SPECIALIST PRACTICE QUALITY FRAMEWORK

Evidence Guide

Domain 6: Workforce and Team Capability

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.

6.1 — Staffing and Workforce Planning

We have enough people with the right skills to deliver safe care and run the practice effectively.

6.1.1 The practice has assessed the staffing levels and skill mix required to deliver its services safely. This assessment considers clinical volumes, the complexity of services provided, leave coverage, and the administrative workload. It is reviewed when services or volumes change.

ESTABLISHED EVIDENCE

- A documented staffing assessment that maps clinical volumes, service complexity, and administrative workload against current staff numbers and capabilities
- Evidence that the assessment considers leave coverage and peak periods (e.g., post-surgical follow-up clinics, scope list days)
- Review notes showing the assessment was revisited when services changed (e.g., new procedural lists added, telehealth introduced, allied health embedded)

MINIMUM FOR DEVELOPING

- The practice has considered whether it has enough staff but the assessment is informal and not documented - the principal practitioner or practice manager "just knows" it works

EXCELLING

- The staffing assessment is reviewed at least annually and linked to practice activity data (appointment volumes, wait times, overtime trends), with documented decisions about whether adjustments are needed

COMMON PITFALLS

- Practice has never formally assessed whether current staffing is safe - it has simply grown organically as the practitioner got busier, and gaps only become visible when someone leaves or is away
- Administrative workload is not considered in the assessment - reception and billing staff are chronically stretched but this is treated as normal

6.1.2 There is a clear allocation of roles and responsibilities across the team. Every staff member can describe their role and who they report to. Key functions - appointment management, billing, results handling, infection control, equipment maintenance - have a nominated responsible person and a backup arrangement.

ESTABLISHED EVIDENCE

- An organisational chart or role allocation document showing who is responsible for each key function: appointment management, billing, results handling, infection control, equipment maintenance, stock ordering, and clinical support
- Each key function has a nominated backup person identified
- Staff can describe their own role and reporting line when asked

MINIMUM FOR DEVELOPING

- Staff generally know what they do, but there is no written role allocation and backup arrangements are informal - "Sarah covers for me" without documented handover

EXCELLING

- Role allocation is reviewed when staff change or when new services are introduced, and backup staff have been cross-trained and have documented access to the systems they need to cover

COMMON PITFALLS

- Key functions are single-person dependent with no documented backup - when that person is away, tasks are either done poorly or not done at all
- Results handling and infection control responsibilities are assumed rather than explicitly allocated, creating risk that nobody is clearly accountable

6.1.3 The practice has a plan for managing foreseeable staff absences, including annual leave, parental leave, and extended sick leave. For critical roles (practice manager, practice nurse, principal practitioner), the plan identifies who steps in and what handover is required.

ESTABLISHED EVIDENCE

- A documented plan for managing foreseeable absences for critical roles (practice manager, practice nurse, principal practitioner)
- The plan identifies who steps in for each critical role and what handover is required (e.g., access to passwords, pending tasks, patient follow-up lists)
- Evidence that the plan has been used - for example, handover notes from recent leave periods

MINIMUM FOR DEVELOPING

- The practice manages leave on an ad hoc basis - coverage is arranged each time but there is no standing plan and no documented handover process

EXCELLING

- The practice conducts a post-leave debrief to identify anything that was missed or went wrong during the absence, and uses this to improve the coverage plan

COMMON PITFALLS

- No coverage plan exists for the practice manager - everything they carry in their head (vendor contacts, banking details, compliance calendar dates) is inaccessible when they are away
- Practitioner leave results in patients being rescheduled rather than seen by a covering clinician, with no process for managing urgent clinical needs during the absence

6.1.4 Where the practice uses casual, agency, or locum staff, there is a process for ensuring those staff are briefed on practice systems, emergency procedures, and key policies before they begin working.

ESTABLISHED EVIDENCE

- A documented briefing checklist or induction pack for casual, agency, and locum staff that covers practice systems, emergency procedures, key policies (infection control, privacy, incident reporting), and who to ask for help
- Evidence the briefing is completed before the temporary staff member begins clinical or administrative work (e.g., signed checklist)
- The briefing includes practical essentials: login credentials, room layout, emergency equipment location, after-hours contacts

MINIMUM FOR DEVELOPING

- Locum or agency staff are given a verbal walkthrough on arrival but there is no checklist and no record that the briefing occurred

EXCELLING

- The practice maintains a standing locum pack that is updated regularly, and feedback from locums is used to improve it - for example, adding information locums commonly asked about

COMMON PITFALLS

- Locum practitioners are assumed to "know what they're doing" because they are experienced clinicians - but they do not know where the emergency trolley is, how the practice management software works, or what the practice's specific consent process involves
- Agency nursing or admin staff are shown around quickly and left to figure things out, leading to errors in booking, billing, or sterilisation processes

6.1.5 Staffing arrangements comply with applicable industrial instruments, including the Health Professionals and Support Services Award (or relevant enterprise agreement), National Employment Standards, and any jurisdictional requirements for health worker ratios or supervision.

ESTABLISHED EVIDENCE

- The practice has identified the applicable industrial instrument - typically the Health Professionals and Support Services Award (MA000027) or a relevant enterprise agreement - and can demonstrate that pay rates, penalty rates, leave entitlements, and classification levels comply
- Evidence of compliance review, such as a pay audit or a comparison of current pay rates against the applicable award
- Overtime and leave records are maintained and consistent with National Employment Standards

MINIMUM FOR DEVELOPING

- Staff are paid above award rates (or the practice believes they are) but no formal comparison against the applicable instrument has been done to verify compliance across all entitlements

EXCELLING

- The practice conducts an annual award compliance review, including when Fair Work Commission annual wage reviews take effect, and adjusts pay rates proactively

COMMON PITFALLS

- Practice assumes that paying above the base hourly rate means full award compliance - but penalties, overtime, allowances, and classification levels are separate obligations that are frequently missed
- Practice nurse classified and paid as a receptionist because "that's what we've always done," creating both underpayment risk and scope of practice issues

6.2 — Recruitment and Pre-Employment Checks

We verify that every person we employ or engage is suitable to work in a healthcare setting.

