CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAMMES UNIT – ABORIGINAL CORPORATION

Recertification Audit Report

Against

ISO 9001:2008 Quality Management System

Conducted by

Institute for Healthy Communities Australia Certification Pty Ltd

13 – 14 December 2016

Audit Summary

This report documents the findings of the ISO 9001:2008 recertification audit conducted at Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation, on the 13-14 December 2016. The audit was based on a sampling process of the available information provided by the organisation in accordance with the audit plan provided 2 December 2016.

Audit Objective and Criteria

To assess continuing compliance with the requirements of ISO 9001:2008 and the Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation quality management system, legal obligations and related policies and procedures.

Scope of Audit

The scope includes provision of residential rehabilitation services and treatment, outreach and safe healing programs.

ANZSIC Codes 8609 Other Residential Care Services; 8790 Other Social Assistance Services

Sites Visited During this Audit

Site	Date	Audit Team
Head Office Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation Lot 290 Ragonesi Road, Alice Springs NT 0870 Scope: Provision of residential rehabilitation services and treatment, outreach and safe healing programs. Exclusions: Clause: 7.3 Design and Development.	13-14/12/16	Caroline Henson
Service Delivery Sites Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation Lot 290 Ragonesi Road, Alice Springs NT 0870 Scope: Provision of residential rehabilitation services and treatment, outreach and safe healing programs. Exclusions: Clause: 7.3 Design and Development.	13-14/12/16	Caroline Henson
Sites included in the Scope of this Certification not visited		
None		

Structure of the Agency

Organisational chart – Refer to end of report.

EXECUTIVE SUMMARY

The Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) is an Aboriginal controlled primary provider of culturally appropriate alcohol counselling and residential treatment services operating from a five hectare property in the rural outskirts of Alice Springs. There are four programs operating at CAAAPU funded by the Northern Territory Department of Health (DoH) and the Department of Prime Minister and Cabinet (PMC).

The organisation has experienced considerable change over the past couple of years including the appointment of a new Board of Directors and a new CEO. The current CEO was seconded from the DoH for a period of eight weeks while a period of special administration commencing 12 January 2016 under the Office of the Registrar of Indigenous Corporations (ORIC) took place. At the end of the period the CEO position was advertised and when no suitable candidates applied, the CEO was asked to remain in the position until February 2017.

In June 2016, future funding contracts were negotiated with the NT Government and PMC. A requirement of these funding contracts was that the current CEO remain in position until February 2018 which she agreed to do.

During the period February to June 2016, several key issues were identified by the Special Administrator:

- Unqualified staff holding senior positions
- Staff salaries in excess of funding contracts
- Occupancy rates fall below funding body requirements
- Lack of adequate treatment programs
- Non-compliance with reporting
- Funds at CAAAPU not being used for the intended purpose

Under the guidance of the CEO, the organisation has taken steps to address all of these issues.

The CEO implemented new systems and reporting mechanisms and a new organisational structure to facilitate good governance and operational oversight.

All organisational policies and procedures were reviewed and updated and significant additions were made to the Quality Management System. These include a new Strategic Plan 2016-2019, Quality Manual 2016-2019 and Annual Plan 2016 as well as a comprehensive Director's Good Governance 2016-2019 document. On 31 May 2016, the new Rule Book of the Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation ICN 1473 was registered. The Rule Book complies with the *Corporations (Aboriginal and Torres Strait Islander) Act 2006.*

A whole of CAAAPU re-structure took place and several redundancies were offered. New position descriptions were provided to employees and staff salaries were aligned with Fair Work Australia requirements. Staff were supported to engage in education and training appropriate to their roles to increase workforce capacity to deliver evidence based treatment programs in line with best practice.

A new comprehensive treatment program was implemented in accordance with funding requirements. This includes accredited training, alcohol awareness, behaviour change, cooking and life-skills, cultural outings, case management, financial preparation and employment with local organisations.

On 28 June 2016, CAAAPU was handed back to the members and new Directors were appointed.

Special requirements were placed on CAAAPU for a period of 12 months following special administration as follows:

- Monthly funding reports to PMC
- Board meeting papers submitted to ORIC within 14 days of a Board Meeting taking place
- Maintenance of occupancy rates for PMC and DoH above 80%
- All CAAAPU staff to complete: first aid training, aggression minimisation training and a minimum of Cert IV in Alcohol and other Drugs.
- CAAAPU funds expenditure in accordance with funding agreements.

