SPECIALIST PRACTICE QUALITY FRAMEWORK

Evidence Guide

Domain 7: Practice Environment and Infrastructure

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.

7.1 — Consulting and Procedure Room Standards

Our rooms are designed, equipped, and maintained to support safe clinical practice.

7.1.1 All consulting rooms provide adequate space for clinical examination

ESTABLISHED EVIDENCE

- Room dimensions allow for a standard examination couch, clinician seating, patient chair, and sufficient clearance for the clinician to move around the patient during examination
- Rooms accommodate a support person or chaperone without crowding
- Layout has been assessed against the type of examinations routinely performed (e.g., musculoskeletal assessment requiring space for gait observation)

MINIMUM FOR DEVELOPING

- Rooms are used for consultations but no formal assessment of adequacy has been conducted
- Space constraints are managed informally (e.g., moving furniture between appointments)

EXCELLING

- Room layouts have been reviewed against specialty-specific requirements and adjusted based on clinician and patient feedback

COMMON PITFALLS

- Rooms repurposed from non-clinical settings (e.g., converted offices) that lack adequate space for proper examination technique
- No consideration of the space required for patients who use mobility aids or attend with carers

7.1.2 Consulting rooms include appropriate privacy screening and acoustic separation

ESTABLISHED EVIDENCE

- Privacy curtains or screens are available in all consulting rooms where patients undress or are examined
- Walls extend to the ceiling slab and doors close fully, providing acoustic separation from waiting areas and adjacent rooms
- Conversations at normal clinical volume cannot be overheard from the corridor or waiting room

MINIMUM FOR DEVELOPING

- Privacy curtains are present but acoustic separation has not been assessed
- Patients sometimes report being able to hear conversations from adjacent rooms

EXCELLING

- Acoustic assessments have been conducted and remediation (e.g., acoustic panels, white noise) has been implemented where deficiencies were identified

COMMON PITFALLS

- Rooms in shared tenancy suites with partition walls that do not reach the ceiling, allowing conversations to travel
- Privacy curtains missing or not replaced after wear, leaving patients exposed during examination

7.1.3 Adequate lighting is available for clinical assessment in all consulting rooms

ESTABLISHED EVIDENCE

- General room lighting is sufficient for clinical documentation and patient interaction
- Task lighting (e.g., adjustable examination lamp) is available for clinical assessments requiring directed illumination
- Lighting is appropriate for the specialty - e.g., dermatology rooms have high-quality colour rendering lighting

MINIMUM FOR DEVELOPING

- General overhead lighting is present but no dedicated examination lighting is available in consulting rooms

EXCELLING

- Lighting quality is reviewed periodically, including colour temperature and rendering index where relevant to the specialty, and upgraded when deficiencies are identified

COMMON PITFALLS

- Relying solely on overhead fluorescent lighting for skin, ENT, or ophthalmic examinations where directed or colour-accurate lighting is clinically necessary
- Burnt-out or flickering lights in consulting rooms not replaced promptly

7.1.4 Procedure rooms are equipped with appropriate clinical furniture and fittings for the procedures performed

ESTABLISHED EVIDENCE

- Procedure rooms contain a height-adjustable procedure table or chair appropriate to the procedures performed
- Adequate bench space for instrument lay-up and consumables
- Appropriate lighting (including overhead surgical light where procedures require it)
- Power outlets sufficient for all equipment used simultaneously

MINIMUM FOR DEVELOPING

- Procedure room exists and is used but equipment has been accumulated over time without a formal assessment of whether it matches current procedure requirements

EXCELLING

- Furniture and fittings are reviewed annually against the practice's current procedure list, with a documented review and replacement schedule

COMMON PITFALLS

- Procedure tables that do not adjust to an appropriate height for the clinician, creating ergonomic risk
- Insufficient bench space leading to instrument lay-up on trolleys in corridors or shared areas

