as a relevant risk factor in suicide risk assessment.

- **Access to means** means the practical ability of a person to act on a suicide plan. Workers do not name or list specific means in conversation with participants or in records, but recognise the concept as part of risk assessment.
- **Reportable Incident** has the meaning given by section 73Z of the NDIS Act and includes, among other things, the death of a person with disability and serious injury of a person with disability.
- **Imminent risk** means there are reasonable grounds to believe the participant is at risk of acting on suicidal ideation in the immediate term.

5. Guiding principles

- Participant safety is the primary priority.
- Every situation is assessed individually. Risk is dynamic and may change quickly.
- Suicide risk is assessed and categorised using the Suicide Risk Matrix in Section 6.
- Workers escalate concerns and involve trained professionals where required. Workers do not attempt clinical assessment or treatment beyond the scope of their training.
- All incidents — regardless of risk level — are documented in Brevity and reviewed by management.
- Worker safety is also a priority. Workers do not put themselves at risk of physical harm in attempting to manage a crisis; emergency services are called when the situation exceeds the worker’s capacity.
- The participant is treated with dignity throughout. Suicidal ideation is engaged with calmly and without judgement.
- Cultural, religious and linguistic context is considered. Where the participant’s background calls for a particular approach, that approach is respected.

6. Suicide Risk Matrix

Workers assess suicide risk using the following matrix. A history of self-harm or previous suicide attempts may elevate a participant’s risk level.

Risk level	Indicators
Low risk	Mild or vague suicidal ideation with no recent suicide attempts and no recent history of self-harm.
Medium risk	Any of the following: mild or vague suicidal ideation with recent suicide attempts and/or recent self-harm; OR a threat of suicide or clear suicidal ideation, without recent attempts.
High risk	Any of the following: repeated threats of suicide; repeated suicidal ideation; or repeated threats or ideation with or without history of attempts or self-harm. High risk also includes any situation where

	the participant has access to means and there are reasonable grounds to believe the risk is imminent.

If the worker is uncertain about the appropriate risk level, the situation is escalated to management immediately and treated at the higher of the possible levels until a clearer assessment can be made.

7. Worker response procedure

This procedure is followed whenever a participant expresses suicidal ideation, exhibits behaviour indicating risk, or where the worker otherwise has reasonable grounds for concern.

7.1 Step 1 — provide immediate emotional support

- Remain calm.
- Speak in a reassuring tone.
- Acknowledge the participant’s feelings without judgement.

Example: "Thank you for sharing how you’re feeling. I’m here to support you."

7.2 Step 2 — ensure immediate safety

Before progressing, the worker ensures the immediate physical safety of the participant and of themselves:

- If the participant is in immediate physical danger, contact emergency services (000) without delay.
- If the environment presents an obvious hazard, calmly support the participant to move away from the hazard or remove the hazard if it is safe to do so.
- Where the participant becomes physically agitated, the worker does not attempt physical intervention. The worker maintains distance and contacts emergency services and Able to Thrive management.
- Restrictive practices are not used by Able to Thrive workers. De-escalation is verbal and supportive.

7.3 Step 3 — ascertain relevant information

The worker asks open, non-threatening questions to understand the participant’s situation and safety. Examples:

- "How are you feeling right now?"
- "Are you thinking about harming yourself?"
- "Do you have a plan?"

Workers also seek to understand:

- the participant’s mental state (for example: depression, psychosis, hopelessness, impulsivity);

- any substance use that may be affecting the participant's state;
- whether the participant has access to means; and
- as soon as reasonably practical, information from the participant's family, Able to Thrive records, behaviour support plan (if any), or previous incident reports.

7.4 Step 4 — categorise the risk level

The worker classifies the participant's risk level using the Suicide Risk Matrix in Section 6 (low, medium or high). If unsure, the worker escalates to management immediately and treats the situation at the higher possible level.