CAAAPU is now compliant with monthly reporting to the PMC, quarterly Acquittal Reports to the DoH, quarterly OCHRESTREAM reports and National Minimum Data Set (NMDS) reports submitted for every client admitted to CAAAPU.

An occupancy report showing figures from November 2015 to October 2016 shows a significant increase across the period and occupancy levels have now been consistently at 80% or above since May 2016. This is a testament to the efforts of organisation under the guidance of the new CEO.

Clients across all four programs operating at CAAAPU are provided with evidence based, holistic and multidimensional treatment and education programs by qualified staff in line with funding body requirements.

CAAAPU is to be commended on its considerable achievements in 2016.

Positive outcomes are illustrated by the following examples:

A client who was in the program for nine months has just secured a position as a CAAAPU outreach worker to assist clients to become work ready. His role will include providing support to enable clients to attain the necessary skills and licences for employment e.g. driver's licence, first aid certificate, white card (construction).

Another client who was initially mandated into treatment successfully completed the program and later secured an administration position at CAAAPU. This is her first time in paid employment and she has now been in the position for three months. She has been supported by the organisation to attend training and is under the mentorship of the Business Administration Manager.

In summary, it was clear to the auditor that CAAAPU is committed to continuous quality improvement and achieving best outcomes for the clients they serve. The CAAAPU Quality Management System (QMS) is consistent with the requirements of the ISO 9001:2008 Standard, with systems and processes in place for management review, document control, records and service monitoring, measurement, review and continuous improvement. The organisation has a strong professional development and mentoring culture and processes to support open communication and team cohesion. Appropriate human resource management processes are in place to support staff in the work that they do. Management and staff demonstrated to the auditor at interview that they are focused and committed to organisational objectives and to the ISO 9001:9008 Quality Management System Standards.

The organisation will transition to ISO9001:2015 at the first surveillance audit in December 2017. At this time, the organisation would like to consider removing the exclusion for Design and Development from the scope.

Explanation of any differences from the information presented to the organisation at the closing meeting (if applicable).

A non-conformance with regard to Management Review was discussed at the closing meeting. This has been downgraded to an observation as the non-conformance relates to the conduct of Management Review meetings only.

The auditor has included as an observation, the commitment made by the organisation to update the Action Register to include all actions required to be undertaken to manage, build and maintain the quality management system including actions resulting from audits, complaints, meetings, incidents and suggestions for improvement. The inclusion of this observation was not discussed at the closing meeting but is related to the observation with regard to Management Review meetings and may be helpful in terms of measuring further progress.

Action plan to address non-conformances (if applicable)

The following table sets out the auditor's findings in relation to each of the observations and continuing improvements noted at the follow-up audit conducted on 29 June 2016.

CI/Obs	Finding	Progress	Current Status
C.I. 3	Clause 5.4 (Planning) The Risk Register requires updating to reflect the current status of the organisation.	Comprehensive Risk Management Plan 2016-2109 developed and implemented September 2016. Risk Register up to date.	Closed
C.I. 4	Clause 5.6 (Management Review) The Management Review Committee has not met since November 2015.	The Management Review Committee meetings have been reinstated and terms of reference developed. Minutes for 28/06/16 and 1/11/2016 sighted.	Closed
Obs. 25	Clause 4.1 (Quality Management System – General Requirements) The QMS is undergoing a full review including policies and procedures and the Quality Manual.	The CEO advised at interview that all policies and procedures including the Quality Manual have been reviewed in 2016. A number of new documents and records have also been developed and implemented.	Closed
Obs. 26	Clause 6.2.2 (Competence, awareness and training) Monitoring and implementation of staff licensing, mandatory training and performance reviews is underway.	Significant headway has been made in this area. The organisation's staff matrix indicates that licensing, mandatory training and performance reviews are now current and complete for the majority of staff. A sample of personnel files sighted by the auditor support this finding.	Open

Four observations were identified at this recertification audit conducted 13-14 December 2016.

Observation 5.6 Management Review
Management Review meeting practice does not currently comply with the organisation's documented procedure in the Management Review Meeting Terms of Reference.

Observation 7.4.1 Purchasing Process
Records of supplier evaluations are not currently kept as stated in the organisation's Quality Manual.

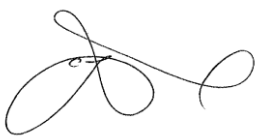
Observation 8.2.1 Customer Satisfaction
There is currently no formal process for gathering client or stakeholder feedback or measuring satisfaction with services.

Observation 8.5.1 Continual Improvement
The Action Register requires updating to include all actions required to be undertaken to manage, build and maintain the quality management system including actions resulting from audits, complaints, meetings, incidents and suggestions for improvement.