7.1.5 Procedure rooms have documented equipment lists that are reviewed at least annually

ESTABLISHED EVIDENCE

- A written list of all equipment and furniture in each procedure room, including item description, manufacturer, model, and serial number where applicable
- The list has a review date and is signed or acknowledged by the responsible person
- The most recent review occurred within the past 12 months

MINIMUM FOR DEVELOPING

- An informal or partial equipment list exists but has not been reviewed or updated recently

EXCELLING

- Equipment lists are linked to the maintenance schedule and asset register, allowing quick identification of items due for service or replacement

COMMON PITFALLS

- No equipment list at all - "we know what's in the room" is not a documented process
- Equipment lists created at fit-out and never updated when items are added, removed, or replaced

7.1.6 Emergency equipment appropriate to the risk profile of the practice is available, accessible, and maintained (including resuscitation equipment where applicable)

ESTABLISHED EVIDENCE

- A risk assessment has been conducted to determine what emergency equipment is required based on the procedures performed and patient population
- Emergency equipment (e.g., defibrillator, anaphylaxis kit, basic airway management) is present and immediately accessible in the clinical area
- Equipment is checked at documented intervals and a checking log is maintained
- All clinical staff know the location of emergency equipment

MINIMUM FOR DEVELOPING

- Some emergency equipment is present (e.g., an anaphylaxis kit) but the inventory is based on assumption rather than a risk assessment
- No documented checking schedule

EXCELLING

- Emergency equipment inventory is benchmarked against published guidance (e.g., ANZCA PS18, ARC guidelines for office-based practice) and reviewed when the practice's procedure profile changes

COMMON PITFALLS

- Defibrillator purchased but pads expired because nobody checks them
- Anaphylaxis kit present but adrenaline ampoules past expiry date
- Emergency equipment stored in a locked cupboard and the key is in the practice manager's desk drawer

7.1.7 Oxygen and suction equipment (where present) is checked and serviced in accordance with manufacturer recommendations

ESTABLISHED EVIDENCE

- Service records for oxygen concentrators, cylinders, regulators, and suction units are current and show servicing at manufacturer-recommended intervals
- Oxygen cylinder contents are checked regularly and replacement cylinders are available
- Suction equipment is tested for adequate suction pressure and canisters are replaced or cleaned as required

MINIMUM FOR DEVELOPING

- Equipment is present and appears functional but there are no service records or documented checking procedures

EXCELLING

- A preventive maintenance schedule is in place with automatic reminders for service intervals, and backup equipment is available in case of primary equipment failure

COMMON PITFALLS

- Oxygen cylinders that are empty or nearly empty because no one checks the gauge
- Suction tubing that is cracked or perished, rendering the unit ineffective in an emergency
- Equipment present but no staff member confident in its setup and use

7.1.8 Clinical equipment is calibrated and maintained in accordance with applicable standards or manufacturer instructions

ESTABLISHED EVIDENCE

- A register of clinical equipment requiring calibration (e.g., blood pressure monitors, audiometers, spirometers, ECG machines, scales)
- Calibration records showing the date, method, result, and next due date for each item
- Equipment serviced by appropriately qualified technicians at manufacturer-recommended intervals

MINIMUM FOR DEVELOPING

- Equipment is in use and appears to work but calibration has not been verified or documented

EXCELLING

- Calibration is integrated into a practice-wide asset management system with automated alerts for upcoming due dates and documented escalation when equipment fails calibration

COMMON PITFALLS

- Blood pressure monitors never calibrated - a 10mmHg error changes clinical decisions
- Spirometers and audiometers used without annual calibration, producing unreliable results that influence diagnosis and management
- Assuming that "new" equipment does not need calibration verification

7.1.9 Equipment maintenance records are kept and reviewed

ESTABLISHED EVIDENCE

- A maintenance log or register covering all significant clinical and non-clinical equipment (procedure tables, autoclaves, fridges, IT hardware, building systems)
- Records include date of maintenance, nature of work performed, who performed it, and when next service is due
- Records are reviewed periodically to identify equipment approaching end-of-life or requiring replacement