6.2.1 The practice has a recruitment process that includes, at a minimum, verification of identity, a check of qualifications relevant to the role, and a reference check from a recent employer. For clinical staff, AHPRA registration verification is completed before commencement (as also covered in Domain 1.3).

ESTABLISHED EVIDENCE

- A recruitment checklist that documents, for each new hire: identity verification (photo ID sighted), qualification verification (original documents or certified copies), reference check from a recent employer, and AHPRA registration verification for clinical staff
- AHPRA verification is completed before the clinician commences - not on their first day, not "when we get around to it"
- Completed checklists are retained in the personnel file

MINIMUM FOR DEVELOPING

- The practice checks AHPRA registration for clinical staff but does not have a consistent process for verifying identity, qualifications, or references for non-clinical staff

EXCELLING

- The recruitment checklist is standardised, version-controlled, and includes a step for the practice manager to verify all checks are complete before the start date is confirmed

COMMON PITFALLS

- Reference checks are skipped because the new staff member was "recommended by a colleague" - personal recommendations are not a substitute for a structured reference check
- AHPRA registration is checked at recruitment but conditions or notations that appear later are not detected because there is no ongoing monitoring (see also Domain 1.3)

6.2.2 Police checks or working with children checks are obtained where required by jurisdictional legislation or where the role involves unsupervised access to vulnerable patients. The practice understands when these checks are legally required versus best practice.

ESTABLISHED EVIDENCE

- Police checks (National Police Certificate or state equivalent) obtained for roles with unsupervised access to vulnerable patients, where required by jurisdictional legislation
- Working With Children Checks obtained where the role involves contact with children and the relevant state/territory legislation requires it
- The practice has a documented position on when these checks are required versus best practice, reflecting the relevant jurisdictional requirements

MINIMUM FOR DEVELOPING

- The practice obtains police checks for some roles but has not determined which roles legally require them and which are discretionary

EXCELLING

- The practice maintains a register of police check and WWCC expiry dates and re-checks are initiated before expiry, not reactively when someone notices

COMMON PITFALLS

- Assuming police checks are only required for staff working in paediatric practices - many jurisdictions require them for roles involving access to vulnerable adults as well
- Not understanding that a Working With Children Check from one state may not be valid in another - practices operating across borders need to check each jurisdiction's requirements

6.2.3 The practice verifies the right to work in Australia for all employees and contractors.

ESTABLISHED EVIDENCE

- For each employee and contractor, evidence that their right to work in Australia has been verified - typically a copy of passport, birth certificate, or visa documentation
- For staff on temporary visas, the visa expiry date and any work conditions (e.g., hours limitations) are recorded
- Verification is completed before commencement of employment

MINIMUM FOR DEVELOPING

- The practice assumes right to work based on the applicant's stated nationality or accent, without verifying documentation

EXCELLING

- Visa expiry dates for staff on temporary visas are tracked and reviewed in advance, and the practice has a process for re-verification when a visa is renewed or changed

COMMON PITFALLS

- Practice has never verified right to work for long-standing staff employed before the practice had formal HR processes - the obligation applies regardless of tenure
- Not understanding that some visa categories (e.g., student visas, certain bridging visas) have work hour limitations that could affect rostering

6.2.4 Where the practice engages contractors or visiting practitioners, the engagement arrangements are documented. This includes evidence of their own professional indemnity insurance, ABN, and any relevant registration or credentialing.

ESTABLISHED EVIDENCE

- Written engagement agreements with each contractor or visiting practitioner, covering the scope of engagement, billing arrangements, professional indemnity insurance requirements, ABN, AHPRA registration, and use of practice facilities
- Evidence that each contractor has current professional indemnity insurance - certificate of currency on file
- Agreements are signed by both parties and stored accessibly

MINIMUM FOR DEVELOPING

- Visiting practitioners work from the practice under an informal arrangement - there is no written agreement and no verification of their insurance

EXCELLING

- Contractor agreements include provisions for clinical governance participation (e.g., incident reporting, participation in audits), and insurance certificates are re-verified annually

COMMON PITFALLS

- A visiting practitioner has been using the practice's rooms for years under a handshake agreement - no one has checked their insurance since they started, and the billing arrangements have never been written down
- Practice assumes the contractor's medical defence organisation covers everything - but the MDO policy may exclude certain procedures performed at the practice

6.2.5 Pre-employment check records are retained securely in the staff member's personnel file.

ESTABLISHED EVIDENCE

- Personnel files contain copies of all pre-employment check records: identity verification, qualification certificates, reference check notes, AHPRA verification printout, police check or WWCC (where applicable), right to work documentation
- Files are stored securely with access restricted to authorised personnel (practice manager, principal practitioner)
- A contents checklist on the front of each file confirms what documents are held

MINIMUM FOR DEVELOPING

- Some records are kept but they are scattered - AHPRA checks in email, reference notes on loose paper, police checks in a drawer

EXCELLING

- Personnel files are audited periodically to ensure completeness, and a standard file contents checklist is used for all staff

COMMON PITFALLS

- Pre-employment checks were completed verbally but not documented - the practice manager "remembers" checking references but there is no written record
- Files are stored in an unlocked filing cabinet accessible to all staff, creating a privacy risk for sensitive personal information

6.3 — Orientation and Onboarding

Every new team member receives a structured introduction to our practice before they start delivering care or performing their role independently.

6.3.1 The practice has a documented orientation program for new staff. The program covers, at a minimum, the practice layout, emergency procedures (including emergency exits, fire extinguisher locations, and clinical emergency response), key policies (infection control, privacy, incident reporting), clinical and administrative systems, and the team structure.

