SPECIALIST PRACTICE QUALITY FRAMEWORK

# Evidence Guide

## Domain 1: Clinical Governance and Leadership

Version 1.0 — First Edition

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This guide provides concrete examples of what evidence looks like for each indicator in this domain. Use it alongside your self-assessment to understand what "Established," "Developing," and "Excelling" mean in practice.

## 1.1 — Governance Structure and Accountability

*We have a defined governance structure that makes clear who is responsible for the safety and quality of care in our practice.*

**1.1.1** The practice has an identified clinical governance lead. In a solo practice, this is the principal practitioner. In a group practice, one practitioner is explicitly nominated and this is documented.

**ESTABLISHED EVIDENCE**

- A named clinical governance lead is documented in an organisational chart, position description, or governance policy
- In solo practices, the principal practitioner is explicitly identified as the governance lead in a written document (not just assumed)
- In group practices, the nomination is recorded in partners' meeting minutes or a governance terms of reference
- Staff can name the clinical governance lead when asked

**MINIMUM FOR DEVELOPING**

- The principal practitioner or a nominated clinician has been verbally identified as the governance lead, but this is not yet documented
- There is intent to formalise the arrangement in a governance policy or organisational chart

**EXCELLING**

- The clinical governance lead has a documented position description that specifies governance responsibilities, time allocation, and authority to act on safety and quality matters
- The governance lead role is reviewed annually, including whether the person holding it has adequate capacity and support

**COMMON PITFALLS**

- Assuming the most senior clinician is the governance lead without documenting it - this creates ambiguity in group practices, especially when partners share equal standing
- Having a governance lead on paper who has no practical involvement in safety and quality decisions day-to-day

**1.1.2** The practice manager's role, responsibilities, and authority are documented. It is clear which decisions the practice manager can make independently and which require clinical sign-off.

#### ESTABLISHED EVIDENCE

- A current position description for the practice manager that includes responsibilities, reporting lines, and decision-making authority
- Clear documentation of which decisions the practice manager can make independently (e.g., rostering, ordering supplies) and which require clinical sign-off (e.g., clinical policy changes, incident escalation)
- The delegation of authority is understood by both the practice manager and clinical staff

#### MINIMUM FOR DEVELOPING

- A position description exists but does not clearly delineate decision-making authority or escalation points
- The practice manager and principal practitioner have a working understanding of the role, but boundaries are informal

#### EXCELLING

- The practice manager's delegation of authority is reviewed when there are changes to practice operations, staffing, or services offered
- The practice manager is included in governance discussions and has a defined role in compliance monitoring

#### COMMON PITFALLS

- Using a generic position description downloaded from a template without tailoring it to the practice's actual operations and the individual manager's capabilities
- No clarity on clinical versus operational decision-making, leading to the practice manager either overstepping or being unable to act when needed

**1.1.3** The practice has a governance calendar or schedule that sets out when policies are reviewed, when team meetings occur, and when key compliance obligations fall due (registration renewals, insurance, equipment servicing, etc.).

#### ESTABLISHED EVIDENCE

- A governance calendar or compliance tracker that identifies key recurring obligations: policy review dates, AHPRA registration renewals, insurance renewals, equipment servicing, CPD deadlines, and team meeting schedules
- The calendar is actively used - entries are checked off, and overdue items are followed up
- Responsibility for maintaining the calendar is assigned to a specific person (typically the practice manager)

#### MINIMUM FOR DEVELOPING

- Some compliance dates are tracked (e.g., insurance renewals in a diary or spreadsheet) but there is no consolidated calendar covering all governance and compliance obligations
- The practice relies on external reminders (e.g., insurer notices, AHPRA emails) rather than proactively tracking dates

#### EXCELLING

- The governance calendar is reviewed at the start of each quarter, with upcoming obligations discussed at team or governance meetings
- The calendar includes triggers for unscheduled reviews - for example, flagging that a policy must be reviewed after a significant incident or legislative change

#### COMMON PITFALLS

- Creating a calendar at setup and never looking at it again - a governance calendar that is not actively maintained is worse than none because it creates a false sense of compliance
- Tracking clinical compliance dates but ignoring operational ones (workers' compensation renewal, fire safety checks, WHS obligations)

**1.1.4** In group practices, there is a documented arrangement for how clinical and operational decisions are made - whether through regular partners' meetings, a management committee, or another structure. Decisions and actions are recorded.