Recommendation to Certification Body

The auditor recommends continued certification for Central Australian Aboriginal Alcohol Programmes Unit – Aboriginal Corporation against ISO 9001:2008.

Signed:



Auditor Caroline Henson

Date: 21 December 2016

Assessment Summaries

Clause 4 – Quality Management System

The CAAAPU Quality Management System (QMS) is consistent with the requirements of the ISO 9001:2008 Standard, with systems and processes in place for management review, document control, records and service monitoring, measurement, review and continuous improvement.

The auditor is satisfied that the Quality Management System is appropriate for the size and complexity of the organisation and the competence of its personnel. Procedures as required by the standard have been established, documented and implemented. Systems have been developed to ensure that the QMS is maintained by the organisation through regular review.

The organisation's Strategic Plan includes clear commitment statements about quality, compliance and reporting, provision of appropriate and effective treatment programs and staff professional development. It also contains the organisation's Vision and Mission and links strategies with performance indicators, identified risks and measurable outcomes.

The Quality Manual 2016-2019 includes the Quality Policy, Management Review process description, Control of Documents and Records Procedures and the Internal Audit Procedure including information on non-conformances and procedures for corrective and preventive action. The QMS Policy, Procedures and Guidelines Register and Records Register are also contained in the Quality Manual. Some information is common to both the Quality Manual and Strategic Plan due to funding body requirements for provision of information.

The Quality Objectives are outlined in the Annual Plan. Each aim is linked to strategies for achievement, measurable outcomes, timeframes and resource allocation.

Quality management system documents are available to all staff electronically on the S drive. S drive folder permissions range from no access to read only and read/write access dependent upon the role and responsibility held by the individual staff member. This information is stored on a Security Groups register. The Purchase Order Database and QuickBooks Database are stored on a separate drive and are accessible only to top management and finance staff. The system is backed up hourly throughout the day.

All policies and procedures have been reviewed in 2016. Currently the 'last modified date' is used to mark the date that the document was last reviewed.

A new custom built electronic quality management system is currently being developed for CAAAPU by Laser Fiche RICOH. The custom build allows the system to be updated and added to as required so that it can grow and develop with the organisation. The Scope of Works and templates provided by RICOH, describe a comprehensive and fully automated QMS with inbuilt systems for document and record keeping, version control, automated review, communication, recruitment processes, compliance and incident management. The scheduled implementation date for phase one is 19/12/16.

	Assessment
General requirements (4.1)	Conforms
Documentation requirements (4.2)	Conforms
Quality Manual (4.2.2)	Conforms
Control of documentation (4.2.3)	Conforms
Control of records (4.2.4)	Conforms

Clause 5 – Management Responsibility

Management commitment to the continuous improvement of the quality management system (QMS) was apparent at interview and is evidenced by the comprehensive review of the QMS and significant improvement in compliance over the past year.

As per the Quality Manual, the CAAAPU Board of Directors appoints the CEO responsibility and delegated authority to ensure the processes for the QMS are developed, implemented and maintained. The CEO reports to the Board on the performance of the QMS and any needs for improvement and ensures directly and through delegation to section managers, the awareness of customer requirements throughout the organisation. At an operational level, responsibility for the implementation of quality systems is shared by the Treatment Manager.

Roles and responsibilities for staff are identified in Position Descriptions and the Organisational Chart identifies lines of communication. Organisational and funding body requirements are summarised and included in the Staff Induction Manual. These documents are held on the intranet and are fully accessible to staff.

The Quality Policy meets all the requirements of the standard and is effectively communicated throughout the organisation in a number of ways, including but not limited to: staff induction processes, position descriptions, daily supervisor meetings and monthly staff meetings.

The CAAAPU Annual Plan developed by the CAAAPU Management Group including Board of Directors, CEO and Section Heads is their Quality Improvement Plan. The aims contained within the Annual Plan are the organisation's Quality Objectives. Each aim is linked to strategies for achievement, measurable outcomes, timeframes and resource allocation. These include funding body service provision and reporting requirements. The Annual Plan operationalises the organisations Strategic and Quality Management Plans.