7.5 Step 5 — respond based on risk level

High risk

- Contact emergency services (000) immediately.
- Remain with the participant where it is safe to do so.
- Notify Able to Thrive management immediately.
- If the participant is physically present, ensure the environment is safe and remain with them until emergency services arrive.

Medium risk

- Notify Able to Thrive management.
- Assist the participant to connect with appropriate crisis services (see Section 7.6).
- Where the participant has a behaviour support plan or a treating clinician, follow any guidance recorded for moments of elevated risk.
- Identify triggers and protective factors that may inform ongoing support.

Low risk

- Continue active monitoring of the participant.
- Assist the participant to connect with appropriate services.
- Schedule follow-up contact within 24–48 hours.

7.6 Step 6 — crisis services

Workers may assist participants to connect with crisis services. The relevant Australian services are:

- Lifeline — 13 11 14 (24/7).
- Beyond Blue — 1300 22 4636 (24/7).
- Suicide Call Back Service — 1300 659 467 (24/7).
- 13YARN (Aboriginal and Torres Strait Islander crisis support) — 13 92 76 (24/7).
- Kids Helpline (for participants aged 5–25) — 1800 55 1800 (24/7).
- Triple Zero (000) — for any situation involving imminent risk to life.

7.7 Step 7 — documentation and incident reporting

All incidents are documented, regardless of risk level. Records include:

- date, time and location of the interaction;
- risk level assessed;
- observed behaviours and direct quotes from the participant where possible;
- the actions taken by the worker;
- who was notified and when; and
- follow-up plan and timing.

An incident report is submitted via the Brevity system for every interaction covered by this Policy, regardless of risk level. Once submitted, the incident report is reviewed by management in accordance with Section 8.

7.8 Step 8 — follow-up

Following the interaction, the worker (or a manager where the worker is unavailable):

- ensures the participant is connected to appropriate ongoing support;
- makes follow-up contact with the participant within 24–48 hours, or sooner where the risk level indicates;
- confirms that the management response described in Section 8 has commenced; and
- participates in any debrief arranged under Section 8.8.

8. Management response procedure

This procedure is followed by Able to Thrive management upon becoming aware that a worker has applied this Policy.

8.1 Step 1 — urgently review the incident report

Management reviews any suicide-related incident report as soon as practicable and treats it as urgent. Minimum checks during review:

- What occurred — clear timeline of events.
- Risk indicators — plan, intent, access to means, timeframe, history of self-harm, mental state, substance use.
- Immediate actions — whether appropriate escalation occurred (emergency response, supervision, handover).
- Notifications — whether management was notified promptly and whether relevant supports were informed.
- Documentation quality — clarity, completeness and inclusion of direct quotes where possible.

If the report is incomplete, management contacts the author immediately to obtain missing details and ensures documentation is corrected promptly.

8.2 Step 2 — confirm participant safety

If the incident report does not clearly confirm the participant is currently safe, management immediately:

- verifies the participant's current location and safety status;
- confirms supervision is in place if required; and
- ensures urgent supports are activated (including emergency services).

If safety cannot be confirmed quickly, management treats the situation as high risk and escalates accordingly.

8.3 Step 3 — assess compliance with this Policy

Management assesses whether the worker response aligned with this Policy:

- correct risk categorisation (low, medium or high);
- correct escalation pathway followed;
- whether the participant was kept engaged and not left alone when required;
- whether crisis services were appropriately offered or contacted; and
- whether incident reporting and documentation were completed correctly.

The compliance outcome is recorded in the corrective action section of the incident report on Brevity.

8.4 Step 4 — take corrective action where the response was not compliant

Where the worker response was not compliant with this Policy, management immediately undertakes the steps that should have occurred under Section 7, and records what was done and by whom.

8.5 Step 5 — communicate with Support Coordinator and external supports

Management ensures the incident report, together with any recommendations, is shared with the participant's Support Coordinator (whether the Coordinator is an Able to Thrive Support Coordinator or external) within the following timeframes:

- High risk: immediately.
- Medium risk: within 4 hours.
- Low risk: within 24 hours.

