

SPECIALIST PRACTICE QUALITY FRAMEWORK

Self-Assessment Guide

Domain 1: Clinical Governance and Leadership

Version 1.0 – First Edition

Published by the SPQF Editorial Group

Licensed under CC-BY 4.0 – spqf.au

Rate your practice against each indicator using the maturity levels below. Be honest – “Developing” is not a failure, it is a starting point. Record evidence or notes to support your ratings.

MATURITY LEVELS

- **Not in Place** – not done or unaware
- **Established** – done reliably with evidence

- **Developing** – done inconsistently or informally
- **Excelling** – actively reviewed and improved

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.

Ref	Indicator	●	●	●	●
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.	○	○	○	○
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.	○	○	○	○
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.).	○	○	○	○
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.	○	○	○	○

SUGGESTED EVIDENCE

- Organisational chart or simple accountability map
- Position descriptions for the practice manager and clinical governance lead
- Governance calendar or compliance tracker
- Minutes of governance or partners' meetings (if applicable)

1.2 – Clinical Policies and Procedures

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

Ref	Indicator	●	●	●	●
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.	○	○	○	○
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.	○	○	○	○
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.	○	○	○	○

Ref	Indicator				
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.				

SUGGESTED EVIDENCE

- Policy register with titles, version dates, and next review dates
- Evidence that policies have been customised (not untouched templates)
- Staff sign-off or acknowledgement records
- Evidence of policy review and update history

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.

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

SUGGESTED EVIDENCE

- AHPRA verification records with dates
- Credentialing documents and scope of practice agreements
- Locum and visiting practitioner agreements
- Practitioner onboarding checklist

1.4 – Incident Management

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

Ref	Indicator				
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.				

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

SUGGESTED EVIDENCE

- Incident reporting form or system
- Incident register (de-identified)
- Examples of completed incident investigations and resulting actions
- Evidence of staff communication following incidents
- Escalation records for serious incidents

1.5 – Complaints Management

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

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

SUGGESTED EVIDENCE

- Complaints policy and patient-facing information
- Complaints register (de-identified)
- Evidence of responses provided within timeframes
- Annual or periodic review of complaint themes
- Examples of changes made in response to complaints

1.6 – Open Disclosure

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

Ref	Indicator				
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.				
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.				
1.6.3	Open disclosure conversations are documented in the patient's clinical record.				
1.6.4	Staff receive guidance or training on how to conduct open disclosure conversations, including when to involve the practice's indemnity provider.				

SUGGESTED EVIDENCE

- Open disclosure policy or guideline
- Evidence of staff awareness (training records, team meeting notes)
- Documentation in clinical records (de-identified examples)

1.7 – Legislative and Regulatory Compliance

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

Ref	Indicator				
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.				
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.				

Ref	Indicator				
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.				
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.				

SUGGESTED EVIDENCE

- Register of applicable legislation and regulations
- Evidence of monitoring process (e.g., newsletter subscriptions, compliance calendar)
- Insurance certificates of currency
- Records of any mandatory notifications made

This document is part of the Specialist Practice Quality Framework (SPQF). Visit spqf.au for the full framework, evidence guides, and more resources.