**ESTABLISHED EVIDENCE**

- A documented governance structure that describes how clinical and operational decisions are made - whether through regular partners' meetings, a management committee, or defined authority levels
- Minutes or records from governance or partners' meetings that capture decisions, actions, and accountability
- Clear process for resolving disagreements between partners or senior clinicians on clinical governance matters

**MINIMUM FOR DEVELOPING**

- Partners meet informally to discuss practice matters, but meetings are not scheduled regularly and decisions are not recorded
- There is an understanding of how decisions are made, but it relies on personal relationships rather than documented process

**EXCELLING**

- Meeting minutes include action items with owners and due dates, and these are followed up at subsequent meetings
- The decision-making structure is reviewed when partners join or leave the practice, or when the practice's scope of services changes

**COMMON PITFALLS**

- Decisions being made in corridor conversations with no record - when a dispute arises or a regulator asks how a decision was reached, there is nothing to point to
- In practices with a dominant principal, other partners or senior clinicians not being genuinely involved in governance decisions despite a documented structure that says otherwise

## 1.2 — Clinical Policies and Procedures

*We maintain current, relevant clinical and operational policies, and our team knows where to find them.*

**1.2.1** The practice maintains a set of clinical and operational policies that is appropriate to the services it provides. At a minimum, this includes policies for infection control, clinical record-keeping, patient consent, complaints management, and incident reporting.

### ESTABLISHED EVIDENCE

- A policy set that covers, at minimum: infection control, clinical record-keeping, patient consent, complaints management, and incident reporting
- Additional policies appropriate to the practice's specific services (e.g., sedation policy for procedural practices, radiation safety for radiology, sterilisation protocols for surgical rooms)
- A policy register or index that lists all policies with version dates and review dates

### MINIMUM FOR DEVELOPING

- Some policies exist but the set is incomplete - for example, the practice has an infection control policy but no documented complaints process or incident reporting procedure
- Policies exist but there is no register or index to track them

### EXCELLING

- The policy set is benchmarked against the SPQF indicator list and any specialty-specific standards, with a gap analysis completed
- Policies cross-reference related documents (e.g., the consent policy references the practice's specific consent forms and relevant college guidelines)

### COMMON PITFALLS

- Having a thick folder of policies purchased from a template provider that no one has read, customised, or could locate under pressure
- Missing policies for the services that actually carry the highest risk in the practice - for example, a dermatology practice with no policy for managing anaphylaxis during patch testing or injectable procedures

**1.2.2** Policies are written in plain language, are relevant to the practice's actual operations (not generic templates that have never been customised), and include a review date.

### ESTABLISHED EVIDENCE

- Policies reflect the practice's actual workflows, premises, staffing, and patient population - not generic hospital-oriented language
- Policies are written in plain language that all staff, including non-clinical team members, can understand
- Each policy includes a version number, approval date, and next review date
- Evidence that policies have been edited or tailored (tracked changes, practice-specific references, named roles rather than generic titles)

### MINIMUM FOR DEVELOPING

- Template-based policies have been adopted but only partially customised - some sections still reference irrelevant settings (e.g., ward-based language in a consulting room practice)
- Review dates are present on some policies but not consistently across the full set

### EXCELLING

- Policies are written with input from the staff who use them, not just the principal practitioner, and this input is documented
- Plain language summaries or quick-reference guides are available for high-use policies (e.g., a one-page infection control summary posted in the sterilisation room)

### COMMON PITFALLS

- Policies that reference "the hospital's infection control committee" or "the nursing unit manager" in a two-doctor consulting suite - a clear sign templates have not been customised
- Including a review date but never actually reviewing the policy when that date arrives

**1.2.3** All staff know where policies are stored and can access them during normal working hours. If policies are electronic, there is a backup arrangement for system outages.

### ESTABLISHED EVIDENCE

- All staff know where policies are stored - whether in a shared drive, a policy management system, or a physical folder at a known location
- If policies are stored electronically, staff have access credentials and the system is accessible from clinical areas
- There is a backup arrangement for accessing policies during IT outages (e.g., a printed copy of critical policies, USB backup, or offline access)
- New staff are shown where to find policies as part of their orientation

### MINIMUM FOR DEVELOPING

- Policies exist but are stored in a location that not all staff can access (e.g., on the principal's personal drive, or in a locked office)
- Staff are generally aware policies exist but could not quickly locate a specific policy if asked

### EXCELLING

- The practice periodically tests policy accessibility - for example, asking a staff member during a team meeting to find a specific policy and timing how long it takes
- Policies are organised logically (by domain or function) with a searchable index

### COMMON PITFALLS

- Policies stored only on one person's computer or in an email attachment chain, making them inaccessible when that person is on leave
- Electronic-only policies with no fallback plan - when the server goes down or internet drops out, clinical staff cannot access infection control or emergency procedures

**1.2.4** Policies are reviewed at least every three years, or sooner when triggered by a change in legislation, clinical guidelines, or a significant incident.

**ESTABLISHED EVIDENCE**

- A policy review schedule showing that all policies are reviewed at least every three years
- Evidence of actual reviews taking place: updated version numbers, documented changes, or a sign-off noting "reviewed, no changes required"
- Evidence that reviews are triggered early when there is a relevant legislative change, updated clinical guideline, or significant incident

**MINIMUM FOR DEVELOPING**

- Some policies have been reviewed since initial adoption, but reviews are ad hoc rather than scheduled
- The practice has committed to a review cycle but has not yet completed a full round of reviews

**EXCELLING**

- Policy reviews involve the staff who use the policy, not just the person who wrote it, and staff input is documented
- The practice tracks review completion rates and reports on them at governance meetings

**COMMON PITFALLS**

- Setting a three-year review cycle and then discovering that half the policies have not been touched in five years because nobody was tracking it
- "Reviewing" a policy by changing the date on the cover page without reading the content or checking whether the practice's operations have changed since the last review

## 1.3 — Scope of Practice and Credentialing

*We ensure that every practitioner working in our practice is qualified, registered, and working within an agreed scope of practice.*

**1.3.1** The practice verifies AHPRA registration for all practitioners (medical, nursing, allied health) at initial engagement and at least annually thereafter. Records of verification are kept.