MINIMUM FOR DEVELOPING

- Some maintenance records exist (e.g., for the autoclave) but there is no central register and many items have no recorded service history

EXCELLING

- Maintenance records feed into capital planning, with a documented replacement schedule for high-value or safety-critical equipment

COMMON PITFALLS

- Maintenance performed by external contractors but the practice retains no copy of the service report
- Relying on the contractor to schedule the next service - if they forget, the equipment goes unserviced

7.1.10 Sharps containers, clinical waste bins, and hand hygiene facilities are accessible in all consulting and procedure rooms

ESTABLISHED EVIDENCE

- Every consulting room and procedure room contains a compliant sharps container (AS 4031), a clinical waste bin (yellow lid), and a general waste bin
- Hand hygiene facilities (either a clinical handwash basin with soap and paper towels, or alcohol-based hand rub dispenser) are present and accessible at the point of care
- Sharps containers are correctly assembled, labelled, and not filled beyond the marked fill line

MINIMUM FOR DEVELOPING

- Hand hygiene facilities are available but not in every room - clinicians walk to a shared basin between patients
- Sharps containers are present but placement is inconsistent

EXCELLING

- Hand hygiene product availability is audited regularly, and sharps container placement and fill levels are checked on a defined schedule

COMMON PITFALLS

- Alcohol-based hand rub dispensers that are empty
- Sharps containers overfilled past the fill line, creating needlestick injury risk
- Clinical waste bins used for general waste (or vice versa), undermining waste segregation

7.1.11 Temperature-sensitive medications and products are stored appropriately (where applicable)

ESTABLISHED EVIDENCE

- A dedicated medication fridge (not a domestic food fridge) is used for vaccines, biologics, and other temperature-sensitive medications
- Temperature monitoring is continuous (data logger or min/max thermometer checked and recorded twice daily)
- Cold chain breach procedure is documented, including who to contact and how to assess affected stock
- Records are retained for at least 12 months

MINIMUM FOR DEVELOPING

- A fridge is used for medication storage but temperature monitoring is irregular or not documented

EXCELLING

- Continuous digital temperature monitoring with automatic alerts for out-of-range readings, and cold chain breach events are reviewed as part of the practice's incident management process

COMMON PITFALLS

- Using a bar fridge that freezes vaccines on the back wall
- Temperature log shows recordings only on weekdays - no monitoring over weekends or public holidays
- No documented response when a breach is detected, leading to wasted stock or unknowing administration of compromised product

7.1.12 Crash trolley or emergency kit is checked at defined intervals and documented

ESTABLISHED EVIDENCE

- The crash trolley or emergency kit has a documented checking schedule (typically weekly for trolleys, monthly for sealed kits)
- A checking log records the date, the person who checked, and whether all items were present and in date
- Expired or used items are replaced immediately after use or on discovery during a check
- Contents match a defined inventory list approved by the principal clinician

MINIMUM FOR DEVELOPING

- An emergency kit exists but checking is ad hoc and there is no log or defined interval

EXCELLING

- Checking records are audited quarterly, and any pattern of missed checks or expired items is addressed through a documented corrective action

COMMON PITFALLS

- Crash trolley present but not checked in months - items expired or missing
- No defined contents list, so the check consists of "it looks about right"
- Sealed emergency kits assumed to be fine because they are sealed - the seal does not stop medications from expiring

7.2 — Accessibility and Wayfinding

Every patient can access and navigate our practice safely and with dignity.