ESTABLISHED EVIDENCE

- A written orientation program or checklist that covers: practice layout and facilities, emergency procedures (exits, fire extinguishers, clinical emergency response), key policies (infection control, privacy, incident reporting), clinical and administrative systems, and team structure
- The program is specific to the practice - not a generic template downloaded from the internet and never customised
- The orientation content is appropriate to the role (clinical staff receive additional clinical systems orientation; administrative staff receive billing and reception-specific content)

MINIMUM FOR DEVELOPING

- Orientation happens informally - new staff shadow a colleague for a day or two, but there is no written program and no checklist to ensure all topics are covered

EXCELLING

- The orientation program includes role-specific modules (e.g., sterilisation procedures for instrument technicians, Medicare billing rules for reception staff) and is reviewed after each use to keep it current

COMMON PITFALLS

- Emergency procedures are not covered during orientation - new staff do not know where the emergency trolley is, how to activate a code blue, or where the fire exits are
- Orientation covers "how we do things" but not "why" - new staff learn the process but not the safety rationale behind it, making it more likely they will take shortcuts

6.3.2 The orientation is completed before the new staff member begins performing their role independently. For clinical staff, this includes supervised familiarisation with the practice's clinical systems, equipment, and procedural protocols.

ESTABLISHED EVIDENCE

- Records showing that orientation was completed before the staff member began working independently - for example, a signed checklist with a completion date that precedes or matches the first unsupervised shift
- For clinical staff, documentation of supervised familiarisation with practice-specific clinical systems, equipment, and procedural protocols
- Where gaps were identified during supervised orientation, evidence that the staff member was not left unsupervised until those gaps were addressed

MINIMUM FOR DEVELOPING

- Orientation is started on the first day but not completed before the staff member begins working independently - they are expected to "pick up the rest as they go"

EXCELLING

- Clinical staff complete a competency sign-off for practice-specific tasks (e.g., operating the autoclave, using the practice's ECG machine, navigating the clinical software) before performing them unsupervised

COMMON PITFALLS

- A new practice nurse starts on a Monday and is left alone in the procedure room by Wednesday because the practice is too busy to supervise - orientation is sacrificed to operational pressure
- Administrative staff are expected to answer phones and manage bookings on day one without adequate orientation to the practice management software or booking protocols

6.3.3 New staff are given access to the practice's policy and procedure manual and know where to find it. They are encouraged to ask questions and are assigned a point of contact during their initial period.

ESTABLISHED EVIDENCE

- New staff are shown where the practice's policy and procedure manual is kept (physical or digital) and can locate it independently
- A named point of contact is assigned for the initial period - someone the new staff member can approach with questions without feeling they are being a nuisance
- Evidence that the new staff member has been actively encouraged to ask questions - for example, this is stated in the orientation checklist or welcome pack

MINIMUM FOR DEVELOPING

- New staff are told "the policies are on the server" but are not shown specifically where, and no point of contact is formally assigned

EXCELLING

- New staff receive a structured follow-up check-in (e.g., at two weeks and at three months) to review how onboarding is going and whether additional support is needed

COMMON PITFALLS

- The policy manual exists but is out of date, poorly organised, or so voluminous that new staff cannot practically navigate it - pointing someone at a 300-page folder is not meaningful access
- The assigned contact is the practice manager, who is too busy to be genuinely available - the new staff member quickly learns not to ask questions

6.3.4 Orientation completion is documented and signed off by the new staff member and their supervisor or the practice manager. Any gaps identified during orientation are addressed with a follow-up plan.

ESTABLISHED EVIDENCE

- A signed orientation completion form or checklist, signed by both the new staff member and their supervisor or the practice manager, confirming that all orientation topics have been covered
- Where gaps were identified, a documented follow-up plan with target dates for completion
- Completed orientation records are retained in the staff member's personnel file

MINIMUM FOR DEVELOPING

- Orientation occurs but there is no sign-off process - the practice cannot demonstrate what was covered or whether the new staff member confirmed they understood

EXCELLING

- The sign-off includes a brief self-assessment by the new staff member ("I feel confident with X, I need more support with Y"), which is used to tailor ongoing support

COMMON PITFALLS

- The orientation checklist was signed on day one as a formality, but several items were not actually completed - the signature became a compliance exercise rather than a genuine confirmation of understanding
- Gaps identified during orientation are noted but never followed up - the follow-up plan exists on paper but no one tracks it

6.3.5 The orientation program is reviewed periodically to ensure it remains current, particularly when systems, policies, or premises change.

ESTABLISHED EVIDENCE

- Evidence that the orientation program has been reviewed and updated - for example, a version history, review date on the document, or meeting minutes noting that the orientation checklist was updated
- Reviews are triggered by relevant changes: new clinical software, updated emergency procedures, changes to premises layout, new infection control requirements
- Feedback from recently onboarded staff is considered during reviews

MINIMUM FOR DEVELOPING

- The orientation program has not been updated since it was first created, even though practice systems and policies have changed

EXCELLING

- Every new staff member is asked for feedback on the orientation process within their first three months, and this feedback is documented and used to improve the program

COMMON PITFALLS

- The orientation checklist still references software the practice replaced two years ago, or emergency procedures that changed when the practice moved premises
- The program was written for clinical staff and has never been adapted for administrative or support roles

6.4 — Ongoing Training and Development

We invest in our team's skills and knowledge so they can perform their roles safely and effectively.

6.4.1 The practice identifies the mandatory and role-specific training requirements for each staff member. At a minimum, this includes BLS certification for clinical staff, infection control training, privacy and confidentiality training, and fire and emergency training. Additional requirements depend on the role and the services the practice provides.

