SPECIALIST PRACTICE QUALITY FRAMEWORK

Evidence Guide

Domain 2: Patient Safety and Risk Management

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.

2.1 — Clinical Risk Assessment

We identify clinical risks in our practice and manage them systematically.

2.1.1 The practice has conducted a risk assessment that identifies the key clinical risks associated with the services it provides. This is documented, reviewed at least annually, and updated when services change.

ESTABLISHED EVIDENCE

- A written clinical risk assessment document exists that identifies key clinical risks specific to the services the practice provides (e.g., procedural complications, diagnostic delays, medication reactions).
- The document has a clear review date and evidence it has been reviewed at least annually (e.g., version history, sign-off by the principal practitioner or practice manager).
- The risk assessment has been updated when services changed - for example, when a new procedure type was introduced or a new clinician with a different scope commenced.

MINIMUM FOR DEVELOPING

- A draft risk assessment exists, even if incomplete or not yet formally reviewed. The practice can describe the key risks it has identified verbally and is working to document them.

EXCELLING

- Risk assessment review is a standing agenda item at team meetings or governance meetings. Updates are triggered proactively by near-misses, incident reports, or changes to clinical guidelines - not just by the annual review date.

COMMON PITFALLS

- Using a generic risk assessment template downloaded from the internet that does not reflect the actual services provided. A gastroenterology practice listing "radiation exposure" as a key risk because the template included it is not meaningful.
- Risk assessment completed once at practice establishment and never revisited.

2.1.2 Identified risks are rated for likelihood and consequence and have a nominated owner responsible for managing each risk. High-rated risks have documented mitigation strategies.

ESTABLISHED EVIDENCE

- Each identified risk is rated using a consistent method (e.g., likelihood x consequence matrix) that allows risks to be prioritised.
- Each risk has a named owner - a specific person, not a role or "the practice." For a small practice, this is often the principal specialist or practice manager; the point is that someone is accountable.
- High-rated risks have documented mitigation strategies that describe what the practice does to reduce likelihood or consequence (e.g., "anaphylaxis risk mitigated by mandatory allergy check at booking and pre-procedure, anaphylaxis kit checked monthly, all clinical staff BLS-trained").

MINIMUM FOR DEVELOPING

- Risks are listed but not yet formally rated. The practice can articulate which risks it considers highest priority and has started documenting mitigations for those.

EXCELLING

- Risk ratings are re-evaluated after incidents, near-misses, or when mitigation strategies change. The practice can demonstrate that a risk was downgraded after effective controls were implemented, or escalated when a gap was found.

COMMON PITFALLS

- Rating all risks as "medium" to avoid triggering additional work. If every risk is rated the same, the rating system is not serving its purpose.
- Nominating a risk owner who has no authority or capacity to actually manage the risk.

2.1.3 The risk assessment considers risks specific to the practice's specialty and setting - for example, procedural complications, diagnostic delay, medication reactions, patient falls, or risks arising from shared tenancy arrangements.

ESTABLISHED EVIDENCE

- The risk assessment includes risks that are clearly specific to the practice's specialty - for example, a dermatology practice identifying wrong-site excision risk, or an ophthalmology practice identifying wrong-eye procedure risk.
- Setting-specific risks are considered - such as risks arising from shared tenancy (e.g., a practice in a medical centre with shared waiting areas or cleaning staff), building layout issues (e.g., no direct ambulance access), or patient population characteristics (e.g., high proportion of elderly patients with falls risk).
- The practice can explain why certain risks were included and others were not, demonstrating that the assessment was a genuine exercise rather than a box-ticking activity.

MINIMUM FOR DEVELOPING

- The practice has begun to identify specialty-specific risks but has not yet fully documented setting-specific risks such as shared tenancy or building access issues.

EXCELLING

- The risk assessment references relevant specialty college guidelines or published literature on specialty-specific complications. The practice benchmarks its risk profile against known incident data for its specialty.

COMMON PITFALLS

- Treating all specialist practices the same. A consulting-only neurology practice and a procedural ENT practice have fundamentally different risk profiles. If the risk assessments are interchangeable, they are not specific enough.
- Ignoring shared tenancy risks. If your building's fire exit routes are controlled by the landlord, that is a risk worth documenting.

2.1.4 The practice's risk assessment informs its policies, training priorities, and equipment decisions. It is not a standalone document that sits unread in a drawer.

ESTABLISHED EVIDENCE

- The practice can point to at least one concrete example where the risk assessment influenced a policy, training decision, or equipment purchase - for example, "We identified sedation-related respiratory depression as a high risk, so we purchased capnography monitoring and trained all nursing staff in its use."
- Policies and procedures reference the risk assessment, or there is a clear mapping between identified risks and corresponding controls documented in policies.
- New staff are oriented to the practice's key risks as part of their induction.

MINIMUM FOR DEVELOPING

- The practice acknowledges that its risk assessment should inform operational decisions and can describe at least one informal example, even if this is not yet systematically documented.
- The risk assessment and the practice's policies exist, even if the link between them has not been made explicit.

EXCELLING

- The risk assessment is a living operational tool. When a new policy is drafted or an equipment decision is made, the risk register is consulted. The practice can show multiple examples over time where the register drove change.
- Staff can describe the top risks for the practice without needing to look them up.

COMMON PITFALLS

- A beautifully formatted risk register that no one in the practice has ever read or referenced when making a decision. If you ask staff what the top three clinical risks are and they cannot answer, the register is decorative.
- Risk assessment filed in a quality folder that is only opened during accreditation preparation.

2.2 — Infection Prevention and Control

We prevent and control infection through evidence-based practices appropriate to our setting.

2.2.1 The practice has an infection prevention and control (IPC) policy that is appropriate to the services it provides. A consulting-only dermatology practice has different IPC requirements from a procedural gastroenterology practice, and the policy reflects this.

ESTABLISHED EVIDENCE

- A written IPC policy exists and is specific to the services provided. It distinguishes between the infection risks in different areas of the practice (e.g., consulting rooms vs. procedure rooms vs. recovery areas).
- The policy reflects the actual scope of practice - a consulting-only practice does not need a section on surgical site infection prevention, while a procedural practice does.
- The policy references current Australian guidelines (e.g., NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare, relevant state health department IPC guidance).

MINIMUM FOR DEVELOPING

- An IPC policy exists but may be generic or not yet tailored to the specific services provided. The practice is aware of the gap and is working to refine it.
- Basic IPC measures are in place in practice even if the documentation does not yet match.

EXCELLING

- The IPC policy is reviewed whenever services change (e.g., a new procedure type is introduced). The practice conducts periodic IPC audits (e.g., hand hygiene compliance observations) and uses findings to update the policy or training.

COMMON PITFALLS

- Adopting a hospital-grade IPC policy verbatim that includes sections on operating theatres, central sterilising departments, and airborne isolation rooms that do not exist in the practice. The policy should be proportionate.
- Having no IPC policy at all because "we are just a consulting practice" - even consulting practices have hand hygiene, cleaning, and immunocompromised patient considerations.