Mechanisms for communication across all levels of the organisation are in place as follows:

- Monthly Board meetings (Board Meetings minutes 21/10/16, 23/9/16, 2/9/16, 14/7/16 sighted). Agenda items include: Conflict of Interest, discussion of role of Directors (Fact sheet from ORIC – Office of the Registrar of Indigenous Corporations), Budget presentation, Financials presentation, Developing direction and purpose as a director, Quality Management System, AGM Planning, Governance training, approval for purchases, occupancy rates, program delivery, Directors insurance.
- Staff Meetings convened on the first Wednesday of every month. Staff meeting minutes sighted showed communication about the QMS, policies and procedures, position descriptions, resources, staff training, interagency relationship building, risk management and workplace health and safety issues. At present the only standard agenda items are program updates (Male Side and Female Side). The organisation is considering the inclusion of the QMS, the Action Register and a policy/procedure refresher as standard agenda items for staff meeting. With the advent of the Workplace Health and Safety (WHS) Committee, WHS will also now be included as a standard agenda item.
- Daily Supervisor Meeting held at 8am every morning where a representative from each area discusses program plans for the day to facilitate communication, team building, consistency of practice and accountability.
- Shift Supervisors organise regular formal and informal catch up meetings for their area.
- Monthly Work, Health and Safety meetings.

Staff were clear that communication between top management and staff is open and transparent. Top management and staff both spoke of an authentic 'open door policy'. Staff spoke of an organisational culture where innovation is welcomed. At interview, staff were able to identify a number of examples where opportunities for improvement that they had identified and communicated to top management had been acknowledged and implemented.

Management Review Committee meetings recommenced in June 2016 after a hiatus and now occur quarterly. The Management Review process is documented in the Quality Manual and the Management Review Meeting Terms of Reference. The Terms of Reference clearly articulate all the inputs required by the standard. The auditor is satisfied that the organisation has a strong commitment to quality improvement and has implemented systems necessary to review the continuing suitability, adequacy and effectiveness of the quality management system. However, Management Review Meeting practice does not currently conform to the organisation's documented procedures. The organisation acknowledged that this is an area for improvement.

In line with the Strategic Plan, the organisation is taking steps to raise the positive profile of CAAAPU in the community and external stakeholders are now actively encouraged to visit CAAAPU. The organisation has current MOUs with the Central Australian Aboriginal Congress (CAAC), the Alcohol and Drug Service of Central Australia (ADSCA) and the Employment Services Assistance Program. The CEO is on the Board of the Association of Alcohol and other Drug Agencies NT (AADANT), the peak body for alcohol and other drug services in the Northern Territory.

A comprehensive Risk Management Plan 2016-2109 was developed and implemented September 2016. The organisations Risk Register is up to date and obviously well used. Information about the use of the risk register and incident reporting is communicated to staff at induction and the relevant documents are accessible on the S drive.

Data collected from Incident Reports for Female and Male AMT Programs is collated and analysed quarterly and used to inform risk management.

Of note in the area of risk is the 'Continuity of Service Provision Policy' which identifies contingencies for minimising impact and maintaining services to CAAAPU clients in case of major disruption to the organisation.

	Assessment
Management commitment (5.1)	Conforms
Customer focus (5.2)	Conforms
Quality policy (5.3)	Conforms
Quality objectives (5.4.1)	Conforms
Quality management system planning (5.4.2)	Conforms
Responsibility, authority and communication (5.5)	Conforms
Management review (5.6)	Conforms
Management Review Meeting practice does not currently conform to the organisation's documented procedures. The minutes sighted for these meetings (28/06/16 and 1/11/2016) show inconsistency between the documented process and the meeting process i.e. not all core focus areas were included for discussion; some assigned actions were not subsequently recorded and monitored through the Action Register.	Observation

Clause 6 – Resource Management

Human resource management practices appear consistent with the organisation's policies and practices and legislative requirements. All staff have written job descriptions and competencies and appropriate records of education, training, skills and experience are maintained for all staff. A Staff Matrix is kept which identifies all staff qualifications, competencies, mandatory training, licenses, contracts and checks required and their currency. The Staff Induction Policy was reviewed in July 2016 and a Staff Induction Booklet developed. At interview, more recently appointed staff spoke of participating in a formal induction process as required by the QMS. Staff were clear that ongoing professional development opportunities are made available to them and all staff interviewed were clear about the requirements of their role.

The auditor was satisfied that staff were aware of the relevance and importance of their activities and how they contribute to the achievement of quality objectives. At interview, staff were clear that they felt involved in the continuous quality improvement of the organisation. There is an organisational Employee Input Policy which specifically states that employee input is valued and documents the 'open door policy'. It was evident that this policy is implemented in practice.