ESTABLISHED EVIDENCE

- A documented list of mandatory training requirements for each role category - at minimum: BLS certification for clinical staff, infection control training, privacy and confidentiality training, and fire and emergency training
- Additional role-specific training is identified based on the services the practice provides (e.g., sedation safety for practices performing procedural sedation, radiation safety for practices with imaging equipment)
- The list specifies the frequency of renewal or refresher training for each requirement

MINIMUM FOR DEVELOPING

- BLS is tracked for clinical staff but other mandatory training areas (infection control, privacy, fire safety) are not systematically identified or tracked

EXCELLING

- Training requirements are mapped to each position description and reviewed when roles change or new services are introduced, creating a clear training needs analysis for the practice

COMMON PITFALLS

- Fire and emergency training is not treated as mandatory - staff have never practiced an evacuation or used a fire extinguisher
- Privacy training consists of "read the policy and sign here" rather than practical training on scenarios relevant to the practice (e.g., handling a phone enquiry about a patient, managing a subpoena, disposing of printed patient information)

6.4.2 Training completion is tracked. The practice maintains a training register or matrix that records what training each staff member has completed, when it was completed, and when it is next due.

ESTABLISHED EVIDENCE

- A training register or matrix (spreadsheet or equivalent) that records each staff member's name, the training completed, the date of completion, and the next due date
- The register is maintained by a nominated person (typically the practice manager) and is reviewed regularly to identify overdue or upcoming training
- Certificates or attendance records are retained as supporting evidence

MINIMUM FOR DEVELOPING

- Some training records exist but they are scattered - BLS certificates in one folder, fire training attendance in an email, infection control training not recorded at all

EXCELLING

- The training register is reviewed monthly, with automated or calendar-based reminders for upcoming expiries, and training compliance rates are reported to the principal practitioner or governance meeting

COMMON PITFALLS

- Training is completed but not recorded - the staff member attended the course but the certificate is on their personal email and the practice has no copy
- The register records completion dates but not expiry dates, so nobody knows when training is due for renewal until it has already lapsed

6.4.3 The practice supports the professional development of its staff beyond mandatory training. This may include attendance at conferences, in-house education sessions, cross-training, or external courses. Support is proportionate to the size and resources of the practice.

ESTABLISHED EVIDENCE

- Evidence that the practice supports staff professional development beyond mandatory requirements - for example, paid study leave, conference attendance, funding for external courses, or time allocated for in-house education
- Support is available to both clinical and non-clinical staff, proportionate to the size and resources of the practice
- Records of professional development activities undertaken by staff in the past 12 months

MINIMUM FOR DEVELOPING

- The practice supports professional development informally and on request, but there is no structured approach, no budget allocation, and requests are approved inconsistently

EXCELLING

- Each staff member has a professional development plan discussed at their annual review, with agreed activities and a budget allocation (even if modest), and the practice tracks the return on investment through improved skills and service quality

COMMON PITFALLS

- Professional development is available to practitioners but not to practice nurses, administration staff, or the practice manager - the people who run the practice day-to-day receive the least investment in their skills
- The practice equates professional development with attending the annual college conference - valuable, but not sufficient for the non-clinical skills that practices also need (leadership, change management, quality improvement)

6.4.4 When new equipment, software, or clinical processes are introduced, relevant staff are trained before the change goes live. Training is documented.

ESTABLISHED EVIDENCE

- Evidence that when new equipment, software, or clinical processes were introduced, relevant staff were trained before the change went live - for example, training session records, sign-off sheets, or vendor training certificates
- Training covered not just how to use the new system but safety considerations, troubleshooting, and who to contact for support
- Staff who were absent during the initial training received catch-up training before using the new system

MINIMUM FOR DEVELOPING

- Training was provided by the vendor at installation but not all relevant staff attended, and there was no follow-up for those who missed it

EXCELLING

- The practice includes a training requirement in its change management process for any significant operational change, and verifies staff competence after training (not just attendance)

COMMON PITFALLS

- New practice management software was rolled out with vendor training for two staff members who were expected to train everyone else - the cascade training never happened properly and staff are still using workarounds months later
- New clinical equipment was purchased but the only person trained to use it is the principal practitioner - when they are away, the equipment sits unused or is operated by untrained staff

6.4.5 Clinical staff, including nurses and allied health professionals employed by the practice, are supported to meet their own registration body's continuing professional development requirements.

ESTABLISHED EVIDENCE

- Clinical staff employed by the practice (practice nurses, allied health professionals, enrolled nurses) are aware of their own registration body's CPD requirements
- The practice provides reasonable support for clinical staff to meet CPD obligations - for example, paid time for CPD activities, access to in-service education, or financial contribution to relevant courses
- CPD completion is discussed as part of annual performance reviews

MINIMUM FOR DEVELOPING

- The practice acknowledges that clinical staff have CPD requirements but treats it as entirely the individual's responsibility, with no time or financial support provided

EXCELLING

- The practice actively identifies CPD opportunities that align with both the staff member's registration requirements and the practice's service priorities, creating a mutually beneficial development approach

COMMON PITFALLS

- Practice nurses are expected to complete CPD in their own time and at their own expense, despite the practice benefiting directly from their updated skills and maintained registration
- The practice is unaware that its employed allied health professionals have CPD obligations, because "we only employ the receptionist and the nurse"

6.4.6 The practice holds or participates in regular team meetings or in-service education sessions. These serve both operational and learning purposes and are documented.

ESTABLISHED EVIDENCE

- Records of regular team meetings or in-service education sessions - typically at least quarterly, preferably monthly - including date, attendees, agenda, and key discussion points or decisions
- Meetings serve both operational purposes (workflow issues, policy updates, incident debriefs) and learning purposes (case discussions, new guideline reviews, shared education topics)
- All staff have the opportunity to attend, and sessions are scheduled to accommodate different working patterns where possible

MINIMUM FOR DEVELOPING

- Meetings happen but are irregular, undocumented, or limited to operational issues with no learning component

EXCELLING

- The meeting program includes a rotating education component where team members present on topics relevant to their role, and attendance and topics are tracked to ensure all staff participate and a range of subjects are covered over the year

COMMON PITFALLS

- Team meetings are dominated by the principal practitioner talking and staff listening - there is no genuine two-way discussion and staff do not feel comfortable raising concerns
- Part-time or casual staff are systematically excluded from meetings because they are always scheduled at times those staff do not work

6.5 — Performance Management

We set clear expectations, provide regular feedback, and address performance issues fairly.