2.2.2 Standard precautions are followed consistently. This includes hand hygiene, use of personal protective equipment, safe handling of sharps, and management of blood and body fluid exposures. Hand hygiene facilities (or alcohol-based hand rub) are available at every point of care.

ESTABLISHED EVIDENCE

- Hand hygiene products (soap and water or alcohol-based hand rub) are available at every clinical point of care, including consulting rooms, procedure rooms, and specimen collection areas.
- PPE (gloves, gowns, masks, eye protection) is available and used appropriately based on the nature of the clinical encounter. Staff can articulate when each type of PPE is required.
- Sharps containers are available in every room where sharps are used, are not overfilled, and are disposed of in accordance with jurisdictional requirements.
- There is a documented procedure for managing blood and body fluid exposures, including immediate first aid, reporting, and follow-up.

MINIMUM FOR DEVELOPING

- Hand hygiene products and sharps containers are available in clinical areas. PPE is accessible though usage may not yet be consistently audited.

EXCELLING

- The practice conducts periodic hand hygiene compliance audits (even informal observations) and provides feedback to staff. Audit results are documented and trends reviewed.

COMMON PITFALLS

- Hand rub dispensers mounted on walls but empty. Sharps containers in rooms but overflowing. The presence of equipment is not the same as its effective use.
- No blood and body fluid exposure protocol because "it has never happened." The point is to have the protocol before the exposure occurs.

2.2.3 Where the practice performs procedures, there are documented protocols for skin preparation, sterile field management, and post-procedure wound care instructions provided to patients.

ESTABLISHED EVIDENCE

- Written protocols exist for skin preparation (including antiseptic agent, contact time, and application method), sterile field management, and aseptic technique relevant to the procedures performed.
- Post-procedure wound care instructions are provided to patients in writing, including signs of infection to watch for and when to seek medical attention.
- Protocols are consistent with current evidence and relevant college guidelines for the specialty.

MINIMUM FOR DEVELOPING

- Skin preparation and wound care protocols exist in some form (e.g., verbal instructions to patients) but are not yet formally documented or standardised across practitioners.

EXCELLING

- The practice monitors surgical site infection rates or post-procedure infection reports and uses this data to review and refine its protocols. Patient feedback on wound care instructions is sought and used.

COMMON PITFALLS

- Assuming all practitioners prepare skin the same way without ever verifying. In multi-practitioner practices, variation in skin preparation technique is common and often unrecognised.
- Post-procedure wound care instructions given verbally only and not reinforced in writing. Patients under the effects of local anaesthetic or anxiolytics do not reliably recall verbal instructions.

2.2.4 Reusable instruments and equipment are reprocessed in accordance with AS/NZS 4187 (or the practice uses single-use devices). If reprocessing occurs on-site, the practice can demonstrate compliance with the relevant standard. If reprocessing is outsourced, there is a documented agreement with the provider.

ESTABLISHED EVIDENCE

- If reprocessing on-site: documented compliance with AS/NZS 4187, including validation and routine testing of sterilisation equipment (e.g., autoclave), batch tracking, and biological indicator testing at defined intervals. Staff performing reprocessing are trained and competency-assessed.
- If reprocessing outsourced: a current written agreement with the external reprocessing provider that specifies the standard of reprocessing, turnaround times, and tracking of instruments.
- If using single-use devices exclusively: documentation confirming the practice's decision to use single-use only, with no reprocessing of single-use items.

MINIMUM FOR DEVELOPING

- The practice can identify which approach it uses (on-site reprocessing, outsourced, or single-use) and has started documenting its compliance. On-site reprocessing records exist but may not yet be complete (e.g., missing biological indicator logs).

EXCELLING

- Regular internal audits of reprocessing compliance are conducted and documented. The practice has a traceability system that can link a reprocessed instrument batch to a specific patient and procedure.

COMMON PITFALLS

- Running an autoclave without documented validation or regular spore testing and assuming items are sterile because the cycle completed. Cycle completion does not guarantee sterilisation without periodic biological verification.
- Outsourcing reprocessing but having no written agreement - relying on a verbal understanding with a third party.

2.2.5 The practice has a process for managing patients who present with, or are known to have, transmissible infections - including scheduling considerations, room cleaning protocols, and staff protection.

ESTABLISHED EVIDENCE

- A documented protocol exists for managing patients known or suspected to have transmissible infections (e.g., active tuberculosis, COVID-19, MRSA, norovirus). The protocol covers scheduling considerations (e.g., booking at end of day), room allocation, additional PPE requirements, and enhanced cleaning after the encounter.
- Staff are aware of the protocol and can describe what they would do if a patient disclosed or presented with symptoms of a transmissible infection.
- The protocol includes how to protect other patients in the waiting area (e.g., separate waiting, mask provision, phone-based check-in).

MINIMUM FOR DEVELOPING

- Staff are generally aware that patients with transmissible infections need special handling, and ad-hoc measures are taken, but there is no written protocol yet.

EXCELLING

- The practice has specific protocols for high-risk scenarios relevant to its specialty (e.g., a respiratory physician with protocols for suspected TB, or a gastroenterologist with protocols for patients colonised with carbapenem-resistant organisms). Protocols are reviewed when new transmissible threats emerge.

COMMON PITFALLS

- A protocol that exists on paper but no one on reception knows about. The first point of contact with the practice is usually reception, and if reception staff are not trained on how to identify and manage a patient with a transmissible infection at check-in, the protocol fails at the front door.
- Assuming transmissible infection management is only relevant to procedural practices. Consulting-only practices still have waiting rooms.

2.2.6 Staff who perform exposure-prone procedures have documented evidence of their immunisation status, consistent with the Australian Immunisation Handbook and relevant jurisdictional requirements.

ESTABLISHED EVIDENCE

- Records of immunisation status are held for all staff who perform exposure-prone procedures, consistent with the Australian Immunisation Handbook and relevant state or territory health department requirements.
- Records include hepatitis B surface antibody status (with quantitative result), and other relevant vaccines as required by jurisdictional policy (e.g., varicella, measles, pertussis, influenza).
- A process exists for managing staff who are not immune or whose status is unknown - including risk assessment and any restrictions on exposure-prone procedures.

MINIMUM FOR DEVELOPING

- The practice has identified which staff require documented immunisation status and has begun collecting records, even if not yet complete for all staff.

EXCELLING

- Immunisation records are reviewed at defined intervals (e.g., annually) and updated. The practice proactively manages boosters and follow-up serology where required. New staff provide immunisation records as part of the onboarding process before commencing clinical duties.

COMMON PITFALLS

- Assuming that because a clinician is a doctor or nurse, they must be immunised. Jurisdictional requirements often specify particular vaccines and serological evidence - "I was vaccinated years ago" is not sufficient documentation.
- Not considering non-clinical staff who may still have exposure risk (e.g., staff who clean procedure rooms or handle clinical waste).

2.2.7 Cleaning schedules are documented and include the frequency of routine cleaning, the products used, and the process for terminal cleaning of procedure rooms between patients.