### ESTABLISHED EVIDENCE

- Records of AHPRA registration verification for every registered practitioner - including the date of verification, the registration type, and any conditions or notations
- Verification is performed at initial engagement and at least annually thereafter
- Verification is done directly through the AHPRA public register, not by relying on the practitioner's word or a photocopy of an old certificate
- A register or spreadsheet tracking all practitioners, their registration numbers, and verification dates

### MINIMUM FOR DEVELOPING

- AHPRA registration was verified when practitioners first joined the practice, but annual re-verification is not yet a routine process
- The practice relies on practitioners to self-declare their registration status at renewal time

### EXCELLING

- AHPRA verification is automated or calendared so that it occurs proactively before registration expiry, not reactively after
- The verification record also captures any changes to conditions, endorsements, or notations and flags these for clinical governance review

### COMMON PITFALLS

- Verifying registration once at hiring and never checking again - practitioners can have conditions imposed mid-cycle or let registration lapse without notifying the practice
- Not verifying allied health practitioners or nurses who work in the practice because "they are not my employees" - if they practise under your roof, verification is your responsibility

**1.3.2** Where locums, visiting practitioners, or allied health professionals work within the practice, there is a documented arrangement covering their scope of practice, supervision requirements, access to records, and indemnity coverage.

### ESTABLISHED EVIDENCE

- Written agreements with locums or visiting practitioners that cover: scope of practice, supervision arrangements (if applicable), access to clinical records, use of practice systems, indemnity coverage, and compliance with practice policies
- Evidence that indemnity coverage has been sighted and is current
- Arrangements address what happens if something goes wrong - including incident reporting, complaints, and medicolegal responsibility

### MINIMUM FOR DEVELOPING

- Locums or visiting practitioners are used, and informal verbal agreements exist, but these are not documented
- The practice has started using a standard agreement template but it has not been completed for all visiting practitioners

### EXCELLING

- Visiting practitioner agreements are reviewed annually and updated when the scope of services changes
- The practice conducts a brief orientation for every locum or visiting practitioner, covering emergency procedures, clinical systems, and key contacts - even if the practitioner has worked there before

### COMMON PITFALLS

- Assuming the locum agency handles credentialing and indemnity - the practice retains its own responsibility to verify these matters
- No documented arrangement at all for visiting allied health practitioners (e.g., a physiotherapist using consulting rooms) because "they are independent practitioners" - the practice still has obligations regarding shared spaces, records, and patient safety

**1.3.3** For group practices, each practitioner's scope of practice is documented and understood. If the practice provides services that require specific credentialing (e.g., procedural sedation, injectable cosmetic treatments, laser procedures), evidence of that credentialing is held on file.

#### ESTABLISHED EVIDENCE

- Each practitioner's scope of practice within the practice is documented - not just their college fellowship or AHPRA registration, but what they actually do in this practice
- For services requiring specific credentialing (procedural sedation, injectable cosmetic treatments, laser procedures, minor surgery), evidence of current credentialing is held on file
- The practice maintains a credentialing register that is reviewed when practitioners take on new procedures or when credentialing requirements change

#### MINIMUM FOR DEVELOPING

- Practitioners have relevant qualifications and credentialing, but the practice does not hold copies or maintain its own register - it relies on practitioners to manage their own credentials
- Scope of practice is understood informally but not written down

#### EXCELLING

- Scope of practice is reviewed as part of an annual practitioner review or re-credentialing process
- The practice actively monitors whether credentialing bodies have changed requirements and notifies affected practitioners

#### COMMON PITFALLS

- A practitioner gradually expanding their scope of practice into areas where they do not hold current credentialing - for example, starting to offer cosmetic injectables based on a weekend course without the practice verifying the adequacy of training
- Confusing college fellowship with credentialing for specific procedures - a fellowship in dermatology does not automatically credential a practitioner for laser procedures in every jurisdiction

**1.3.4** The practice has a process for onboarding new practitioners that covers clinical systems, practice protocols, emergency procedures, and medicolegal expectations.