6.5.1 Every staff member has a position description that sets out their responsibilities, reporting relationships, and the key competencies required for the role. Position descriptions are reviewed when the role changes.

ESTABLISHED EVIDENCE

- A current position description for every role in the practice (including the practice manager and principal practitioner's governance role), specifying responsibilities, reporting relationships, and key competencies required
- Position descriptions have a review date and are updated when the role changes
- Staff have received and acknowledged their position description

MINIMUM FOR DEVELOPING

- Position descriptions exist for some roles but are out of date or generic - they do not reflect what the person actually does day-to-day

EXCELLING

- Position descriptions are reviewed with the staff member at their annual performance review and updated collaboratively to reflect any changes in role scope, with both parties signing the updated version

COMMON PITFALLS

- The practice manager's position description was written when the practice had one practitioner and two staff - the practice now has four practitioners and eight staff, but the position description has not changed
- Position descriptions are created for recruitment purposes and then filed away, never to be seen again - they are not used as a living document for performance management

6.5.2 The practice conducts performance reviews at least annually for all staff. Reviews are a two-way conversation that covers what is going well, areas for development, and goals for the coming period. Reviews are documented.

ESTABLISHED EVIDENCE

- Records of annual performance reviews for all staff, including the date, a summary of the discussion (what is going well, areas for development, agreed goals), and signatures of both the reviewer and the staff member
- Reviews are conducted by the staff member's direct supervisor or the practice manager - not by someone who does not observe their work
- Goals from the previous review are revisited and progress discussed

MINIMUM FOR DEVELOPING

- Performance conversations happen informally but there is no scheduled annual review and no written record of feedback or agreed goals

EXCELLING

- Reviews include input from multiple sources where appropriate (e.g., feedback from practitioners about the practice nurse's clinical support, feedback from reception about the billing officer's accuracy), and development goals are linked to the practice's strategic priorities

COMMON PITFALLS

- Reviews are conducted for administrative staff but not for clinical staff or practitioners - there is an implicit assumption that clinicians do not need performance feedback from the practice
- Reviews are a tick-box exercise - the form is completed but the conversation is superficial, goals are vague ("keep doing a good job"), and nothing changes as a result

6.5.3 Feedback is not limited to annual reviews. The practice encourages a culture of regular, informal feedback - both positive and constructive - throughout the year.

ESTABLISHED EVIDENCE

- Observable evidence of a feedback culture - for example, feedback is mentioned in team meeting records, positive feedback is shared visibly (in meetings, in writing), and constructive feedback is given promptly rather than saved for the annual review
- The practice manager models giving both positive and constructive feedback regularly
- Staff report feeling comfortable receiving and giving feedback (this may be evidenced through staff survey responses or team meeting discussions)

MINIMUM FOR DEVELOPING

- Feedback happens but is ad hoc and inconsistent - some staff receive regular feedback while others hear nothing until something goes wrong

EXCELLING

- The practice has a deliberate approach to feedback, such as including a "feedback" item in team meeting agendas, recognising good work in a structured way, or using brief post-shift debriefs after complex clinic days

COMMON PITFALLS

- "Feedback" in the practice means criticism - positive feedback is rare and staff associate being called into the practice manager's office with something having gone wrong
- The principal practitioner gives feedback in the moment but it is delivered harshly or publicly, undermining the intent - the issue is not the feedback itself but the way it is given

6.5.4 Where performance concerns arise, the practice has a documented process for addressing them. The process is fair, consistent, and proportionate. It includes an opportunity for the staff member to respond and, where appropriate, a support plan before escalating to formal action.

ESTABLISHED EVIDENCE

- A documented performance management process that includes: early identification and discussion of the concern, an opportunity for the staff member to respond, a support plan with clear expectations and timeframes (where appropriate), and a pathway to formal action if the concern is not resolved
- Evidence that the process is applied consistently - the same approach for all staff, regardless of seniority or tenure
- Records of performance management actions are retained in the personnel file

MINIMUM FOR DEVELOPING

- The practice addresses performance concerns when they arise but there is no documented process - each situation is handled differently and outcomes depend on who is involved

EXCELLING

- The practice provides training or coaching for managers on how to conduct difficult conversations, and performance management outcomes are reviewed to ensure consistency and fairness across the team

COMMON PITFALLS

- Performance concerns are not addressed until they become critical - the practice tolerates poor performance for months or years, then escalates directly to termination without any documented support or warnings
- The process exists on paper but is not followed for practitioners or long-standing staff - "we can't performance manage the surgeon, he owns the practice"

6.5.5 Where a performance concern relates to clinical competence or patient safety, it is escalated immediately to the clinical governance lead and, if required, to AHPRA under mandatory notification provisions. The practice understands the threshold for mandatory notification and does not delay reporting to manage the issue internally.