ESTABLISHED EVIDENCE

- Cleaning schedules are documented and specify the frequency of routine cleaning for different areas (e.g., consulting rooms, procedure rooms, waiting areas, bathrooms), the cleaning products used, and the process for terminal cleaning of procedure rooms between patients.
- Product safety data sheets (SDS) for cleaning and disinfection products are accessible to cleaning staff.
- There is a clear distinction between routine environmental cleaning and clinical-grade disinfection required in procedure areas.

MINIMUM FOR DEVELOPING

- Cleaning occurs regularly but the schedule is informal or not written down. The practice can describe its cleaning arrangements but has not yet documented product details or frequencies.

EXCELLING

- Cleaning compliance is audited (e.g., spot checks, cleaning verification tools such as UV markers or ATP testing). Cleaning staff receive IPC-specific training relevant to a healthcare setting, not just general commercial cleaning training.

COMMON PITFALLS

- Relying entirely on a commercial cleaning company for after-hours cleaning without specifying healthcare-grade requirements. Standard commercial cleaning contracts often do not cover clinical-grade disinfection of procedure rooms.
- No documented process for between-patient cleaning of procedure rooms during the day. After-hours cleaning does not address contamination between patients.

2.3 — Medication Safety

Where we store, supply, or administer medications, we do so safely.

2.3.1 The practice maintains a current list of all medications held on the premises, including emergency medications, local anaesthetics, procedural sedation agents, and any medications supplied to patients.

ESTABLISHED EVIDENCE

- A written inventory exists listing all medications held on the premises, including emergency medications (e.g., adrenaline, salbutamol, aspirin), local anaesthetics, procedural agents, and any medications supplied or dispensed to patients.
- The inventory includes the name, strength, form, quantity, location, and expiry date of each medication.
- The inventory is updated when new medications are added or discontinued.

MINIMUM FOR DEVELOPING

- The practice knows what medications it holds and can locate them, but has not yet compiled a formal written inventory. Key items such as emergency medications are identified.

EXCELLING

- The inventory is maintained in a format that enables quick identification of expiring stock. The practice reviews its medication holdings periodically to remove items that are no longer clinically needed, reducing unnecessary stock and waste.

COMMON PITFALLS

- Medications held in multiple locations (e.g., consulting rooms, procedure rooms, emergency kit) with no single inventory that captures them all. Items get missed during expiry checks because no one knew they were there.
- Failing to include medications held in the emergency kit or anaphylaxis kit on the main inventory.

2.3.2 Medications are stored in accordance with manufacturer requirements (including cold chain where applicable) and are secured appropriately. Schedule 8 medications, if held, are stored and recorded in compliance with jurisdictional requirements.

ESTABLISHED EVIDENCE

- Medications are stored according to manufacturer requirements - including temperature-sensitive items in a monitored refrigerator with min/max temperature records.
- Cold chain compliance is documented (e.g., daily temperature log or continuous monitoring device with alerts).
- Schedule 8 (controlled) medications, if held, are stored in a locked facility meeting jurisdictional requirements, with a register that records every receipt, administration, and disposal.
- Medications are secured from unauthorised access - at minimum, clinical areas containing medications are not accessible to patients or visitors unsupervised.

MINIMUM FOR DEVELOPING

- Medications are stored appropriately (e.g., refrigerated items in a fridge) but monitoring and documentation are incomplete. The practice has identified the need for formal cold chain records and S8 compliance.

EXCELLING

- The practice uses a continuous temperature monitoring system with alerts for cold chain medications. S8 reconciliation is performed at defined intervals with a second signatory. Medication storage areas are included in periodic audit.

COMMON PITFALLS

- Using a bar fridge without a thermometer or temperature log for medications requiring cold chain. "The fridge feels cold" is not cold chain monitoring.
- Schedule 8 medications stored in a locked drawer rather than a fixed, locked cabinet as required by jurisdictional legislation.

2.3.3 Medication expiry dates are checked at defined intervals (monthly as a benchmark). Expired medications are removed and disposed of appropriately.

ESTABLISHED EVIDENCE

- Expiry dates are checked at a defined interval - monthly is the accepted benchmark. A log or checklist records the date of each check, who performed it, and what actions were taken (e.g., "all items in date" or "removed expired lignocaine 2% - batch X, expiry 01/2026").
- Expired medications are disposed of appropriately (e.g., returned to a pharmacy for destruction, not placed in general waste).
- The checking process covers all locations where medications are held, including emergency kits.

MINIMUM FOR DEVELOPING

- Expiry checks occur but are not yet performed at a regular defined interval, or the log is inconsistent. The practice is establishing a routine.

EXCELLING

- The practice tracks expiry dates proactively and orders replacements before items expire. A bring-forward system (e.g., flagging items expiring within 3 months) prevents last-minute gaps. Expiry checking data is reviewed for patterns (e.g., consistently wasting a particular item suggests over-ordering).

COMMON PITFALLS

- Checking the emergency kit separately from the medication cupboard, or not at all. Emergency medications are the items most likely to be forgotten because they are used least often - and most critical when needed.
- Disposing of expired medications in the clinical waste bin without documenting what was removed. For Schedule 4 and 8 items, disposal must be documented and, in some jurisdictions, witnessed.

2.3.4 Where medications are administered in the practice, there is a documented process for patient identification, allergy checking, dose verification, and recording of administration.

ESTABLISHED EVIDENCE

- A documented process exists for administering medications in the practice, covering the "five rights" - right patient, right medication, right dose, right route, right time - plus allergy verification.
- Administration is recorded in the patient's clinical record, including the medication name, dose, route, time, administering clinician, and batch number where applicable.
- A process exists for double-checking high-risk medications (e.g., sedation agents, chemotherapy agents, look-alike/sound-alike medications).

MINIMUM FOR DEVELOPING

- Medications are administered by qualified staff and recorded in the clinical notes, but the process is not yet formally documented as a standard procedure. Allergy checking occurs but may not be systematically verified at every encounter.

EXCELLING

- The practice has identified its high-risk medications and has specific additional safety checks for them. Medication administration records are audited periodically for completeness and accuracy. Near-misses involving medication are reported and reviewed.

COMMON PITFALLS

- Recording only the medication name in the clinical record without dose, route, batch, or who administered it. In the event of an adverse reaction, incomplete records make it impossible to investigate.
- Relying on a single practitioner to draw up, check, and administer a medication with no independent verification step - particularly for sedation or injectable biologics.

2.3.5 The practice has current, accessible protocols for managing adverse medication reactions, including anaphylaxis. All clinical staff can locate and use the anaphylaxis kit, and its contents are checked at defined intervals.

ESTABLISHED EVIDENCE

- A written anaphylaxis management protocol is accessible in every clinical area where medications are administered. The protocol is consistent with current ASCIA guidelines.
- An anaphylaxis kit is available and contains, at minimum, adrenaline (in-date, correct concentration), syringes/needles (or auto-injectors), and the protocol. Additional contents (e.g., salbutamol, oxygen) are appropriate to the practice's risk profile.
- The kit is checked at defined intervals (monthly as a benchmark) with a documented log showing check date, checker, and confirmation all items are in date and complete.
- All clinical staff can locate the kit and describe the steps for managing anaphylaxis. Training or competency assessment is documented.