Recommendations may include referral to:

- the participant's GP;
- a psychologist or psychiatrist;
- a behaviour support practitioner;
- community mental health services;
- crisis services; or
- family, guardian or carers where the participant consents (or where consent is not required because of the nature and seriousness of the risk).

Information sharing complies with the Privacy and Confidentiality Policy. Where information is shared without the participant's consent on the basis of imminent risk, the basis for the disclosure is documented in the incident record.

8.6 Step 6 — update participant assessment and support plan

Where required, the participant's assessment is reviewed and updated, and the participant's Support Plan is updated to reflect new risks and supports. Where the participant lives alone and receives sole-worker personal support, the Living Alone Risk Assessment is re-run in accordance with that Policy.

8.7 Step 7 — corrective action on staff performance and supervision

Where gaps in worker performance are identified, management:

- provides immediate guidance to the worker;
- arranges additional supervision or retraining;
- reviews the worker's suitability if necessary; and
- documents all corrective action taken.

8.8 Step 8 — staff debrief and wellbeing support

For all medium and high risk incidents, and for any incident involving a participant death or serious self-harm, management conducts a debrief with the responding worker(s) within 24 hours. The debrief covers:

- a clear account of what occurred;
- what worked well and what did not;
- required changes for future responses; and
- the worker's wellbeing and any support needs.

Workers are offered access to confidential external counselling support through the Able to Thrive Employee Assistance Program (or, where the Program is not yet in place, through Lifeline's workplace support line) and time off as appropriate.

8.9 Step 9 — management record

Management completes the management record via Brevity, including:

- date and time of management review;
- participant safety confirmation outcome;
- compliance outcome (compliant or non-compliant, with reasons);
- actions taken;
- recommendations provided to the Support Coordinator and to other external parties;
- follow-up actions, with named owner and due date; and
- entry into the Continuous Improvement Register where systemic learning is identified.

9. NDIS Reportable Incidents notification

Suicide-related events may fall within the NDIS Reportable Incidents framework under section 73Z of the NDIS Act and the rules made under it. The following notification obligations apply:

- A serious injury arising from a suicide attempt is a Reportable Incident and is notified to the NDIS Commission. Where the incident meets the threshold for immediate notification, notification is made within 24 hours. Otherwise, a 5-day notification is lodged.
- The death of a person with disability is a Reportable Incident in all circumstances and is notified to the NDIS Commission immediately on becoming aware of the death (and within 24 hours at the latest), using the NDIS Commission Reportable Incident — Immediate Notification Form.
- The notification is followed by the 5-day notification, with any further information requested by the Commission supplied within the required timeframes.

The Director (Compliance) is responsible for ensuring notifications to the NDIS Commission are made within time. The Lead Compliance Officer prepares the notification under the Director’s sign-off.

10. Mandatory reporting where the participant is a child

Where the participant at risk is a child (under 18 years of age), workers and management have mandatory reporting obligations under the Children and Young Persons (Care and Protection) Act 1998 (NSW). Suspected risk of significant harm — which includes risk of suicide or serious self-harm — is reported to the NSW Child Protection Helpline on 132 111.

The mandatory reporting obligation operates in addition to the NDIS reportable incident framework. Both reports are made where both thresholds are met. The Child Safety Officer (Eyad Shadid) is the internal point of accountability for child mandatory reporting.

11. Coronial obligations where a participant has died

Where a participant has died and the death is reportable under section 6 of the Coroners Act 2009 (NSW), the death is reported to the police or directly to the State Coroner. Where the death is being managed by hospital, ambulance or police authorities at the scene, those authorities will commonly initiate the coronial notification; Able to Thrive cooperates fully with that process.

Able to Thrive preserves all records, communications and incident reports relating to the participant. No records are altered or destroyed following the death. The Director (Compliance) is the single point of liaison with police, coronial officers and the NDIS Commission.