There is a formal Recruitment and Selection Policy and all position descriptions include selection criteria. All staff are required to have a current Criminal History Check, a valid Working with Children's Card (OCHRE Card) and a current First Aid certificate. Mandatory training includes a minimum of a Cert IV in Alcohol and Drugs and Aggression Management (P3 - Prevent, Plan, Protect) training.

In order to provide supervision to Alcohol Mandatory Treatment (AMT) clients, staff are required to become Authorised Officers approved by the DoH. Specific requirements include an understanding of the role, a valid First Aid Certificate dated within the past two years, completion of P3 online and practical training and no history of offences involving actual or threatened violence. There are currently 16 Authorised Officers on staff.

In order to be able to provide Aggression Management training to staff onsite in a sustainable way, the CEO, Treatment Manager and the Men's Shift Supervisor/Life Skills Officer have completed a 'Train the Trainer' course for the P3 Program.

Twelve staff are currently completing a Cert IV in Alcohol and Drugs. The organisation has committed to enrolling the remaining staff without this qualification in the next round. Core units in the Cert IV include working effectively in the alcohol and other drugs sector, assessment, engagement, communication, evidence based interventions, case management for clients with complex needs, legal and ethical issues and workplace health and safety for direct care work.

Of note is the personal investment the CEO demonstrates in up-skilling staff. She offers tutoring assistance to staff that are studying, especially those whose literacy and numeracy skills are less well developed. At interview, all staff said that they felt extremely well supported in the area of professional development. One staff member made special mention of the CEO's leadership in this area.

Workplace Partnership Plans (WPPs) are completed with all staff within six months of employment and reviewed bi-annually. Suggested improvements, contribution to organisational goals and demonstrated commitment to organisational values are key discussion questions in the self-reflection section of the WPP. Learning and development priorities and professional goals including KPIs and timeframes are included in the plan. This is an area of continuing improvement for the organisation and although significant progress has been made, there are still some staff who do not have WPPs in place.

All staff were provided with a manual containing the new and revised CAAAPU Policy, Procedures and Guidelines. Each document was required to be signed off as read and returned to be stored with the individuals personnel file. This included a Confidentiality Agreement and a Code of Conduct as well as policies on personal grievances, anti-discrimination and equal employment opportunity, bullying in the workplace, staff use of drugs and alcohol and staff training and development. A sample of signed and returned copies were sighted by the auditor. The electronic versions are available on the S drive for access by all staff.

Personnel files are audited every six months by the CEO. Each personnel file contains a checklist and contents list. The CEO keeps copies of all staff training certificates in addition to copies being stored on the personnel files. The sample of personnel files sighted by the auditor contained copies of training records and required clearances and certificates.

All staff have current contracts as recorded on the Staff Matrix. The Contracts of Employment 2016 file held by the CEO was sighted and a sample of contracts viewed. Staff contracts are in line with the CAAAPU Enterprise Agreement (EA 2012). All staff are paid in accordance with the Social, Community, Home Care and Disability Services Industry Award (SCHADS) award. As part of the organisational restructure, staff who fell below the award received an increase to pay on 1 July 2016. Staff paid above award rates were given the option of redundancy or a pay reduction to be paid in line with the SCHADS award. Approximately 50% took redundancy and 50% stayed. At interview the CEO reported that the majority of staff who chose to stay with the organisation agreed to the pay reduction with good will.

In summary, staff induction, supervision and professional development processes are in place and are being implemented. The majority of staff have now completed most of the mandatory training required by the organisation and in accordance with funding contracts. This is recorded on the Staff Matrix. The gaps identified are currently being addressed.

The comprehensive Director's Good Governance 2016-2019 document developed in September 2016 serves as a manual for Board members. It includes the Rule Book and organisational information including but not limited to: roles and responsibilities, guidelines for good governance, code of conduct, complaints and dispute resolution processes, financial, compliance and quality management and an overview of AOD residential treatment good practice.

All positions with CAAAPU are dependent upon ongoing funding. The budgets negotiated with funding bodies under previous management are no longer appropriate to the needs of the organisation e.g. the amount budgeted for telecommunication is excessive. The result is significant underspends in some areas and limited funds for use in others e.g. staff training. The CEO has plans to re-negotiate the budgets at the end of the contract term in order to make more effective use of the available resources.