MINIMUM FOR DEVELOPING

- An anaphylaxis kit is present with in-date adrenaline. Staff know where it is. Formal checking schedules and training documentation are being established.

EXCELLING

- The practice conducts anaphylaxis simulation drills at least annually. The drill tests not only medication administration but also team roles, calling 000, and patient transfer logistics. Drill outcomes are documented and deficiencies addressed.

COMMON PITFALLS

- An anaphylaxis kit that has not been opened or checked in over a year. Adrenaline has a shelf life and degrades - an expired kit is functionally useless.
- Clinical staff who can point to the kit on the wall but cannot describe the correct adrenaline dose, concentration, or route for an adult vs. a child. Having the kit is not the same as being able to use it.

2.3.6 Where the practice supplies medications to patients (e.g., dispensing samples, providing take-home medications post-procedure), there is a record of what was supplied, to whom, and with what instructions.

ESTABLISHED EVIDENCE

- Where the practice supplies medications to patients (e.g., take-home antibiotics post-procedure, sample packs, compounded preparations), a record is kept that includes the patient's name, the medication supplied, the quantity, the date, and the instructions given.
- The record is linked to the patient's clinical record so that their GP or other treating practitioners can be informed.
- The practice is aware of and complies with jurisdictional requirements for supplying medications (e.g., labelling requirements, Schedule 4 supply restrictions).

MINIMUM FOR DEVELOPING

- Medications are supplied to patients with verbal instructions, and a note is made in the clinical record, but a formal supply register or standardised recording process is not yet in place.

EXCELLING

- The practice sends a summary to the patient's GP whenever medications are supplied, including the indication, quantity, and duration. Supply records are audited periodically for completeness.

COMMON PITFALLS

- Handing a patient a blister pack of antibiotics post-procedure with no label, no written instructions, and no record in the notes. This creates a patient safety risk and a medicolegal gap.
- Not considering that supplying medications, even samples, triggers regulatory obligations in most Australian jurisdictions.

2.4 — Equipment and Device Management

Our clinical equipment is safe, maintained, and fit for purpose.

2.4.1 The practice maintains a register of all clinical equipment, including the device type, serial number, date of purchase or lease, and servicing schedule.

ESTABLISHED EVIDENCE

- A register exists listing all clinical equipment, including device name/type, manufacturer, model, serial number, date of purchase or lease commencement, warranty expiry, and scheduled servicing intervals.
- The register covers all clinical equipment - not just large or expensive items. Items such as pulse oximeters, blood pressure monitors, ophthalmoscopes, and dermatoscopes are included.
- The register is kept current and updated when equipment is acquired, replaced, or decommissioned.

MINIMUM FOR DEVELOPING

- The practice can identify its major clinical equipment and knows when it was purchased, but a formal register with serial numbers and servicing schedules has not yet been compiled.

EXCELLING

- The register is linked to a servicing calendar with automated reminders. The practice tracks total cost of ownership and uses the register to plan equipment replacement before end-of-life failures.

COMMON PITFALLS

- Registering the ultrasound machine and the autoclave but not the examination lamps, blood pressure cuffs, or thermometers. Smaller items still require calibration and replacement.
- Maintaining the register in a spreadsheet that no one updates after initial setup.

2.4.2 Equipment is serviced, calibrated, and tested in accordance with manufacturer recommendations and relevant Australian Standards. Service records are retained.

ESTABLISHED EVIDENCE

- Service records are retained for all clinical equipment, showing the date of service, what was performed, who performed it (internal staff or external technician), and the outcome (pass/fail, items replaced).
- Servicing and calibration are performed in accordance with manufacturer recommendations and relevant Australian Standards (e.g., AS 3551 for electrical medical equipment).
- Overdue servicing is identified and addressed. Equipment that fails servicing or calibration is taken out of service until repaired.

MINIMUM FOR DEVELOPING

- Major equipment is serviced when a problem is noticed or when the manufacturer sends a reminder, but there is no proactive servicing schedule. The practice is establishing one.

EXCELLING

- The practice maintains a forward servicing calendar and books servicing in advance. It retains a complete service history for each piece of equipment and tracks whether recommended actions from previous services have been completed.

COMMON PITFALLS

- Assuming that equipment does not need servicing if it is still working. Many devices drift out of calibration gradually - a blood pressure monitor that reads 10 mmHg low will still produce a number, just not an accurate one.
- No records of servicing - a technician visited, but there is no documentation of what was done or what the findings were.

2.4.3 Staff who operate clinical equipment are trained in its correct use and can demonstrate competency. Training records are kept.

ESTABLISHED EVIDENCE

- Training records show that each staff member who operates clinical equipment has been trained in its correct use. Training may be provided by the manufacturer, an in-house competent person, or through a formal course.
- Competency is assessed - not just "attended training" but demonstrated correct use. For high-risk equipment (e.g., lasers, electro-surgical units, sedation monitoring), competency assessment is documented with sign-off by a qualified assessor.
- Training is refreshed when new equipment is introduced, when significant software or operational changes occur, or at defined intervals.

MINIMUM FOR DEVELOPING

- Staff have received informal training (e.g., shown how to use the device by a colleague) but this has not been formally documented. The practice is establishing training records.

EXCELLING

- Training is role-specific - nursing staff trained on the equipment they operate, reception staff on equipment relevant to their role (e.g., defibrillator). The practice identifies training gaps proactively when new staff join or new equipment is acquired.

COMMON PITFALLS

- Assuming that a clinician with 20 years of experience does not need training on a new piece of equipment because they have used "something similar." Specific device training is required regardless of general experience.
- No training records for locum or casual staff who use clinical equipment.

2.4.4 The practice has a process for managing equipment faults or failures, including how to take faulty equipment out of service, how to report the fault, and what interim arrangements apply while equipment is unavailable.

ESTABLISHED EVIDENCE

- A documented process exists for managing equipment faults, covering: how to identify and report a fault, how to take faulty equipment out of service (e.g., tagging, labelling, physical removal), who is responsible for arranging repair, and what interim arrangements apply while the equipment is unavailable.
- Staff know how to report a fault and can demonstrate the process. There is a record of reported faults and their resolution.
- The process addresses whether patients need to be rescheduled or referred elsewhere if critical equipment is unavailable.

MINIMUM FOR DEVELOPING

- Staff generally know to stop using faulty equipment and tell the practice manager, but the process is not written down. Fault reporting is informal.

EXCELLING

- Fault reports are reviewed for patterns (e.g., recurring faults with the same device, indicating it may need replacement). The practice has pre-arranged backup options for critical equipment failures (e.g., a loan device agreement with a supplier).

COMMON PITFALLS

- Faulty equipment placed in a cupboard with no label, and someone else takes it out and uses it the next day. If a device is out of service, it must be clearly marked and physically separated from operational equipment.
- No interim plan for equipment failure. If the only colposcope breaks, what happens to the patients booked this week?