12. Cultural and accessibility considerations

Workers consider cultural, religious, linguistic and accessibility factors throughout the application of this Policy. In particular:

- Aboriginal and Torres Strait Islander participants are offered access to 13YARN as the culturally informed crisis service, and engagement with Aboriginal and Torres Strait Islander health workers or community supports where available.
- Participants whose first language is not English are offered interpreting services. Crisis communication is not conducted through informal interpreters (such as family members) where the matter is sensitive and a professional interpreter can be arranged within the required timeframe.
- Participants with cognitive disability, communication impairment or other access needs are supported with communication aids, simplified language and time as required. Workers do not require participants to articulate distress in a particular way before applying this Policy.

13. Worker wellbeing and post-incident support

Responding to a participant in suicidal crisis is demanding. Able to Thrive supports the worker through:

- a debrief with management within 24 hours of any medium or high risk incident (see Section 8.8);
- access to confidential external counselling through the Employee Assistance Program;
- time off as appropriate, agreed with the HR Coordinator and Operations Manager;
- peer support arrangements where appropriate; and
- post-incident review of any practice change, training need or systemic issue identified by the worker.

14. Training

All workers complete training in this Policy as part of induction before delivering any service. Training covers:

- the Suicide Risk Matrix;
- the worker response procedure in Section 7;
- practical exercises in calm engagement and de-escalation;
- use of the Brevity incident reporting system;
- the NDIS Code of Conduct and the reportable incident framework; and
- worker wellbeing and the supports available under Section 13.

Refresher training is delivered at least annually and after any material change to this Policy or to the NDIS reportable incident requirements. Training completion is recorded against each worker’s file.

15. Continuous improvement

Every incident managed under this Policy is reviewed for systemic learning. Trends, repeated themes, and any practice gaps identified are recorded in the Continuous Improvement Register, assigned to an owner, and tracked to completion. The Director (Compliance) reports a summary of trends to the Directors at each scheduled Director meeting.

16. Roles and responsibilities

Role	Responsibility under this Policy
Director (Compliance) — Eyad Shadid	Accountability for compliance with this Policy. Sign-off on NDIS Commission reportable incident notifications. Designated Child Safety Officer for mandatory reporting. Liaison with police, coroner and NDIS Commission following a participant death. Authorisation of urgent disclosure to family or carers where the participant has not consented but imminent risk is present.
Lead Compliance Officer	Owner of this Policy. Preparation of reportable incident notifications. Compliance review of every worker response. Coordination of debriefs and corrective action. Maintenance of training records. Quarterly trend reporting to the Directors.
Client Services and Acquisition — Akash	In-person Sydney response where required. Communication with the participant and external Support Coordinators. Coordination of follow-up contact with the participant.
HR Coordinator and Operations Manager — Kriz	Roster adjustments where supervision or backup support is required. Coordination of debriefs across remote and in-person workforce. Liaison with workers regarding time off and Employee Assistance Program access.
Support workers	Execution of the worker response procedure in Section 7. Incident documentation in Brevity. Participation in debrief. Honest engagement with management about any wellbeing impact.

17. Review of this Policy

This Policy is reviewed at least annually and out of cycle whenever any of the following occurs: a change in the NDIS reportable incident framework or the Code of Conduct; an audit finding bearing on suicide-related incidents; an incident under this Policy that identifies

a systemic gap; or a material change in Able to Thrive’s participant cohort or service mix that affects suicide risk profile.

ABLE TO THRIVE PTY LTD

Policy and Procedure Manual v1.0

MASTER ENDORSEMENT

The Directors of Able to Thrive Pty Ltd jointly endorse this Policy and Procedure Manual through their signatures on this page. The signatures below cover the Manual as a whole and every controlled policy contained within it.

The endorsement records that:

- the Manual has been reviewed in its entirety by both Directors;
- each policy contained in the Manual has been considered and approved as part of the Manual through the Directors' joint approval process recorded in the Governance Policy (P-1.01);
- the Manual supersedes the Policy and Procedure Manual V3 (May 2023) prepared by Sarah Sword as the operating policy framework for Able to Thrive;
- the Manual will be maintained as a controlled document, with each constituent policy reviewed on its own schedule and the Manual as a whole reviewed in May 2027.