**ESTABLISHED EVIDENCE**

- A documented onboarding checklist for new practitioners that covers: clinical systems (PMS, prescribing, pathology ordering), practice protocols, emergency procedures, infection control practices, consent processes, incident reporting, and medicolegal expectations
- Evidence that the checklist has been completed for recent new starters (signed, dated)
- Onboarding includes a familiarisation period or mentorship arrangement, especially for practitioners new to private specialist practice

**MINIMUM FOR DEVELOPING**

- New practitioners receive an informal walkthrough of the practice and its systems, but there is no structured checklist or documented process
- Some elements of onboarding are covered (e.g., PMS training) but others are missed (e.g., emergency procedures, incident reporting)

**EXCELLING**

- Onboarding includes a follow-up check at 4-8 weeks to confirm the new practitioner has settled in, understands practice systems, and has had any initial questions addressed
- The onboarding process is updated based on feedback from recently onboarded practitioners

**COMMON PITFALLS**

- Assuming that an experienced specialist does not need onboarding - even a senior practitioner needs to know where the emergency equipment is, how the practice handles incidents, and what the local protocols are
- Onboarding the practitioner but not their support staff (e.g., a new surgeon's scrub nurse or a new physician's registrar) who also need to understand practice systems

## 1.4 — Incident Management

*We identify, report, and learn from clinical incidents and near misses.*

**1.4.1** The practice has a simple, accessible process for reporting clinical incidents and near misses. All staff - clinical and non-clinical - know how to report and feel safe doing so.

#### ESTABLISHED EVIDENCE

- A documented incident reporting procedure that explains what constitutes a reportable incident or near miss, how to report, and what happens after a report is made
- A reporting mechanism that is simple and accessible - whether a paper form, an online form, or a feature within the practice management system
- All staff, including reception and administrative staff, know how to report and have been told explicitly that reporting is expected and that they will not be penalised for doing so
- Evidence of a "just culture" approach - the practice distinguishes between system failures and individual negligence

#### MINIMUM FOR DEVELOPING

- Staff know they should report serious incidents to the principal practitioner, but there is no formal process, no form, and no defined threshold for what should be reported
- Near misses and minor incidents tend to be discussed informally but not recorded

#### EXCELLING

- The practice actively encourages near-miss reporting as a learning opportunity and can demonstrate examples of near misses that led to system improvements
- Incident reporting rates are tracked over time - an absence of reports is treated as a concern, not a reassurance

#### COMMON PITFALLS

- A reporting system that exists on paper but has never been used - zero incident reports in a busy practice is not evidence of safety, it is evidence of underreporting
- Non-clinical staff not knowing they can or should report incidents, such as a receptionist who notices a patient left the practice without collecting their pathology results

**1.4.2** Every reported incident is acknowledged, assessed for severity, and investigated proportionately. Not every incident requires a root cause analysis, but every incident requires someone to ask what happened and whether it could happen again.

### ESTABLISHED EVIDENCE

- Each reported incident is acknowledged to the person who reported it, confirming the report was received and will be reviewed
- Incidents are assessed for severity using a simple classification (e.g., no harm, minor harm, moderate harm, serious harm, death)
- Investigation is proportionate to severity - minor incidents may require a brief review and corrective action; serious incidents require a structured investigation
- Documentation of the investigation, including what was found and what was decided

### MINIMUM FOR DEVELOPING

- Incidents are reviewed by the principal practitioner when reported, but assessment and investigation is informal and not consistently documented
- There is no severity classification in use - all incidents are treated the same regardless of impact

### EXCELLING

- The practice uses a structured investigation methodology for serious incidents (e.g., a simplified root cause analysis or "5 whys" approach) and can provide examples
- Investigation findings are reviewed by someone other than the person involved in the incident, to provide objectivity

### COMMON PITFALLS

- Over-investigating minor incidents (wasting time on bureaucratic process for trivial matters) or under-investigating serious ones (a brief conversation when a formal investigation is warranted)
- The person who caused the incident being the only person who investigates it, with no independent review

**1.4.3** Findings from incident investigations are communicated to relevant staff and, where appropriate, result in changes to policy, process, or training.

#### ESTABLISHED EVIDENCE

- Evidence that investigation findings and any resulting changes are communicated to relevant staff - through team meetings, memos, email updates, or notice board postings
- Communication is timely - staff hear about findings and changes while the incident is still relevant, not months later
- Communication focuses on system learnings, not blame - it explains what changed and why, without identifying individuals involved in the incident

#### MINIMUM FOR DEVELOPING

- The principal practitioner discusses significant incidents with directly involved staff, but findings are not communicated to the broader team
- There is no routine mechanism for sharing incident learnings (e.g., no standing agenda item at team meetings)

#### EXCELLING

- Incident learnings are a standing agenda item at regular team meetings, with de-identified case discussions
- The practice can demonstrate a clear link between specific incidents and specific changes to policy, process, or training

#### COMMON PITFALLS

- Investigating an incident thoroughly but never closing the loop with staff - the investigation sits in a file and the team continues with the same unsafe process
- Only communicating with clinical staff about clinical incidents, when non-clinical staff may also need to know (e.g., reception staff need to know about a changed process for managing urgent pathology results)

**1.4.4** The practice maintains an incident register that records what happened, the investigation findings, the actions taken, and whether those actions were completed.