7.2.1 The practice entry is step-free or has an accessible alternative entry route

ESTABLISHED EVIDENCE

- The main entry is step-free with a level or ramped threshold compliant with AS 1428.1
- If an alternative accessible entry exists, it is clearly signposted from the main entry and does not require the patient to travel an unreasonable distance or through a service area
- The accessible entry is unlocked during practice hours or can be opened without requiring the patient to call ahead

MINIMUM FOR DEVELOPING

- An accessible entry exists but is not clearly signposted, or patients must call on arrival to have it unlocked

EXCELLING

- The practice has conducted an accessibility audit of its entry and approach (including car park to entrance) and addressed identified barriers

COMMON PITFALLS

- A ramp exists but is too steep, too narrow, or lacks handrails - technically present but not compliant or usable
- The accessible entry is via a back door through a loading dock, sending a clear message about whose convenience matters

7.2.2 Accessible toilet facilities are available to patients (or their location is clearly communicated at booking)

ESTABLISHED EVIDENCE

- An accessible toilet compliant with AS 1428.1 is available within the practice or on the same floor of the building
- If the accessible toilet is outside the practice tenancy, its location is communicated to patients at the time of booking and signposted within the practice
- The toilet is maintained and not used as a storage area

MINIMUM FOR DEVELOPING

- An accessible toilet exists in the building but the practice has not confirmed its availability or communicated its location to patients

EXCELLING

- The practice has confirmed that the accessible toilet meets current standards, includes appropriate fixtures (grab rails, adequate turning circle), and is regularly checked for maintenance and cleanliness

COMMON PITFALLS

- The building has an accessible toilet but it is locked, and nobody at the practice has the key
- The accessible toilet is used to store boxes, mops, or equipment, rendering it unusable

7.2.3 Consulting rooms can accommodate patients using wheelchairs, mobility aids, or bariatric equipment

ESTABLISHED EVIDENCE

- At least one consulting room (ideally the room closest to the accessible entry) has doorways, turning space, and furniture arrangement that accommodates a standard wheelchair
- An appropriate examination surface (height-adjustable, wider top, or transfer-friendly) is available for patients with mobility limitations
- Bariatric-rated furniture (chairs in waiting and consulting rooms) is available where the patient population requires it

MINIMUM FOR DEVELOPING

- Wheelchair access is possible to at least one room but the fit is tight and furniture must be moved to accommodate the patient

EXCELLING

- The practice has consulted with patients or disability advocacy groups to assess accessibility and has made documented improvements based on feedback

COMMON PITFALLS

- Consulting room doors too narrow for a wheelchair - the patient is examined in the corridor or waiting room
- All chairs in the waiting room have arms that limit access for bariatric patients, or are lightweight stackable chairs that are unstable for larger patients

7.2.4 Signage is clear, readable, and guides patients from entry to reception and waiting areas

ESTABLISHED EVIDENCE

- External signage identifies the practice and its entry point
- Internal signage directs patients from the entry to reception, waiting area, consulting rooms, and toilets
- Signage uses a minimum font size readable from a reasonable distance, with high contrast (dark text on light background or vice versa)
- Floor or suite numbers are clearly visible

MINIMUM FOR DEVELOPING

- Basic signage exists but is inconsistent, handwritten, or not visible from the points where patients make directional decisions

EXCELLING

- Signage has been reviewed for accessibility (font size, contrast, Braille or tactile elements where appropriate) and is consistent in style and placement throughout the practice

COMMON PITFALLS

- Practice located in a multi-tenancy building with no signage at the building entrance or in the lift lobby - patients arrive at the wrong suite
- Signage in English only in an area with a significant non-English-speaking patient population

7.2.5 The practice has a documented process for supporting patients who require additional assistance to access the building or rooms

ESTABLISHED EVIDENCE

- A written process describes how patients with mobility, sensory, or cognitive impairments are supported - including who assists them from the entrance, how rooms are prepared, and what alternative arrangements are made if the standard environment is not suitable
- The process is known to reception and clinical staff
- Patient notes or booking system can flag accessibility requirements so that arrangements are made before the patient arrives

MINIMUM FOR DEVELOPING

- Staff assist patients informally but there is no documented process and accessibility needs are not identified before the appointment

EXCELLING

- The process has been developed with input from patients with lived experience of disability and is reviewed when the practice environment changes

COMMON PITFALLS

- Assuming that patients will call ahead if they need help - many patients do not disclose accessibility needs unless asked
- No process for transferring patients safely from a wheelchair to an examination table