2.4.5 The practice monitors TGA safety alerts and recall notices relevant to the equipment and devices it uses, and can demonstrate that it has acted on any applicable alerts.

ESTABLISHED EVIDENCE

- The practice is subscribed to TGA safety alerts (e.g., via the TGA email alert service or System of Alerts) relevant to the types of equipment and devices it uses.
- A process exists for reviewing incoming alerts and determining whether they are applicable to the practice's equipment. Applicable alerts are actioned (e.g., equipment quarantined, patients contacted, manufacturer contacted).
- A log or record demonstrates that alerts have been received, reviewed, and actioned (or noted as not applicable with a reason).

MINIMUM FOR DEVELOPING

- Someone in the practice is aware of TGA alerts and checks them periodically, but there is no formal subscription or documented review process.

EXCELLING

- Alert review is assigned to a specific person with a defined turnaround time. The practice can demonstrate rapid response to a relevant alert, including communication with affected patients if applicable.

COMMON PITFALLS

- Subscribed to TGA alerts but all emails go to a shared inbox that no one monitors. Subscription without review is not monitoring.
- Assuming TGA alerts only apply to implantable devices. Alerts also cover diagnostic equipment, software, consumables, and in-vitro diagnostic devices.

2.4.6 Single-use devices are not reprocessed or reused unless the practice holds a TGA-approved reprocessing arrangement.

ESTABLISHED EVIDENCE

- The practice has a clear policy that single-use devices are not reprocessed or reused. Staff are aware of this policy.
- Single-use devices are identifiable (e.g., labelled by the manufacturer with a "do not reuse" symbol) and are disposed of after each use.
- If the practice uses any device that could be ambiguous (single-use vs. reusable), the manufacturer's instructions for use have been reviewed and the classification is documented.

MINIMUM FOR DEVELOPING

- Staff understand that single-use devices should not be reused. The practice has not yet formally documented this as a policy but complies in practice.

EXCELLING

- The practice periodically reviews its consumable inventory to verify that single-use items are correctly identified and that no reprocessing of single-use devices is occurring. New staff are oriented to this requirement during induction.

COMMON PITFALLS

- Reusing biopsy forceps or other devices labelled as single-use because "we autoclave them." Autoclaving a single-use device does not make it safe for reuse - the device material may degrade, and the practice assumes liability.
- Not checking the manufacturer's instructions for use on devices that appear reusable but are classified as single-use.

2.5 — Emergency Preparedness

We are prepared to respond to clinical emergencies that could reasonably occur in our practice.

2.5.1 The practice has identified the clinical emergencies that could reasonably occur in its setting - based on the patient population, the procedures performed, and the medications administered. A practice that performs procedural sedation has different emergency preparedness requirements from a practice that provides consulting services only.

ESTABLISHED EVIDENCE

- A documented emergency risk assessment identifies the clinical emergencies that could reasonably occur, based on the patient population (e.g., elderly patients at risk of falls or cardiac events), the procedures performed (e.g., procedural sedation carrying a risk of respiratory depression), and the medications administered (e.g., injectable biologics carrying a risk of anaphylaxis).
- The assessment distinguishes between the practice's actual risk profile and generic emergency lists. A consulting-only rheumatology practice has different emergency risks from a procedural dermatology practice.
- The emergency preparedness measures (equipment, training, protocols) are proportionate to the identified risks.

MINIMUM FOR DEVELOPING

- The practice can articulate its main emergency risks verbally but has not yet documented a formal emergency risk assessment. Basic emergency measures (e.g., a phone to call 000) are in place.

EXCELLING

- The emergency risk assessment is reviewed when services change (e.g., a new procedure type is introduced) and after every actual emergency or near-miss. The practice adjusts its emergency preparedness accordingly.

COMMON PITFALLS

- Preparing for emergencies that are extremely unlikely while ignoring common ones. A vasovagal episode in a blood collection room is far more likely than a cardiac arrest - yet many practices have a defibrillator and no protocol for managing a faint.
- Not considering non-clinical emergencies such as fire, power failure during a procedure, or a gas leak in a shared building.

2.5.2 Emergency equipment is available, accessible, and appropriate to the identified risks. At a minimum, this includes a means of calling for external emergency assistance (000), oxygen delivery equipment (where procedures are performed), a basic airway management kit, and an anaphylaxis kit.

ESTABLISHED EVIDENCE

- Emergency equipment is available, accessible (not locked in a cupboard that requires a key no one can find), and appropriate to the practice's identified emergency risks.
- At minimum, the practice has: a means of calling 000, oxygen delivery equipment (where procedures are performed), a basic airway management kit (oropharyngeal airways, bag-valve-mask), and an anaphylaxis kit with in-date adrenaline.
- Additional equipment is available where the risk profile warrants it - for example, a pulse oximeter and capnography for practices performing procedural sedation, or a defibrillator for practices with high-acuity patient populations.
- Emergency equipment is stored in a known, consistent location that all staff can identify.

MINIMUM FOR DEVELOPING

- An anaphylaxis kit with in-date adrenaline is available. Oxygen equipment is present if procedures are performed. Staff know where to find the emergency equipment.

EXCELLING

- Emergency equipment is standardised across rooms where applicable. The practice has considered whether an automated external defibrillator (AED) is warranted based on its patient population and response time for ambulance services in its area.

COMMON PITFALLS

- Emergency oxygen cylinder that has not been tested or is empty. Having an oxygen cylinder on the wall is not the same as having functioning oxygen delivery capability - someone must check the gauge.
- Emergency equipment stored in a location that is logical to the practice manager but unknown to clinical staff, especially locums or casual staff.

2.5.3 Emergency equipment is checked at defined intervals (monthly as a benchmark) and after every use. Check records are maintained.

ESTABLISHED EVIDENCE

- Emergency equipment is checked at defined intervals - monthly is the accepted benchmark. A check log records the date, the person who checked, and the findings (e.g., "all items present and in date," "oxygen cylinder pressure at X," "replaced expired oropharyngeal airway").
- Equipment is also checked and restocked after every use.
- The checking process covers all components: medication expiry dates, equipment function (e.g., does the suction unit turn on?), oxygen cylinder pressure, battery-operated device charge levels, and completeness of contents.

MINIMUM FOR DEVELOPING

- Emergency equipment is checked periodically, though not yet at a formally defined monthly interval. A log has been started.

EXCELLING

- Check records are reviewed by the practice manager or a nominated person to confirm checks are occurring. The practice has a backup plan for items that are found to be expired or faulty during a check (e.g., a spare adrenaline ampoule kept separately).

COMMON PITFALLS

- A check log with 12 months of identical entries ("all OK") that suggests the check is a tick-box exercise rather than a genuine inspection. If every check for a year found zero issues, the check may not be thorough.
- Checking the anaphylaxis kit but not the oxygen cylinder, or vice versa. All emergency equipment must be included in the check.