ESTABLISHED EVIDENCE

- Evidence that the practice understands the mandatory notification provisions under the Health Practitioner Regulation National Law - specifically, the thresholds for notifiable conduct (practising while intoxicated, sexual misconduct, significant departure from accepted professional standards placing the public at risk, impairment)
- A documented escalation pathway: clinical competence concern raised with the clinical governance lead, assessed against the mandatory notification threshold, reported to AHPRA if the threshold is met, with the decision and rationale documented
- Staff are aware that they can (and in some cases must) make a notification directly if they believe patient safety is at risk

MINIMUM FOR DEVELOPING

- The practice would deal with a clinical competence concern if one arose, but there is no documented escalation pathway and staff are not clear on mandatory notification obligations

EXCELLING

- The practice has discussed mandatory notification obligations at a team meeting or education session, and the escalation pathway is included in the policy manual with worked examples relevant to the practice's setting

COMMON PITFALLS

- The practice attempts to manage a serious clinical competence issue internally to "protect" the practitioner - delaying or avoiding an AHPRA notification that should have been made, which itself creates legal and regulatory risk
- Staff are unaware that mandatory notification obligations can apply to them individually, not just to the practice - a nurse who witnesses notifiable conduct has their own obligation to report

6.5.6 The practice maintains personnel files for all staff that include position descriptions, employment contracts, pre-employment check records, training records, performance reviews, and any formal correspondence related to conduct or performance.

ESTABLISHED EVIDENCE

- Personnel files are maintained for all current staff and contain, at minimum: position description, employment contract, pre-employment check records, training records, performance review records, and any formal correspondence related to conduct or performance
- Files are stored securely (locked cabinet or access-controlled digital system) with access limited to the practice manager and principal practitioner (or equivalent)
- A standard contents checklist is used to ensure consistency across all files

MINIMUM FOR DEVELOPING

- Personnel files exist but are incomplete - some documents are missing, records are not filed consistently, and there is no standard structure

EXCELLING

- Personnel files are audited annually for completeness using the standard checklist, and gaps are followed up and rectified within a documented timeframe

COMMON PITFALLS

- The principal practitioner does not have a personnel file or governance record - only employed staff have files, and the practice owners' credentials, insurance, and performance are not documented
- Files are stored on a shared drive with no access restrictions - any staff member could access another staff member's performance reviews or disciplinary records

6.6 — Workplace Culture and Behaviour

Our practice fosters a respectful, inclusive, and psychologically safe workplace.

6.6.1 The practice has a code of conduct or set of behavioural expectations that applies to all staff, including practitioners. The code addresses respectful communication, anti-bullying, anti-discrimination, and expected standards of professional behaviour.

ESTABLISHED EVIDENCE

- A written code of conduct or behavioural expectations document that applies to all staff, including practitioners and practice owners
- The code addresses, at minimum: respectful communication, anti-bullying, anti-discrimination, use of social media, professional boundaries, and expected standards of behaviour toward patients and colleagues
- All staff have received and acknowledged the code (signed acknowledgement on file)

MINIMUM FOR DEVELOPING

- Behavioural expectations are communicated informally ("we treat each other with respect here") but there is no written code and no formal acknowledgement by staff

EXCELLING

- The code of conduct is actively referenced - not just signed and filed - and is included in orientation, discussed at team meetings, and used as the benchmark when addressing behavioural concerns

COMMON PITFALLS

- The code of conduct applies to "staff" but explicitly or implicitly excludes the principal practitioner or practice owner - the person most likely to set the tone is not bound by the same expectations
- The code was adopted from a template and includes language that does not reflect the practice's actual values or context - staff view it as a corporate exercise, not a genuine commitment

6.6.2 Staff know how to raise concerns about workplace behaviour - including behaviour by a practitioner or practice owner - without fear of retaliation. There is a clear process, and staff are confident it will be taken seriously.

ESTABLISHED EVIDENCE

- A documented process for raising concerns about workplace behaviour, including behaviour by a practitioner or practice owner
- The process includes at least two pathways (e.g., raise with the practice manager, raise with the principal practitioner, or raise with an external contact if the concern involves both), so that staff are not forced to report to the person whose behaviour is the problem
- Staff are aware of the process and know how to use it - evidenced through orientation records, team meeting discussions, or staff acknowledgement

MINIMUM FOR DEVELOPING

- Staff would raise a concern with the practice manager if they had one, but there is no documented process and no alternative pathway if the concern involves the practice manager themselves

EXCELLING

- The practice has an external reporting pathway available (e.g., a nominated external advisor, an industry body contact, or a confidential hotline) for situations where internal reporting is not safe or appropriate, and this pathway is communicated to staff

COMMON PITFALLS

- The only pathway for raising concerns leads to the person whose behaviour is the problem - in a small practice, this is a common structural issue that must be addressed with an alternative reporting channel
- Staff know the process exists on paper but do not believe concerns will be taken seriously - previous complaints were dismissed or resulted in retaliation, and the process has no credibility

6.6.3 The practice does not tolerate bullying, harassment, sexual harassment, or discrimination. Where such behaviour is reported, it is investigated and addressed. The practice understands its obligations under the Sex Discrimination Act, Fair Work Act, and relevant state or territory anti-discrimination legislation.

ESTABLISHED EVIDENCE

- An anti-bullying and anti-harassment policy that is specific enough to be actionable - it defines what constitutes bullying, harassment, and sexual harassment, provides examples relevant to a healthcare setting, and sets out the consequences
- The policy references the practice's obligations under the Sex Discrimination Act 1984, Fair Work Act 2009, and relevant state or territory anti-discrimination and work health and safety legislation
- Evidence that reported concerns are investigated and addressed - not necessarily formal investigations for every matter, but a proportionate response that takes every complaint seriously

MINIMUM FOR DEVELOPING

- The practice has a general statement that bullying is not tolerated, but no specific policy, no defined investigation process, and no evidence that reported concerns have been actioned

EXCELLING

- The practice conducts proactive prevention - for example, including respectful workplace behaviour in team education sessions, reviewing positive duty obligations under the Sex Discrimination Act, and ensuring managers are trained to recognise and respond to bullying and harassment

COMMON PITFALLS

- A longstanding practitioner's behaviour is known to be problematic (yelling at staff, belittling nurses in front of patients) but is tolerated because "that's just how they are" or because they generate significant revenue for the practice
- The practice does not understand the positive duty provisions introduced by the Respect@Work reforms, which require employers to take proactive steps to prevent harassment - not just respond to it after it occurs

6.6.4 The practice actively promotes a culture where raising safety concerns, reporting incidents, and admitting errors is encouraged, not punished. This applies to clinical and non-clinical staff equally.