7.2.6 Booking and reception staff are aware of accessibility considerations and can assist patients proactively

ESTABLISHED EVIDENCE

- Staff induction includes accessibility awareness - how to ask about access needs, what to do when a need is identified, and who to escalate to if the practice cannot accommodate a patient
- Booking scripts or templates include a prompt to ask about accessibility or mobility requirements
- Reception staff are trained in safe manual handling if they assist patients physically

MINIMUM FOR DEVELOPING

- Staff are willing to help but have not been trained in accessibility awareness or safe manual handling techniques

EXCELLING

- Staff have completed formal accessibility or disability awareness training, and the practice periodically reviews how effectively it identifies and responds to access needs

COMMON PITFALLS

- Booking staff do not ask about access needs because "we don't want to offend anyone" - the result is that patients arrive to find barriers they were not warned about
- Staff attempt to physically assist patients without training, creating injury risk for both parties

7.2.7 Patients with sensory impairments (hearing or vision) are accommodated in the practice communication and appointment process

ESTABLISHED EVIDENCE

- The practice can provide written materials in large print or digital format on request
- Communication with hearing-impaired patients is supported (e.g., written notes, hearing loop in reception, SMS communication for booking and reminders)
- Clinical staff are aware of how to communicate effectively with patients who have sensory impairments (e.g., facing the patient, speaking clearly, confirming understanding)

MINIMUM FOR DEVELOPING

- Staff are aware of common sensory impairments but the practice has no formal process or resources for accommodating them

EXCELLING

- The practice has invested in hearing loop technology, provides patient information in accessible formats as standard, and seeks feedback from patients with sensory impairments about their experience

COMMON PITFALLS

- Calling the patient's name across a noisy waiting room when the patient is hearing-impaired
- Providing post-appointment instructions only verbally to a patient with hearing loss, with no written backup

7.2.8 Interpreter requirements are identified at booking and appropriate arrangements are made (see also Domain 4)

ESTABLISHED EVIDENCE

- Booking processes include a question about language preference and interpreter needs
- The practice has an account with a telephone or video interpreting service (e.g., TIS National) and staff know how to access it
- Interpreter use is documented in the patient record
- Family members are not used as primary interpreters for clinical discussions (except in emergencies or at the patient's informed request)

MINIMUM FOR DEVELOPING

- Interpreter needs are sometimes identified but the practice relies on family members or ad hoc arrangements rather than qualified interpreters

EXCELLING

- The practice monitors interpreter usage data, ensures access to face-to-face interpreters for complex consultations, and provides staff training on working effectively with interpreters

COMMON PITFALLS

- Using a patient's child as interpreter for sensitive clinical conversations - common in specialist practice and clinically inappropriate
- Not identifying the correct language or dialect at booking, resulting in an interpreter the patient cannot understand

7.2.9 Car parking or public transport access information is provided to patients at the time of booking

ESTABLISHED EVIDENCE

- Booking confirmation (letter, email, or SMS) includes information about parking options (including accessible parking bays), public transport routes, and any useful landmarks or directions
- If the practice has dedicated parking, this is communicated at booking with any relevant instructions (e.g., display a permit, maximum stay)
- If parking is limited or unavailable, the practice suggests alternatives

MINIMUM FOR DEVELOPING

- Some information is provided verbally at booking but nothing is included in written appointment confirmations

EXCELLING

- Access information is reviewed annually and updated when transport routes, parking arrangements, or building access changes

COMMON PITFALLS

- No parking information provided, and the patient spends 20 minutes circling the block and arrives late, compressing the consultation
- Accessible parking information not included - the patient arrives in a wheelchair and the nearest accessible bay is two blocks away

7.2.10 Emergency exit routes are clearly marked and accessible to patients with disabilities

ESTABLISHED EVIDENCE

- Exit signs are illuminated and comply with AS 2293 (emergency escape lighting and exit signs)
- Exit routes are free from obstruction and lead to a safe assembly area
- Where the building has multiple levels, the practice has considered how patients with mobility impairments will evacuate (e.g., refuge area, evacuation chair, personal emergency evacuation plan)
- Staff have been briefed on evacuation procedures for patients who cannot use stairs