2.5.4 All clinical staff have current Basic Life Support (BLS) certification. Where the practice performs procedures that carry a risk of cardiopulmonary compromise, at least one practitioner present during procedures holds Advanced Life Support (ALS) certification.

ESTABLISHED EVIDENCE

- All clinical staff hold current Basic Life Support (BLS) certification from a recognised provider (e.g., Australian Resuscitation Council-compliant course). Certificates are on file with expiry dates tracked.
- Where the practice performs procedures carrying a risk of cardiopulmonary compromise (e.g., procedural sedation, administration of agents with a risk of severe allergic reaction), at least one practitioner present during procedures holds current Advanced Life Support (ALS) certification.
- A system exists to ensure certifications are renewed before they expire.

MINIMUM FOR DEVELOPING

- Most clinical staff have current BLS certification. The practice is aware of any gaps and has a plan to address them (e.g., staff booked for upcoming training).

EXCELLING

- All clinical staff, including nursing and allied health staff, hold current BLS. The practice supports and funds regular refresher training beyond the minimum certification cycle. Non-clinical staff (e.g., reception) have completed a first aid course that includes CPR.

COMMON PITFALLS

- BLS certification that expired six months ago for half the clinical team, with no plan for renewal. Certification is only valid while it is current.
- ALS certification held by the principal specialist only, who is sometimes absent during procedures. The requirement is for an ALS-certified practitioner to be present during procedures - not just employed by the practice.

2.5.5 The practice conducts or participates in emergency response drills or simulations at least annually. Drills are documented and any lessons learned are acted upon.

ESTABLISHED EVIDENCE

- The practice conducts or participates in emergency response drills or simulations at least annually. Drills are relevant to the practice's identified emergency risks (e.g., anaphylaxis scenario, cardiac arrest in the waiting room, vasovagal collapse during a procedure).
- Drills are documented, including the date, the scenario, the participants, and the observations or lessons learned.
- Lessons learned from drills result in documented changes - for example, "We found the oxygen tubing was too short to reach the patient in the procedure chair, so we purchased a longer set" or "Reception staff did not know the practice address to give to 000."

MINIMUM FOR DEVELOPING

- The practice has conducted at least one drill or simulation, or key staff have participated in emergency training that included a simulation component, even if a formal in-practice drill has not yet occurred.

EXCELLING

- Drills are conducted more than once a year, cover different emergency scenarios, and involve all staff including reception. The practice uses drills to build team capability, not just to satisfy a compliance requirement. Debrief discussions are documented.

COMMON PITFALLS

- A drill conducted once three years ago as part of an accreditation push, with no drills since. Emergency skills are perishable - annual practice is the minimum.
- Drills that only involve the specialist and the nurse but not reception staff. In an actual emergency, the person who calls 000, unlocks the front door for paramedics, and directs them to the right room is often the receptionist.

2.5.6 The practice has a documented arrangement for patient transfer to a hospital in the event of a clinical emergency, including the nearest appropriate facility, the transfer process, and communication responsibilities.

ESTABLISHED EVIDENCE

- A documented arrangement exists for transferring a deteriorating patient to a hospital. The document identifies: the nearest appropriate hospital (and an alternative), the transfer process (ambulance via 000, or direct contact arrangement with the hospital), who is responsible for calling, and what clinical information is communicated during handover.
- The arrangement reflects the practice's location and the realistic response time of emergency services. A practice in a metropolitan area has different considerations from one in a regional or rural setting.
- The arrangement is known to all clinical staff and is accessible (e.g., posted on the wall of the procedure room, not buried in a policy manual).

MINIMUM FOR DEVELOPING

- Staff know to call 000 in an emergency and can identify the nearest hospital. A formal documented arrangement has not yet been developed.

EXCELLING

- The practice has established a direct relationship with the nearest emergency department or receiving hospital (e.g., a phone contact for pre-alert). The transfer protocol includes a structured clinical handover format (e.g., ISBAR). The practice has considered how to manage a patient who deteriorates after hours or when only a skeleton staff is present.

COMMON PITFALLS

- Assuming "call 000" is sufficient as a transfer arrangement. The ambulance service will want to know the practice address, the nature of the emergency, and access details (e.g., which floor, is there a lift for a stretcher, is there a loading bay). Preparing this information in advance saves critical minutes.
- Not considering that the nearest hospital may not be the most appropriate. A patient with a suspected STEMI needs a percutaneous coronary intervention-capable facility, which may not be the closest ED.

2.6 — Safe Management of Procedures

Where we perform procedures in our rooms, we apply appropriate safety standards.

2.6.1 The practice has defined which procedures are performed on-site, and has assessed the suitability of its facilities, equipment, and staffing for each procedure type.

ESTABLISHED EVIDENCE

- The practice maintains a written list of all procedures performed on-site.
- Each procedure has been assessed for the suitability of the practice's facilities (e.g., room size, lighting, ventilation), equipment (e.g., correct instrumentation, monitoring capability), and staffing (e.g., whether an assistant is required, whether a sedation-trained nurse must be present).
- The suitability assessment is reviewed when new procedures are proposed or when facilities change.

MINIMUM FOR DEVELOPING

- The practice can describe which procedures it performs on-site but has not yet formally documented the list or completed suitability assessments. Procedures are performed in appropriate conditions based on clinical judgement.

EXCELLING

- The practice benchmarks its procedure list and suitability criteria against relevant college guidelines or day surgery standards. It has clear escalation criteria for when a procedure that is normally suitable for in-rooms should be moved to a day surgery or hospital setting based on individual patient factors.

COMMON PITFALLS

- "We have always done this procedure in rooms" without ever formally assessing whether the room, equipment, and staffing are appropriate. Familiarity is not the same as suitability.
- Expanding the range of procedures performed in-rooms without reassessing facility and equipment requirements for the new procedures.

2.6.2 Pre-procedure processes include patient identification, confirmation of the planned procedure (including site and side where relevant), verification of informed consent, and a check of relevant allergies, medications, and comorbidities.

ESTABLISHED EVIDENCE

- A documented pre-procedure process exists that includes: patient identification (confirmed with the patient, not assumed from the appointment book), confirmation of the planned procedure including site and side where relevant, verification of informed consent (signed consent form reviewed before proceeding), and a check of allergies, current medications, and relevant comorbidities.
- The process is followed consistently, regardless of how many times the clinician has seen the patient or how "straightforward" the procedure is.
- The verification is documented in the clinical record.

MINIMUM FOR DEVELOPING

- Patient identity and consent are confirmed before procedures. Allergy and medication checks occur but may not be systematically documented for every encounter. The practice is working to standardise the pre-procedure process.

EXCELLING

- The pre-procedure verification includes a structured pause or "time-out" that involves the patient and all team members present. The process is audited periodically and non-compliance is addressed.

COMMON PITFALLS

- Treating the consent form as the verification step. Consent should be confirmed (i.e., the patient still agrees and understands), not just checked for a signature. A consent form signed three months ago in a different appointment does not constitute verified consent on the day.
- Skipping the verification for "simple" or "routine" procedures. Wrong-site errors are most common in high-volume, repetitive procedure settings - exactly the procedures practitioners consider routine.