Eyad Shadid	**Dante Michael**
Director — Compliance, HR, Operations & Client Experience	Director — Finance, Technology, Sales, Marketing & Growth
Qualified compliance lead	
Signature: ______________________ Date: 29/05/2026	Signature: ______________________ Date: 29/05/2026

Related controlled documents not contained in this Manual

The following documents are referenced by the policies in this Manual but are held separately as controlled documents in their own right. They are not reproduced in this Manual.

Document	Current version	Owner
Business Plan	**v2.0**	Directors (joint)
Labour Hire Agreement between Able to Thrive Pty Ltd and Able to Thrive Personnel Pty Ltd	**v2.0**	Directors (joint)
Policy Review Action Plan	**v1.0**	Lead Compliance Officer
Risk Register (held in Brevity)	**Live**	Lead Compliance Officer
Continuous Improvement Register (held in Brevity)	**Live**	Lead Compliance Officer
Conflict of Interest Register (held in Brevity)	**Live**	Lead Compliance Officer
Gifts and Benefits Register (held in Brevity)	**Live**	Lead Compliance Officer
Incident Register (held in Brevity)	**Live**	Lead Compliance Officer
Complaints Register (held in Brevity)	**Live**	Lead Compliance Officer
Living Alone Register (held in Brevity)	**Live**	Lead Compliance Officer
Information Asset Register	**Live**	Lead Compliance Officer
Delegations Schedule	**Live**	Directors (joint)
Key Personnel record (held against NDIS Commission portal)	**Live**	Lead Compliance Officer
Constitution of Able to Thrive Pty Ltd	**As filed with ASIC**	Directors (joint)

Templates and forms referenced by this Manual

The policies in this Manual reference operational templates and forms that are held in Brevity (or other designated systems) for day-to-day use. The principal templates are listed below for reference.

- Service Agreement template (with current Conflict of Interest and Condition 2 clauses).
- Living Alone Risk Assessment template and Supervision and Monitoring Plan template (P-1.31).
- Alternatives Offered Log (P-1.03 §6.2 and P-2.15 §8).
- Conflict of Interest Declaration Form (P-1.03).
- Incident Report Form in Brevity (P-2.06).
- Reportable Incident Notification template (P-2.06).
- Complaint Lodgement Form in Brevity (P-2.03).
- Child-friendly complaints summary (P-2.03 — to be developed).
- Medication Administration Record (MAR) template (P-2.07).
- PRN Medication Protocol template (P-2.07).
- Mealtime Management Plan template (P-2.08).
- Spill Response procedure (P-2.09).
- Grievance Lodgement Form (P-1.27).
- Code of Conduct for Working with Children acknowledgement (P-2.17, P-1.26).
- Photography and Digital Recording Consent Form (P-2.17, P-2.20).
- Parent/Carer Consent Form (P-2.20).
- Pre-program Risk Assessment template for holiday programs (P-2.20).
- Staff Code of Conduct Acknowledgement Form (P-1.26).
- Brevity workflow definitions for incidents, complaints, supervision, and continuous improvement.

Acknowledgement

Able to Thrive Pty Ltd acknowledges the Traditional Custodians of the lands on which we work, including the Gadigal people of the Eora Nation upon whose lands our Campsie head office sits. We pay our respects to Elders past and present, and extend that respect to all Aboriginal and Torres Strait Islander people we are privileged to support.

We acknowledge people with disability and the disability rights movement that produced the framework within which we operate. We acknowledge the participants we support and the families, friends, advocates and allies who walk alongside them.

We acknowledge the workers — the support workers, the operational staff, the compliance and finance and technology teams — whose daily work brings these policies to life. The policies in this Manual will only ever be as good as the people who implement them.

END OF MANUAL