A number of mechanisms are in place to maintain infrastructure and maximise staff and client safety:

- Evacuation Plans are posted in all areas.
- First Aid kits are accessible in all main areas and vehicles.
- Duress alarms are in all offices attached to residential blocks. Chubb fire and security maintains the automatic fire sprinkler and fire detection and alarm systems. These were last checked on 2/11/16. A fire drill was conducted on 04/11/16.
- All electrical items were tested and tagged on 24/11/2016 by a licenced electrician.
- CCTV security cameras showing property boundaries, entrances and thoroughfares in client accommodation areas are linked to monitors in the Night Carer's office. These are maintained by Optimal Security.
- Key access to all areas. There is a key matrix which indicates different levels of key access to the various CAAAPU buildings.
- A maintenance contractor was engaged in late October to conduct regular maintenance on CAAAPU property. This is an area that has been neglected in the last few years. In January 2017, the contractor will conduct a comprehensive inspection of all buildings and establish a maintenance program.

- Information Technology support is outsourced to BIZCOM. The CEO receives backup reports hourly throughout the day and monitors and reports any issues.
- The organisation current holds Association Liability, Voluntary workers, Public Liability, Professional Indemnity, Building and Contents, Workers Compensation and Motor Vehicle Insurance. All insurances are current until 30/06/2017.

In October 2016, a small business advisor from NT WorkSafe was invited to conduct a document and work place review of CAAAPU. The organisation was advised that they have an adequate WHS System place. The only gap identified was in the area of consultation with workers. To address this, the Business Administration Manager formed a WHS Committee to investigate, discuss and make recommendations about health and safety matters. The WHS Committee meets monthly and comprises representatives from all departments. Agenda items are invited from all staff for discussion at the meetings. Memos are released to inform staff of WHS Committee actions.

In an endeavour to increase organisational knowledge in the area of WHS, the CEO, Business Administration Manager and Treatment Manager completed a Cert IV in Workplace Health and Safety in November 2016. Training for WHS Committee members is currently being organised with a service provider in Darwin.

	Assessment
Provision of resources (6.1)	Conforms
Competence, awareness and training (6.2.2)	Conforms
Infrastructure and Work environment (6.3 and 6.4)	Conforms

Clause 7 – Product Realisation

Service requirements are largely prescribed by funding body service/project agreements and differ for each program. However, within this scope, the service model is planned and developed by the organisation. The quality objectives for service delivery are contained within the organisation's Annual Plan.

There are currently four programs at CAAAPU as follows:

- Alcohol Mandatory Treatment Female funded by NT DoH – 10 beds
- Alcohol Mandatory Treatment Male funded by NT DoH – 10 beds
- Residential Rehabilitation funded by the NT DoH – 10 beds
- Residential Rehabilitation funded by PMC – 10 beds

The Alcohol Mandatory Treatment Residential Rehabilitation Service is for adults who are taken in to custody three or more times in two months for being intoxicated in public. They are clinically assessed and an independent tribunal decides the best treatment options for the individual. During treatment, clients are comprehensively case managed and offered a range of development programs including life skills.

The DoH funded Residential Rehabilitation program is open to all and specifies that clients must be provided with AOD education.

The PMC funded Residential Rehabilitation program is available for Aboriginal clients only. Clients must be offered AOD education and attend accredited training as part of their treatment plan.

Clients are provided with information about the program prior to entry by the Treatment Manager during an initial assessment phase. Upon entry clients are provided with a program timetable, a statement of their rights and a contract outlining their responsibilities and the program requirements.

Upon admission to the program, clients have the rules and guidelines of the program explained to them and sign an agreement which includes a request for admission and authorisation for treatment. The screening and intake form includes information on privacy, confidentiality and the sharing of information which is signed by the clinician to confirm that it has been explained to the client in a way that they understand. A Client Consent Form is signed by the client to acknowledge that their information will be collected and shared for treatment under the Privacy Amendment (Private Sector) Act 2000. De-identified data only is submitted for the NMDS. If information sharing between services is required for treatment purposes, this is discussed with the client and they complete and sign a Consent to Share Information form.

CAAAPU staff working in direct service delivery are trained in evidence based assessment and treatment methods. The Association of Alcohol and Other Drug Agencies NT AADANT client case management toolkit was adopted in March 2016, all clients are fully assessed and have individualised treatment plans with client records maintained on ARNIE and in hard copy. The validated screening tool and brief intervention Indigenous Risk Impact Screen (IRIS) is also used to assess alcohol and other drug use, and associated mental health issues in a culturally appropriate manner for Aboriginal clients.

Clients sign a release to allow CAAAPU staff to search their property upon arrival. If a client leaves property behind when they exit the service, it is stored for them until they return. At this stage, there has been no need to develop a process or timeframes for disposal of client property.