ESTABLISHED EVIDENCE

- Observable evidence that the practice encourages raising safety concerns, reporting incidents, and admitting errors - for example, team meeting records showing incident discussion without blame, a visible incident reporting system, or stated values that explicitly encourage reporting
- Non-clinical staff feel equally included in the safety culture - they are expected and encouraged to report concerns, not just clinical staff
- There are no examples of staff being punished or disadvantaged for reporting in good faith

MINIMUM FOR DEVELOPING

- An incident reporting system exists but staff report being reluctant to use it for fear of blame, or non-clinical staff are not aware they can report concerns

EXCELLING

- The practice celebrates reporting as a positive contribution to safety - for example, acknowledging reports at team meetings, sharing lessons learned, or tracking reporting rates as a measure of a healthy culture rather than a problem to be minimised

COMMON PITFALLS

- The practice says it has a "no blame" culture but staff observe that the person who reports an incident is the one who gets questioned, while the underlying system issue is not addressed
- Safety reporting is seen as a clinical function - administrative staff who notice a booking error, a misfiled document, or a billing discrepancy do not think of these as safety-relevant and do not report them

6.6.5 Interprofessional respect is expected. Clinical hierarchies do not justify disrespectful or dismissive behaviour toward staff in non-clinical or junior roles. The principal practitioner or practice owner models this standard.

ESTABLISHED EVIDENCE

- The practice's code of conduct or behavioural expectations explicitly address interprofessional respect - clinical hierarchies do not justify dismissive or disrespectful behaviour toward non-clinical or junior staff
- The principal practitioner or practice owner visibly models this standard - observed in their interactions with all team members
- Where disrespectful behaviour occurs, it is addressed regardless of the seniority of the person involved

MINIMUM FOR DEVELOPING

- Interprofessional respect is generally present but not explicitly stated as an expectation, and there have been instances where hierarchical behaviour was tolerated because of the seniority of the person involved

EXCELLING

- The practice actively builds interprofessional relationships - for example, including all staff in clinical discussions where appropriate, seeking input from non-clinical staff on workflow changes, and recognising the expertise each role contributes

COMMON PITFALLS

- The surgeon speaks respectfully to other surgeons and dismissively to nurses and reception staff - and nobody addresses it because "he's the boss" or "that's just how surgeons are"
- Interprofessional respect is expected from staff toward practitioners, but not reciprocally - respect flows upward in the hierarchy but not downward

6.6.6 The practice periodically checks in on team culture - whether through anonymous staff surveys, structured team discussions, or other feedback mechanisms. Results are considered and acted upon where concerns are identified.

ESTABLISHED EVIDENCE

- Evidence that the practice periodically assesses team culture - for example, an anonymous staff survey (even a short one), structured team discussions about what is working and what is not, or a formal workplace culture assessment
- Results are reviewed by the practice manager and/or principal practitioner, and actions are taken where concerns are identified
- Staff are informed about the outcomes and actions resulting from their feedback

MINIMUM FOR DEVELOPING

- The practice manager has a general sense of team culture based on informal observations but there has been no structured assessment and no opportunity for staff to provide anonymous feedback

EXCELLING

- Culture assessments are conducted annually, results are benchmarked over time to identify trends, and action plans are documented and followed through - staff can see that their feedback leads to change

COMMON PITFALLS

- A staff survey was conducted once but the results were not shared with staff and no actions were taken - staff are now more cynical about giving feedback than they were before the survey
- The practice avoids assessing culture because "we're a small team, we all get along" - which may be true, or may reflect that staff do not feel safe raising concerns

6.7 — Staff Wellbeing

We recognise that the health and wellbeing of our team directly affects the safety and quality of care we provide.

6.7.1 The practice acknowledges the wellbeing of its staff as a governance responsibility, not just a personal matter. Workload, rostering, and leave arrangements are managed with staff wellbeing in mind.

ESTABLISHED EVIDENCE

- Evidence that staff wellbeing is considered at a governance level - for example, wellbeing is a standing item in team meetings, workload is discussed when rostering decisions are made, or the practice's governance framework explicitly identifies staff wellbeing as a responsibility
- Rostering and workload allocation demonstrate consideration of staff wellbeing - not consistently requiring overtime, spreading difficult shifts fairly, and accommodating reasonable flexibility requests
- Leave arrangements are managed proactively, not reactively

MINIMUM FOR DEVELOPING

- The practice cares about staff wellbeing in principle but it is not reflected in governance structures or operational decisions - workload is driven by patient demand and staff are expected to cope

EXCELLING

- Wellbeing metrics are monitored - for example, overtime hours, sick leave trends, staff turnover rates - and are discussed at governance level as indicators of organisational health, with actions taken when patterns of concern emerge

COMMON PITFALLS

- Staff wellbeing is treated as an individual responsibility - if someone is struggling, the response is "you should see your GP" rather than examining whether the workload, culture, or working conditions are contributing
- The practice acknowledges wellbeing during wellness week or R U OK? Day but does not embed it into everyday operational decisions

6.7.2 Staff are encouraged to take their leave entitlements. Patterns of excessive hours, cancelled leave, or persistent presenteeism are identified and addressed by the practice manager.