### ESTABLISHED EVIDENCE

- A maintained incident register that records: date, description of the incident, severity classification, investigation summary, actions taken, responsible person, and completion status
- The register is kept in a secure location with appropriate access controls (de-identified where possible)
- The register is reviewed periodically (at least annually) to identify patterns and trends
- Historical entries show that actions were actually completed, not just planned

### MINIMUM FOR DEVELOPING

- Some incidents have been recorded in an ad hoc manner (e.g., notes in a diary, emails) but there is no structured register
- The practice has set up a register template but it has not been consistently used

### EXCELLING

- The register is reviewed quarterly, with trend data reported to the governance lead
- The register includes a "lessons learned" field that captures what the practice now does differently as a result of each incident

### COMMON PITFALLS

- An incident register that records what happened but never records what was done about it - a register full of incidents with blank "action taken" columns is a red flag for any reviewer
- Keeping the register in a format that makes trend analysis impossible (e.g., unstructured free text in a Word document rather than a spreadsheet or database with consistent fields)

**1.4.5** Serious incidents - including those that could give rise to a coronial inquiry, a notification to AHPRA, or a medical indemnity claim - are escalated promptly to the clinical governance lead and the practice's indemnity provider.

**ESTABLISHED EVIDENCE**

- A documented process for escalating serious incidents - those that could give rise to a coronial inquiry, an AHPRA notification, a complaint to a health complaints commissioner, or a medical indemnity claim
- The process identifies who must be notified (clinical governance lead, indemnity provider, legal adviser) and within what timeframe
- Evidence that practitioners and senior staff know the escalation thresholds and the process to follow
- Records of any serious incident escalations that have occurred, including notification to indemnity providers

**MINIMUM FOR DEVELOPING**

- The principal practitioner understands that serious incidents need to be escalated to the indemnity provider, but there is no documented process or defined threshold
- Staff other than the principal would not know what to do if a serious incident occurred on a day the principal was absent

**EXCELLING**

- The escalation process includes a checklist covering immediate clinical actions, documentation requirements, preservation of records, communication with the patient, and notification timelines
- The practice conducts a tabletop exercise or scenario discussion annually to test the escalation process

**COMMON PITFALLS**

- Waiting too long to notify the indemnity provider - most indemnity policies require notification "as soon as practicable" and delay can prejudice coverage
- Not recognising a serious incident for what it is until the complaint letter or coronial subpoena arrives - the practice needs clear criteria for what triggers escalation, not just retrospective recognition

## 1.5 — Complaints Management

*We welcome feedback, take complaints seriously, and use them to improve.*

**1.5.1** The practice has a documented complaints process that is accessible to patients. Patients are told how to raise concerns - this information is available in the waiting area, on the practice website, or provided at intake.

### ESTABLISHED EVIDENCE

- A documented complaints policy that describes how patients can raise concerns, what will happen when they do, and expected timeframes for acknowledgement and resolution
- Patient-facing information about how to complain is visible and accessible - in the waiting area, on the practice website, or provided in new patient intake packs
- The complaints process allows complaints to be made verbally, in writing, or electronically - it does not require patients to navigate a complex or intimidating process
- Information about the relevant state or territory Health Complaints Commissioner is included as an external avenue

### MINIMUM FOR DEVELOPING

- The practice accepts complaints when they arise but has no documented process and does not proactively tell patients how to raise concerns
- There is no patient-facing information about the complaints process in the waiting room or online

### EXCELLING

- The practice actively invites feedback, not just complaints - for example, through patient surveys, suggestion boxes, or post-consultation feedback mechanisms
- Complaints information is available in languages other than English where the patient population warrants it

### COMMON PITFALLS

- Making the complaints process so formal or legalistic that patients feel intimidated or give up and go straight to the Health Complaints Commissioner instead
- Treating all negative feedback as a "complaint" and responding defensively, rather than distinguishing between feedback that requires a conversation and a formal complaint that requires investigation

**1.5.2** Complaints are acknowledged in a timely manner (within five business days as a benchmark) and the patient is told what will happen next.

#### ESTABLISHED EVIDENCE

- A defined timeframe for acknowledging complaints - five business days is the benchmark
- Evidence that complaints are acknowledged within this timeframe: dated acknowledgement letters, emails, or file notes recording verbal acknowledgement
- The acknowledgement tells the patient what will happen next and provides a realistic timeframe for the investigation and response

#### MINIMUM FOR DEVELOPING

- Complaints are responded to, but there is no defined timeframe and some complaints take weeks to be acknowledged
- Acknowledgement is verbal and not recorded

#### EXCELLING

- The practice tracks acknowledgement times and can demonstrate consistent compliance with its stated timeframe
- The acknowledgement is personalised and empathetic, not a generic template letter

#### COMMON PITFALLS

- Ignoring or delaying a response to a complaint in the hope it will go away - delayed acknowledgement escalates patient frustration and increases the likelihood of a formal external complaint
- Conflating acknowledgement with resolution - the patient needs to hear quickly that their complaint has been received, even if the investigation will take longer

**1.5.3** Complaints are investigated fairly, with findings and any proposed resolution communicated to the patient. Where a complaint cannot be resolved internally, the practice informs the patient of external avenues, including the relevant state or territory Health Complaints Commissioner.