The organisation works collaboratively with a number of external services to provide a holistic and multidimensional treatment and education program for clients. These include but are not limited to, the Central Australian Aboriginal Congress (CAAC) Social and Emotional Wellbeing and Aftercare Teams, Holyoake Counselling Services, Institute for Aboriginal Development (IAD), Centre for Applied Technology (CAT) and Charles Darwin University. CAAC has recently received funding from DoH to deliver an aftercare program to CAAAPU clients.

Within the program, clients: participate in AOD education including harm reduction and prevention; and receive work readiness skills training provided through accredited programs including literacy and numeracy. There are classes which teach practical skills such as woodwork and leatherwork and life skills training including personal hygiene, budgeting, sewing, cooking, cleaning and gardening. There is a fully equipped gym onsite and clients are taken to the town pool to encourage physical fitness. In line with Family Inclusive Practice principles, the organisation holds an open house on the weekend for family members.

At interview it was evident that staff are continually looking for innovative ways to increase client engagement and improve treatment outcomes. Initiatives include the Better Mob class co-facilitated by the clients, Live for Life fitness program, cultural outings and camping trips. Clients are engaged through art and craft sessions to discuss AOD and relationship issues. Popular hair dressing, nail care and henna tattoo sessions provide a social and enjoyable atmosphere through which the women learn about personal hygiene.

All clients are seen by a GP within 24hrs of entry. The organisation works closely with clinical services including Congress Aboriginal Medical Service and Alice Springs Hospital and has a nurse from the DoH based at the centre. 24-hour medical cover is provided from both services.

Medicines Management training is provided a regular intervals throughout the year by Central Australia Health Services (CAHS). Personal medications are provided via Webster packs, which are locked in a safe in the Night Carer's office. All medications are managed by the Nurse. Staff do not dispense medications to clients but do encourage compliance and assist client's to take medication from the correct section of the Webster pack where necessary. Dosages are recorded on ARNIE and the medications folder. Systems are in place to observe, monitor and manage incidents where clients miss medication.

Hard copy client files are kept in locked filing cabinets in the Treatment Manager's office and Carer's office. All files have numeric identifiers and are labelled with the client's name. All communication and documentation with regard to clients is loaded onto the ARNIE client management system daily. The AOD External Provider Client System runs parallel with ARNIE and collects National Minimum Data Set statistics. The storage and integrity of the data is protected through backups run hourly by BIZCOM IT. Reports are sent through to the CEO so that any issues can be addressed immediately.

Alcolizer breathalysers are used by the organisation. A new breathalyser was purchased three months ago. As these are sent offsite for re-calibration, the purchase of a second Alcolizer is being organised so that there is always one onsite. The Alcolizer has an inbuilt facility which advises when re-calibration is due.

The cook monitors the temperature of the cool room and freezer daily and documented records are kept in the kitchen. These were sighted by the auditor.

At interview, the Head Chef described a stringent and continual review process of products purchased from suppliers in terms of quality and value for money. It was clear that he is committed to efficient use of organisational resources and the delivery of a high quality product. There are no written records kept of this process.

Sub Clause	Assessment
Planning of product/service realisation (7.1)	Conforms
Customer related processes (7.2)	Conforms
Design and development (7.3)	Not Applicable
Purchasing (7.4)	Conforms
There are currently no records of supplier evaluations kept as stated in the organisation's Quality Manual. This was acknowledged by the organisation as an opportunity for improvement.	Observation
Product and service provision (7.5)	Conforms
Control of monitoring and measuring equipment (7.6)	Conforms

Clause 8 – Measurement, Analysis and Improvement

The Annual Plan 2016 includes funding body service provision and reporting requirements. The requirements for planning and evaluating performance in relation to service activities and outcomes are largely prescribed in the funding body service/project agreements. Client data is collected using ARNIE and the AOD External Provider Client System (National Minimum Data Set). Periodic reports to funding bodies show that the organisation is meeting its obligations in terms of the planning, evaluation and reporting required by these agreements.

CAAAPU has a written Complaints Procedure and Complaints Form. An easy to understand diagrammatic representation of the Complaints Procedure is included in the Complaints Procedure. This is included in the Staff Induction package to raise staff awareness and is posted on the walls throughout the common areas on the property for the benefit of clients. The complaints register showed three complaints in 2014, three complaints in 2015 and no complaints logged for 2016. The Treatment Manager advised that the register was up to date. There is no compliments register.

Staff interviewed report an increasing number of self-referrals based on recommendation from ex-clients of the service.

The Internal Audit Procedure is documented in the Quality Manual and exists as a standalone procedure accessible to staff on the S/ drive. This includes information on non-conformance and procedures for corrective and preventive actions.