2.6.3 For procedures that carry a risk of wrong-site or wrong-patient error, the practice uses a procedural safety checklist or time-out process.

ESTABLISHED EVIDENCE

- For procedures that carry a risk of wrong-site, wrong-side, or wrong-patient error, the practice uses a procedural safety checklist or time-out process. This includes at minimum: patient identification, procedure confirmation, site/side marking and confirmation, allergy review, and confirmation that required equipment and consumables are available.
- The checklist or time-out is performed immediately before the procedure begins, not during the booking or earlier in the day.
- Completion is documented in the clinical record.

MINIMUM FOR DEVELOPING

- A verbal confirmation process occurs before procedures but is not yet formalised as a written checklist or structured time-out. The practice is developing one.

EXCELLING

- The checklist is tailored to the specific procedure types performed in the practice (not a generic surgical safety checklist designed for operating theatres). It includes procedure-specific items (e.g., for skin excision: "specimen pot labelled with patient name, site, and side"). The practice reviews its checklist based on incident reports or near-misses.

COMMON PITFALLS

- Using a time-out process for major procedures but not for minor ones. A wrong-site skin biopsy is still a wrong-site procedure - the consequences may be less severe, but the system failure is the same.
- A checklist that is completed after the procedure as a retrospective documentation exercise rather than as a real-time safety check.

2.6.4 The practice has documented post-procedure care instructions that are provided to patients, including expected recovery, warning signs, and how to contact the practice or seek emergency care after hours.

ESTABLISHED EVIDENCE

- Written post-procedure care instructions are provided to patients (or their carer) for every procedure performed. Instructions cover: expected recovery (what is normal), warning signs that require medical attention, wound care where applicable, activity restrictions, and how to contact the practice or seek emergency care after hours.
- Instructions are specific to the procedure performed - not a single generic handout for all procedures.
- A record is kept that instructions were provided (e.g., noted in the clinical record, or the patient signs an acknowledgement).

MINIMUM FOR DEVELOPING

- Verbal post-procedure instructions are given routinely. Written instructions exist for some procedures but not all. The practice is developing standardised handouts.

EXCELLING

- Instructions are available in languages other than English where the patient population warrants it. The practice follows up with patients after higher-risk procedures (e.g., a phone call the following day). Post-procedure instruction content is reviewed and updated based on patient feedback or reported complications.

COMMON PITFALLS

- Post-procedure instructions that say "call the rooms if you have concerns" but the practice closes at 4:30pm and has no after-hours contact or voicemail. Patients need to know what to do when the practice is closed.
- Instructions written in medical terminology that patients do not understand. "Monitor for signs of cellulitis" is meaningless to most patients - "Watch for increasing redness, swelling, warmth, or pus around the wound" is actionable.

2.6.5 The practice has defined patient selection criteria for in-rooms procedures - including circumstances where a procedure should be performed in a day surgery or hospital setting instead, based on patient complexity, anaesthetic requirements, or procedural risk.

ESTABLISHED EVIDENCE

- The practice has documented criteria for determining which patients are suitable for in-rooms procedures and which should be referred to a day surgery or hospital setting. Criteria include patient factors (e.g., BMI, ASA classification, comorbidities, anticoagulation status), procedural factors (e.g., estimated duration, complexity, anticipated blood loss), and anaesthetic factors (e.g., whether local anaesthetic alone is sufficient or sedation/general anaesthesia is required).
- The criteria are applied consistently and are known to all practitioners who perform procedures.
- Decisions to perform a procedure in-rooms despite borderline patient factors are documented with the clinical rationale.

MINIMUM FOR DEVELOPING

- Practitioners exercise clinical judgement about patient suitability for in-rooms procedures and can describe their general approach, but formal written selection criteria have not yet been documented.

EXCELLING

- Patient selection criteria are benchmarked against relevant specialty college guidelines and reviewed periodically. The practice audits outcomes for in-rooms procedures and reviews any complications to determine whether patient selection was appropriate.

COMMON PITFALLS

- No documented criteria - each practitioner uses their own judgement, which may vary significantly. In multi-practitioner practices, this leads to inconsistency and potential risk.
- Selection criteria that are too permissive because the alternative (booking a day surgery or hospital) is inconvenient or has long wait times. Convenience should not override patient safety.

2.6.6 Procedure outcomes, including any complications, are recorded in the patient's clinical record.

ESTABLISHED EVIDENCE

- The clinical record for every procedure includes: the procedure performed (including site and side), the findings, the technique used, the outcome, and any complications (including intra-procedure and immediate post-procedure complications).
- Complications are recorded factually and contemporaneously - not retrospectively when a complaint is received.
- The practice maintains a log or register of complications that enables review of trends over time (e.g., infection rates, unplanned returns, complications by procedure type).

MINIMUM FOR DEVELOPING

- Procedure details and outcomes are documented in clinical notes. Complications are recorded when they occur but a separate complications register or trend analysis is not yet in place.

EXCELLING

- Complication data is reviewed at regular intervals (e.g., quarterly) as part of clinical governance. The review considers whether complication rates are within expected benchmarks, whether any trends are emerging, and whether practice changes are needed. Findings are documented.

COMMON PITFALLS

- Recording "procedure completed without complication" as a standard phrase for every case, even when a minor complication did occur. Under-reporting of minor complications prevents the practice from identifying trends.
- No mechanism for capturing complications that present after the patient has left the practice (e.g., post-procedure infection reported to the GP). If the practice does not hear about it, it cannot learn from it.

2.7 — Workplace Health and Safety

We provide a safe working environment for our staff, contractors, and visitors.

2.7.1 The practice meets its obligations under the relevant jurisdictional Work Health and Safety Act. A person has been nominated with responsibility for WHS within the practice.

ESTABLISHED EVIDENCE

- The practice meets its obligations under the relevant state or territory Work Health and Safety Act (or Occupational Health and Safety Act in Victoria). The principal practitioner or practice owner understands their duties as a person conducting a business or undertaking (PCBU).
- A specific person is nominated with day-to-day responsibility for WHS within the practice. This person is identified by name, not just by role, and their WHS responsibilities are documented (e.g., in a position description or WHS policy).
- Key WHS documents are in place: a WHS policy, a hazard register, and an incident reporting process.

MINIMUM FOR DEVELOPING

- The practice has basic WHS awareness and someone informally manages WHS matters. Formal documentation (policy, hazard register) is in development.

EXCELLING

- WHS is a standing agenda item at team meetings. The nominated WHS person has completed relevant training (e.g., a WHS for healthcare course). The practice conducts an annual WHS review and can demonstrate continuous improvement.

COMMON PITFALLS

- Assuming WHS obligations are limited to large employers. Even a solo specialist practice with one employee has PCBU duties under the WHS Act.
- Nominating the practice manager as the WHS person without providing any training or time allocation for the role.

2.7.2 Workplace hazards are identified and managed. This includes manual handling risks, sharps injuries, exposure to hazardous substances (including sterilising chemicals and cytotoxic agents where applicable), slip and trip hazards, and risks of occupational violence.