### ESTABLISHED EVIDENCE

- Each complaint is investigated proportionately, with findings documented
- The patient receives a substantive response that addresses the issues raised, explains what was found, and describes any actions taken or proposed
- Where a complaint cannot be resolved to the patient's satisfaction internally, the practice informs the patient of external avenues, including the relevant Health Complaints Commissioner
- The practitioner who is the subject of the complaint is given a fair opportunity to respond as part of the investigation

### MINIMUM FOR DEVELOPING

- Complaints are addressed, but the investigation is informal and findings are not consistently communicated back to the patient in writing
- The practice is not systematically informing patients of external complaint avenues when internal resolution fails

### EXCELLING

- The practice conducts a debrief after each complaint investigation to identify whether the issue was systemic or isolated, and documents this assessment
- Patients who have complained are followed up after the resolution to confirm they are satisfied with the outcome

### COMMON PITFALLS

- The practitioner who is the subject of the complaint investigating their own complaint without any independent oversight
- Providing a defensive, minimising response that dismisses the patient's concerns rather than genuinely engaging with them - this is the single most common accelerant for complaints escalating to external bodies

**1.5.4** Complaints are recorded in a register that tracks the nature of the complaint, the investigation, the outcome, and any systemic changes made as a result.

#### ESTABLISHED EVIDENCE

- A complaints register that records: date received, nature of the complaint, investigation summary, outcome, any systemic actions taken, and date closed
- The register is maintained in a structured format that allows review and trend identification
- Access to the register is restricted to appropriate staff, and patient-identifying information is handled in accordance with privacy requirements

#### MINIMUM FOR DEVELOPING

- Some complaints have been recorded, but there is no consistent register - records are scattered across emails, file notes, and individual practitioners' memories
- The practice has set up a register but it is not consistently used for all complaints

#### EXCELLING

- The register categorises complaints by theme (e.g., wait times, communication, clinical care, billing) to enable meaningful trend analysis
- The register is reviewed at governance meetings with trends and actions discussed

#### COMMON PITFALLS

- Recording the complaint but not recording the outcome or actions taken - a register that tracks what went wrong but not what was done about it is of limited value
- Not recording verbal complaints because "it was sorted out on the spot" - verbal complaints that are resolved quickly still warrant a register entry if they reveal a systemic issue

**1.5.5** Complaint trends are reviewed periodically (at least annually) to identify recurring themes and inform quality improvement.

**ESTABLISHED EVIDENCE**

- Evidence of at least annual review of complaint data to identify recurring themes, patterns, or systemic issues
- A written summary or report of the review, including any actions or changes arising from it
- The review is discussed at a governance or team meeting, not just done in isolation by one person

**MINIMUM FOR DEVELOPING**

- The practice is aware of recurring complaint themes from memory or anecdote, but has not conducted a structured review of complaint data
- There is intent to begin periodic reviews but the first one has not yet occurred

**EXCELLING**

- Complaint trend data is compared year-on-year to assess whether actions taken have been effective
- Complaint themes are cross-referenced with incident data to identify overlapping patterns

**COMMON PITFALLS**

- Reviewing complaint data but taking no action on the findings - identifying that 40% of complaints relate to wait times and then doing nothing about it
- Only reviewing complaints that were formally lodged, ignoring informal feedback, verbal complaints, and online reviews that may reveal the same issues

## 1.6 — Open Disclosure

*When something goes wrong in a patient's care, we are honest and transparent.*

**1.6.1** The practice has a process for open disclosure that is consistent with the Australian Open Disclosure Framework. Clinicians understand the difference between open disclosure and legal admission of liability.

#### ESTABLISHED EVIDENCE

- A documented open disclosure policy or guideline that references the Australian Open Disclosure Framework
- The policy explains when open disclosure should occur, who should be involved, what should be communicated, and how it should be documented
- Clinicians can articulate the difference between open disclosure (being honest with a patient about what happened) and legal admission of liability
- The policy addresses when the practice's indemnity provider should be contacted before or during the disclosure process

#### MINIMUM FOR DEVELOPING

- Practitioners understand the concept of open disclosure and would have a conversation with a patient if something went wrong, but there is no documented process or policy
- There is uncertainty about the boundary between open disclosure and legal liability, and practitioners are hesitant as a result

#### EXCELLING

- The practice has a brief open disclosure guide or prompt card that clinicians can refer to in the moment, covering key steps and phrases
- The practice has reviewed the Australian Commission on Safety and Quality in Health Care open disclosure resources and adapted them for the specialist practice setting

#### COMMON PITFALLS

- Confusing open disclosure with apologising and admitting fault - this confusion causes many practitioners to avoid open disclosure entirely, which is worse than an imperfect attempt
- Having a policy but no practical guidance - a ten-page policy document is not useful to a clinician who has just realised a patient has been harmed and needs to know what to say right now

**1.6.2** When a patient is harmed or experiences an adverse outcome related to their care, the treating practitioner (or clinical governance lead) initiates a conversation with the patient or their family that acknowledges what happened, explains what is known, describes what will be done to investigate, and offers an apology where appropriate.