Processes requiring audit are listed in the Quality Manual and an Audit Compliance Register is kept and updated annually. The register includes both internal audits and testing and maintenance checks by external service providers. This covers financial audit, assets register maintenance, building inspection, IT security, fire equipment, electrical equipment, kitchen supplies review, and HR and client files.

The end of year Financial Audit is undertaken by Perks and the Assets Register is updated by Maloney's Accountants.

Client File and Staff File audit procedures are documented and include required timeframes, methodology and bench marks. Client file audits are conducted every six months by the Treatment Manager, the results of which are passed to the CEO. Staff file audits are conducted every six months by the CEO during which a random selection of six staff files are reviewed. The last file audit was conducted June 2016 and audit results showed a considerable level of non-compliance. This was noted as an observation in the Follow-up Audit conducted on 29 June 2016. In the past six months significant headway has been made toward addressing currency and completion of licensing, mandatory training and performance reviews for all staff. The Mandatory Training register indicates that the majority of requirements for most staff have been met. Identified gaps are currently being addressed. Staff file audits and client file audits are held on the S drive and accessible to staff. The results of these audits and opportunities for improvement are taken to the Morning Supervisors Meeting and Staff meeting for supervisors to follow up with staff.

The organisation keeps an Action Register which is a log of all actions required to be undertaken to manage, build and maintain the quality management system. This includes all actions resulting from audits, complaints, meetings, incidents and suggestions for improvement. The Action Register lists the action to be taken, the source (e.g. funding body requirement, audit finding, incident), person responsible, timeframe, date completed, comments and outcome. The Treatment Manager maintains the Action Register based on input from all areas within the organisation. Staff currently have read only access to the Action Register however there is a Maintenance Register where staff can log identified non-conformances, preventive actions and opportunities for improvement. There are still some gaps in recording and the Treatment Manager is working toward addressing these. The forward plan is for the Action Register to be included as a standing agenda item at staff meetings and taken to Management Review. Where relevant, items on the Action Register are reported to the Board by the CEO. Specifically, the results of occupancy and financial audits go to the Board and funding bodies.

	Assessment
Monitoring and measurement (8.1 and 8.2)	Conforms
Customer satisfaction (8.2.1)	Conforms
There is currently no formal process for gathering client or stakeholder feedback or measuring satisfaction with services. At interview, the CEO advised that the organisation has plans to implement formal feedback processes however the focus at present is on building relationships with external stakeholders and improving the reputation of CAAAPU in the wider community.	Observation
Internal Audit (8.2.2)	Conforms
Control of nonconforming product/service (8.3)	Conforms
Analysis of data (8.4)	Conforms
Continual Improvement (8.5.1)	Conforms
The Action Register requires updating to include all actions required to be undertaken to manage, build and maintain the quality management system including actions resulting from audits, complaints, meetings, incidents and suggestions for improvement.	Observation
Corrective and Preventive action (8.5.2 and 8.5.3)	Conforms

Assessment Criteria

The Audit team assessed the organisation's performance against the ISO 9001:2008 Standard using the following indicators:

***Conforms*:**	The organisation has met the requirements of ISO 9001:2008.
Non-conformance	The absence of, or failure to implement and maintain, one or more of the Quality Management System (QMS) requirements of the Standard, or a situation which would, on the basis of available objective evidence, raise significant doubt as to the quality of the organisation in supplying (product or service). Corrective action is required within a timeframe stipulated by the Lead Auditor, with objective evidence that corrective action has been taken which will be followed-up at the next Surveillance Audit.
Major Non-conformance	A major nonconformance is where there is significant doubt there is effective process controls in place or that services will meet specified requirements. A number of non-conformances associated with the same requirement or issue could demonstrate a systemic failure and therefore constitute a major nonconformity.
Continuing Improvement	A minor shortfall identified against the requirements, or an isolated lapse in the implementation of the organisation's QMS, but not considered to warrant a rating of non-conformance.
Observation	Observations include suggestions in relation to opportunities for continuous improvement regarding the implementation and effectiveness of the quality system and positive findings. It may be a minor shortfall identified against the requirements, or an isolated lapse in the implementation of the organisation's QMS, but not considered to warrant a rating of non-conformance.

Closure of Non-conformances

For organisations seeking certification, failure to act on nonconformities within six months of written advice from IHCA Certification may result in the conduct of an additional full audit.

For organisations already certified, failure to act on nonconformities within six months of written advice from IHCA Certification may result in the suspension or withdrawal of certification.

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