ESTABLISHED EVIDENCE

- Evidence that staff are actively encouraged to take their leave entitlements - for example, leave balances are reviewed periodically, the practice manager prompts staff with high accrued leave to take time off, and leave requests are approved unless there is a genuine operational barrier
- Patterns of excessive hours, cancelled leave, or persistent presenteeism are identified and addressed by the practice manager
- Leave data is reviewed at least annually and excessive accruals are flagged

MINIMUM FOR DEVELOPING

- Leave is available if staff request it, but there is no active encouragement to take leave and no monitoring of leave balances or patterns of presenteeism

EXCELLING

- The practice monitors leave trends as a wellbeing indicator, proactively plans for leave coverage so that taking leave does not create guilt or workload anxiety for the person taking it, and addresses presenteeism (coming to work unwell) as a safety concern

COMMON PITFALLS

- The principal practitioner never takes leave, creating an implicit cultural expectation that dedication means being always available - staff feel they cannot take leave if the boss never does
- Staff accrue excessive leave because the practice is "too busy" to release them - this creates both a financial liability and a burnout risk

6.7.3 The practice provides or facilitates access to employee support services. For practices too small to fund a formal Employee Assistance Program (EAP), this may include information about external support services such as the Doctors' Health Advisory Service, Nurse & Midwife Support, or Beyond Blue's healthcare worker resources.

ESTABLISHED EVIDENCE

- The practice provides or facilitates access to employee support services - either a formal EAP contract or, for smaller practices, documented information about external support services available to staff
- Relevant services are communicated to all staff and include: the Doctors' Health Advisory Service (for practitioners), Nurse & Midwife Support, Beyond Blue's healthcare worker resources, and Lifeline
- Contact details are displayed or accessible (e.g., in the staff room, in the orientation pack, on the practice intranet) without requiring staff to ask for them

MINIMUM FOR DEVELOPING

- Staff would be directed to support services if they asked, but information is not proactively communicated and contact details are not readily visible

EXCELLING

- The practice has an EAP contract (even a basic one) or a relationship with a local psychologist who can provide timely support, and staff are reminded of available services periodically - not just at orientation

COMMON PITFALLS

- Support service information was included in the orientation pack but never mentioned again - staff who were not onboarded recently have no idea these services exist
- The practice assumes that because practitioners have access to their MDO support services, no further support needs to be facilitated - this overlooks practice nurses, reception staff, and the practice manager

6.7.4 The practice has a process for supporting staff following a distressing clinical event - such as a patient death, a serious complication, an aggressive patient, or involvement in a complaint or coronial inquiry. Support is offered proactively, not only in response to a request.

ESTABLISHED EVIDENCE

- A documented process for offering support to staff following a distressing clinical event - such as a patient death, a serious complication, an aggressive or threatening patient, or involvement in a complaint, litigation, or coronial inquiry
- Support is offered proactively by the practice manager or a designated person - staff are not expected to self-identify as needing help
- The process includes both immediate support (check-in within 24-48 hours) and follow-up (checking in again at a later date)

MINIMUM FOR DEVELOPING

- Staff would be supported if they raised a concern after a distressing event, but there is no proactive process - support depends on the individual staff member asking for help or their distress being noticed by a colleague

EXCELLING

- The practice conducts structured debriefs after significant clinical events (not just for the practitioner but for all staff involved, including reception staff who may have dealt with distressed family members), and monitors staff wellbeing in the weeks following the event

COMMON PITFALLS

- Support is offered to the practitioner involved in a clinical incident but not to the practice nurse who assisted, the reception staff who fielded calls from the distressed family, or the practice manager who coordinated the complaint response
- The practice treats post-incident support as a one-time check-in - "Are you OK? Good." - without recognising that the impact of distressing events can emerge over days or weeks

6.7.5 Practitioners within the practice are encouraged to maintain their own health, including having a regular GP. The practice does not create conditions - through workload, culture, or financial pressure - that discourage practitioners from seeking help for their own health concerns.

ESTABLISHED EVIDENCE

- The practice actively encourages practitioners to maintain their own health, including having their own regular GP who is not a colleague within the practice
- The practice does not create conditions - through workload, culture, or financial pressure - that discourage practitioners from seeking help for their own health concerns
- Information about practitioner-specific health services (Doctors' Health Advisory Service, specialist medical practitioner health programs) is available

MINIMUM FOR DEVELOPING

- The practice does not actively discourage practitioners from looking after their health, but there is no positive encouragement and the workload implicitly makes self-care difficult

EXCELLING

- Practitioner health is discussed openly as a governance topic - for example, the practice has agreed that practitioners will not self-prescribe, has established arrangements for covering clinical load when a practitioner is unwell, and actively promotes the Doctors' Health Advisory Service

COMMON PITFALLS

- Practitioners self-prescribe, self-investigate, and treat their own minor conditions because they are "too busy" or "it's easier" - the practice culture normalises this rather than recognising it as a risk to both the practitioner and their patients
- A practitioner who discloses a health concern (mental health, substance use, burnout) is met with concern about practice revenue or patient lists rather than genuine support and a safe pathway to treatment

6.7.6 The practice considers the physical ergonomics of the work environment, including workstation setup, repetitive movement risks for procedural clinicians, and the physical demands placed on nursing and administrative staff.

ESTABLISHED EVIDENCE

- Evidence that the practice has considered the physical ergonomics of the work environment - for example, workstation assessments for staff who spend extended periods at a computer, consideration of repetitive movement risks for procedural clinicians, and attention to manual handling requirements for nursing staff
- Adjustable chairs, appropriate desk heights, monitor positioning, and adequate lighting are provided for sedentary workstations
- Where ergonomic risks have been identified, reasonable adjustments have been made

MINIMUM FOR DEVELOPING

- Ergonomics have not been formally assessed, but the practice has responded to individual complaints (e.g., buying a new chair after a staff member reported back pain)

EXCELLING

- Ergonomic assessments are conducted for all workstations (including procedure rooms and clinical areas) as part of the WHS program, and are repeated when staff change roles, equipment changes, or complaints are received

COMMON PITFALLS

- Reception staff sit at a poorly designed workstation for eight hours a day and have never had an ergonomic assessment - the practice invested in the procedure room but not in the workspace where staff spend most of their time
- Procedural clinicians experience repetitive strain or postural injuries but do not raise them because "it comes with the job" - the practice does not proactively assess the physical demands of clinical work