#### ESTABLISHED EVIDENCE

- Evidence that the practice initiates open disclosure conversations when a patient is harmed or experiences an adverse outcome related to their care
- The conversation acknowledges what happened, explains what is known, describes what will be done to investigate, and offers an apology or expression of regret where appropriate
- Open disclosure occurs in a timely manner - ideally within the first consultation after the adverse event is identified
- The patient or their family is given an opportunity to ask questions and is informed of any follow-up steps

#### MINIMUM FOR DEVELOPING

- Practitioners have had informal conversations with patients about adverse outcomes but these were not framed as open disclosure and did not follow a structured approach
- There is willingness to conduct open disclosure but hesitation about how to do it or concern about medicolegal consequences

#### EXCELLING

- The practice can provide de-identified examples of open disclosure conversations that were conducted well and resulted in maintained patient trust
- Senior clinicians model open disclosure behaviour and support junior practitioners in conducting these conversations

#### COMMON PITFALLS

- Avoiding the conversation entirely - hoping the patient will not notice or will not ask - which breaches the ethical obligation and significantly increases the risk of a formal complaint or legal action
- Delivering open disclosure as a defensive monologue rather than a dialogue - not giving the patient space to respond, ask questions, or express their feelings

**1.6.3** Open disclosure conversations are documented in the patient's clinical record.

### ESTABLISHED EVIDENCE

- Open disclosure conversations are documented in the patient's clinical record, including: the date, who was present, what was discussed, the patient's response, and any agreed follow-up actions
- Documentation is factual and non-defensive - it records what was said, not justifications for what happened
- The clinical record entry is consistent with the information communicated to the patient (i.e., the record does not contain a different version of events)

### MINIMUM FOR DEVELOPING

- Some disclosure conversations have occurred but were not documented, or documentation is limited to a brief note like "discussed with patient"
- There is no standard approach to what should be recorded

### EXCELLING

- The practice uses a structured documentation template or prompt for open disclosure entries that ensures consistent and complete recording
- Documentation is reviewed by the clinical governance lead to confirm it is appropriate, factual, and complete

### COMMON PITFALLS

- Not documenting the conversation at all - if it is not in the record, it did not happen from a medicolegal perspective
- Documenting the conversation in a way that is defensive or self-serving ("explained to patient that no error occurred") rather than factual and empathetic

**1.6.4** Staff receive guidance or training on how to conduct open disclosure conversations, including when to involve the practice's indemnity provider.

**ESTABLISHED EVIDENCE**

- Evidence that clinical staff have received guidance or training on open disclosure - through team meetings, in-house training sessions, online modules, or college CPD activities
- Training covers: when open disclosure is required, how to conduct the conversation, what to document, and when to involve the indemnity provider
- Training records or meeting minutes that document when training occurred and who attended

**MINIMUM FOR DEVELOPING**

- The principal practitioner is personally familiar with open disclosure principles but has not provided any training or guidance to other staff
- Open disclosure has been discussed informally but there is no record of structured training or guidance

**EXCELLING**

- Open disclosure training includes role-play or scenario-based exercises, not just a presentation or reading material
- Training is refreshed periodically (at least every two years) and is provided to new practitioners as part of onboarding

**COMMON PITFALLS**

- Treating open disclosure as something only the principal practitioner needs to know about - any clinician in the practice could be the first to identify an adverse event and needs to know how to respond
- One-off training with no reinforcement - open disclosure is a skill that atrophies without practice, and staff who trained three years ago may not remember the key steps when they need them

## 1.7 — Legislative and Regulatory Compliance

*We understand and meet our legal obligations as a healthcare provider.*

**1.7.1** The practice maintains awareness of the key legislation and regulations that apply to its operations. At a minimum, this includes obligations under the Health Practitioner Regulation National Law, the Privacy Act, relevant state or territory health complaints legislation, workplace health and safety law, and any legislation specific to the procedures or services the practice provides.