ESTABLISHED EVIDENCE

- A documented hazard identification process has been conducted, covering: manual handling risks (e.g., moving equipment, patient handling), sharps injury risks, chemical hazards (e.g., glutaraldehyde for reprocessing, liquid nitrogen for cryotherapy, cytotoxic agents), slip/trip/fall hazards, and risks of occupational violence or aggression.
- Safety Data Sheets (SDS) are accessible for all hazardous substances used in the practice.
- Controls are in place for identified hazards, following the hierarchy of controls (elimination, substitution, engineering controls, administrative controls, PPE).

MINIMUM FOR DEVELOPING

- Major hazards are known to staff and basic controls are in place (e.g., sharps containers available, spill kits present). A formal hazard register is being developed.

EXCELLING

- The practice conducts regular workplace inspections (e.g., quarterly walk-throughs) to identify new hazards. Hazard reports from staff are encouraged and acted upon. The hazard register is reviewed and updated at least annually.

COMMON PITFALLS

- Ignoring occupational violence risk because "our patients are not like that." Specialist practices see distressed, frustrated, and sometimes cognitively impaired patients. Occupational violence is not limited to emergency departments.
- SDS folders that exist but have not been updated since the practice opened. If you have changed cleaning products, the SDS must reflect what you actually use.

2.7.3 Staff have access to appropriate personal protective equipment, and its use is consistent with practice policy and the nature of the task.

ESTABLISHED EVIDENCE

- Appropriate PPE is available to all staff who require it, including gloves (in multiple sizes), gowns or aprons, surgical masks, P2/N95 respirators (where required), and eye protection (safety glasses or face shields).
- PPE use is consistent with the practice's IPC policy and relevant safe work procedures - for example, eye protection worn during procedures with a risk of splash, P2 respirators available for staff managing patients with airborne infections.
- Staff have been trained in correct PPE donning and doffing procedures.

MINIMUM FOR DEVELOPING

- Basic PPE (gloves, masks) is available in clinical areas. The practice recognises that a broader range of PPE may be required and is assessing its needs.

EXCELLING

- PPE stock levels are monitored and minimum stock levels are maintained to prevent supply shortages. Fit testing has been conducted for staff who may need to use P2/N95 respirators. PPE compliance is observed and feedback provided.

COMMON PITFALLS

- Gloves available in only one size, making them effectively unavailable for staff with smaller or larger hands. Ill-fitting PPE compromises both protection and dexterity.
- PPE available but not used because "it slows things down" or "patients find it off-putting." The decision to use PPE should be risk-based, not comfort-based.

2.7.4 There is a process for reporting and recording workplace injuries and incidents, including sharps injuries and blood or body fluid exposures. Post-exposure protocols are documented and accessible.

ESTABLISHED EVIDENCE

- A documented process exists for reporting and recording workplace injuries and incidents, including sharps injuries, blood and body fluid exposures, manual handling injuries, slips/trips/falls, and incidents of occupational violence.
- The process is known to all staff and includes: how to report (e.g., incident report form), who to report to, and what immediate actions to take (e.g., post-exposure prophylaxis protocol for needlestick injuries).
- A post-exposure management protocol is documented and accessible, covering: immediate first aid, risk assessment of the source, referral for testing and prophylaxis, and follow-up.
- Incident records are reviewed to identify patterns and prevent recurrence.

MINIMUM FOR DEVELOPING

- Staff know to report injuries to the practice manager. A sharps injury protocol exists or is being developed. Formal incident recording is being established.

EXCELLING

- All workplace incidents (including near-misses) are reported and reviewed. The practice tracks incident data over time and presents findings at team meetings. Actions arising from incident reviews are documented and followed through.

COMMON PITFALLS

- No post-exposure protocol for needlestick injuries - staff are told to "go to the GP" but there is no documented protocol for immediate first aid, source patient assessment, or time-sensitive referral for post-exposure prophylaxis. After a needlestick is not the time to work out what to do.
- Workplace injuries go unreported because staff consider them minor or because there is a culture of "just getting on with it." Under-reporting prevents systemic hazard identification.

2.7.5 First aid supplies are available and maintained. At least one staff member holds a current first aid certificate.

ESTABLISHED EVIDENCE

- A first aid kit is available and maintained, with contents appropriate to a healthcare workplace. The kit is checked at defined intervals (e.g., quarterly) and restocked as needed. Check records are maintained.
- At least one staff member holds a current first aid certificate. Their certificate is on file.
- The first aid kit location is known to all staff.

MINIMUM FOR DEVELOPING

- A first aid kit is present on the premises. Its contents may not have been recently checked or restocked. The practice is identifying which staff hold current first aid certificates.

EXCELLING

- Multiple staff hold current first aid certificates, ensuring coverage across shifts and leave periods. First aid kit contents are tailored to the specific hazards of the practice (e.g., additional burns dressings for a practice using cryotherapy or cautery). The practice has considered first aid needs for patients as well as staff.

COMMON PITFALLS

- A first aid kit that was stocked when the practice opened and has not been checked since. Dressings and saline expire. Bandages deteriorate. An unchecked kit is an unreliable kit.
- Assuming that because the practice has clinical supplies (e.g., dressings, gauze), a separate first aid kit is not needed. Staff injuries may occur in non-clinical areas (e.g., the kitchen, the storeroom) where clinical supplies are not accessible.

2.7.6 The practice has considered security risks appropriate to its setting, including after-hours access, duress arrangements for staff, and management of aggressive or distressed patients.

ESTABLISHED EVIDENCE

- The practice has conducted a security risk assessment appropriate to its setting. This considers: after-hours access (who has keys or access codes, is there a process for managing lost keys), duress arrangements for staff (e.g., a duress alarm, a coded word system, or a process for alerting colleagues if a situation escalates), and management of aggressive, distressed, or behaviourally disturbed patients.
- Physical security measures are in place where warranted - for example, controlled access to clinical areas, CCTV in waiting areas and entrances, or a panic button connected to a security response.
- Staff have been briefed on what to do if they feel unsafe, including how to de-escalate a situation, how to call for help, and when to call police.

MINIMUM FOR DEVELOPING

- The practice has considered its basic security arrangements (e.g., door locks, after-hours access) but has not yet conducted a formal security risk assessment or established a duress protocol.

EXCELLING

- The practice has a documented occupational violence prevention plan. Staff receive training in de-escalation techniques. Security arrangements are reviewed following any security incident. The practice has considered specific risks such as lone worker safety (e.g., a practitioner working alone after hours) and has controls in place.

COMMON PITFALLS

- No duress system for staff working in consulting rooms behind closed doors. If a patient becomes aggressive during a consultation, the clinician needs a way to alert other staff without escalating the situation.
- Assuming security is only a concern for practices in high-crime areas. Occupational violence in healthcare is driven by patient distress, cognitive impairment, and frustration - not postcode.

This document is part of the Specialist Practice Quality Framework (SPQF). Visit spqf.au for the full framework and self-assessment tools.