#### ESTABLISHED EVIDENCE

- A documented list or register of the key legislation and regulations that apply to the practice, including: the Health Practitioner Regulation National Law, the Privacy Act 1988, relevant state or territory health complaints legislation, WHS legislation, and any specialty-specific legislation (e.g., radiation safety, poisons and therapeutic goods, assisted reproductive technology)
- The register identifies who in the practice is responsible for monitoring compliance with each piece of legislation
- The practice can demonstrate awareness of state or territory-specific requirements, not just Commonwealth legislation

#### MINIMUM FOR DEVELOPING

- The principal practitioner has a general awareness of key legislative obligations but there is no documented register or list
- Compliance is managed reactively - the practice responds to regulatory requirements as they arise rather than maintaining a proactive awareness

#### EXCELLING

- The legislative register is cross-referenced to practice policies, so it is clear which policy addresses which legislative requirement
- The practice has sought legal or compliance advice to confirm its register is comprehensive for the services it provides and the jurisdiction it operates in

#### COMMON PITFALLS

- Assuming that compliance with AHPRA requirements and Medicare billing rules covers all legislative obligations - practices routinely overlook state-specific requirements around health records, reportable diseases, radiation safety, or controlled substances
- No awareness of WHS obligations as an employer - specialist practices are small businesses with all the same WHS obligations as any other employer

**1.7.2** The practice has a process for staying informed about regulatory changes that affect its operations - whether through college communications, industry associations, indemnity provider updates, or a designated responsibility within the practice.

### ESTABLISHED EVIDENCE

- A defined process for monitoring regulatory changes - this could include: subscribing to college newsletters, AHPRA updates, state health department alerts, indemnity provider bulletins, or industry association communications
- Someone in the practice (typically the practice manager or governance lead) is responsible for reviewing incoming regulatory information and flagging changes that require action
- Evidence that the practice has acted on regulatory changes - for example, updating policies after a legislative amendment or briefing staff on new requirements

### MINIMUM FOR DEVELOPING

- The principal practitioner reads college communications and indemnity provider updates but there is no systematic process and information is not shared with other staff
- The practice has identified the need for a monitoring process but has not yet established one

### EXCELLING

- Regulatory changes are a standing agenda item at governance or team meetings, with a brief update on any relevant developments
- The practice subscribes to multiple information sources and cross-references them to avoid relying on a single channel

### COMMON PITFALLS

- Relying solely on the principal practitioner reading their college newsletter - if they are busy, travelling, or on leave, regulatory changes are missed
- Receiving regulatory updates but not acting on them - a full inbox of unread compliance bulletins does not constitute a monitoring process

**1.7.3** Required notifications are made in a timely manner. This includes mandatory notifications to AHPRA, notifiable data breaches to the OAIC, workplace incidents to the relevant WHS regulator, and any reporting obligations specific to the practice's specialty.

#### ESTABLISHED EVIDENCE

- The practice understands its mandatory notification obligations: to AHPRA (for notifiable conduct), to the OAIC (for notifiable data breaches), to the relevant WHS regulator (for notifiable incidents), and any specialty-specific reporting requirements
- Records of any mandatory notifications that have been made, including the date of the triggering event, the date of notification, and the outcome
- Staff who might identify a notifiable matter (e.g., a data breach, a practitioner impairment concern) know the escalation pathway

#### MINIMUM FOR DEVELOPING

- The principal practitioner is generally aware of AHPRA mandatory notification obligations but is less certain about other notification requirements (data breach, WHS, specialty-specific)
- There is no documented process for identifying when a notification is required

#### EXCELLING

- The practice maintains a reference guide or decision tree for mandatory notifications that covers the most common scenarios for its specialty
- The governance lead reviews the notification register annually, even if no notifications have been made, to confirm the practice's understanding of its obligations remains current

#### COMMON PITFALLS

- Not recognising a notifiable data breach - for example, a misdirected referral letter containing patient health information is a notifiable breach under the Privacy Act if it is likely to result in serious harm, but many practices do not report these
- Confusion about the mandatory notification threshold for AHPRA - practitioners sometimes avoid making notifications because they are unsure whether the threshold has been met, when the obligation is to report and let AHPRA make the determination

**1.7.4** The practice holds current public liability, professional indemnity (or confirms practitioner coverage), and workers' compensation insurance. Policy details and renewal dates are tracked.

#### ESTABLISHED EVIDENCE

- Current certificates of currency for: public liability insurance, professional indemnity insurance (practice-level or confirmation that each practitioner holds individual coverage), and workers' compensation insurance
- A register or tracker that records policy details, coverage amounts, insurer, policy number, and renewal dates for each policy
- Renewal dates are included in the governance calendar so they are not missed
- For group practices, there is clarity about whether indemnity is held at practice level, individual practitioner level, or both

#### MINIMUM FOR DEVELOPING

- Insurance policies are current but details are not centrally tracked - renewal dates are managed by individual practitioners or the insurer's reminder notices
- The practice has not confirmed that all practitioners' individual indemnity coverage is current and appropriate for the services they provide

#### EXCELLING

- Insurance coverage is reviewed annually for adequacy, not just renewed automatically - the practice considers whether its services, revenue, or risk profile have changed in ways that affect coverage needs
- The practice maintains a summary document that records all insurance arrangements in one place, accessible to the governance lead and practice manager

#### COMMON PITFALLS

- Letting a policy lapse because the renewal notice went to an old email address or was missed during a busy period - even a short gap in coverage can be catastrophic if an incident occurs during that window
- Not understanding what the professional indemnity policy actually covers - many practitioners assume their indemnity covers all the services they provide without checking exclusions, particularly for cosmetic, aesthetic, or off-label treatments