MINIMUM FOR DEVELOPING

- Exit signs are present but exit routes have not been assessed for accessibility, and there is no plan for evacuating patients with disabilities

EXCELLING

- The practice conducts annual evacuation drills that include scenarios involving patients with mobility impairments, and addresses any gaps identified

COMMON PITFALLS

- Emergency exits blocked by stored equipment, furniture, or boxes
- No consideration of how a patient in a wheelchair will evacuate from an upper floor - the plan is essentially "wait for the fire brigade"

7.3 — Cleaning Hygiene and Environmental Standards

Our premises are clean, safe, and free from environmental hazards.

7.3.1 A documented cleaning schedule exists and is followed for all clinical and non-clinical areas

ESTABLISHED EVIDENCE

- A written cleaning schedule specifying tasks, frequency (daily, weekly, between patients for procedure rooms), and the products to be used for each area
- The schedule distinguishes between clinical areas (consulting rooms, procedure rooms) and non-clinical areas (reception, toilets, kitchen)
- Responsibility for each task is assigned (internal staff, external cleaner, or cleaning contractor)

MINIMUM FOR DEVELOPING

- Cleaning occurs regularly but there is no written schedule - it relies on the cleaner's knowledge of what needs doing

EXCELLING

- The cleaning schedule is reviewed at least annually or when the practice layout or services change, and cleaning audits are conducted periodically to verify compliance

COMMON PITFALLS

- A cleaning schedule exists in a folder but has not been updated since the practice opened - new rooms or areas added since then are not covered
- No between-patient cleaning specified for procedure rooms, relying on "the room looked clean"

7.3.2 Cleaning products used are appropriate to the surfaces and areas being cleaned (including clinical-grade products in procedure areas)

ESTABLISHED EVIDENCE

- Clinical areas are cleaned with TGA-listed hospital-grade disinfectants appropriate to the surfaces (e.g., non-corrosive products for stainless steel, compatible products for vinyl flooring)
- Safety Data Sheets (SDS) are available for all cleaning products used in the practice
- Non-clinical areas are cleaned with products appropriate to the surfaces and task
- Product selection has been reviewed against manufacturer recommendations for clinical furniture and equipment

MINIMUM FOR DEVELOPING

- Cleaning products are used but there has been no assessment of whether they are appropriate for clinical areas or compatible with the surfaces being cleaned

EXCELLING

- Product selection is reviewed when new equipment or surfaces are introduced, and SDS are updated when products change

COMMON PITFALLS

- Using domestic cleaning products (e.g., supermarket spray-and-wipe) on clinical surfaces where a hospital-grade disinfectant is required
- Using bleach-based products on surfaces where they cause corrosion or discolouration, leading to surface damage that harbours organisms

7.3.3 Cleaning records or logs are maintained

ESTABLISHED EVIDENCE

- A cleaning log that records the date, time, area cleaned, and the initials or name of the person who performed the cleaning
- For procedure rooms, a log of between-patient cleaning is maintained (this can be a simple sign-off sheet)
- Records are retained for a defined period (typically 12 months minimum)

MINIMUM FOR DEVELOPING

- Cleaning occurs but is not recorded - there is no way to verify that it was done on any specific date

EXCELLING

- Cleaning logs are audited periodically by the practice manager, and gaps or patterns (e.g., missed weekend cleans) are addressed with the cleaning team

COMMON PITFALLS

- Cleaning log exists but is pre-filled (all entries completed at the start of the week rather than at the time of cleaning)
- Logs maintained for common areas but not for consulting or procedure rooms

7.3.4 Cleaning staff receive induction and ongoing training appropriate to clinical environments

ESTABLISHED EVIDENCE

- Cleaning staff (internal or contractor) have completed an induction covering the practice's cleaning schedule, products, clinical waste handling, infection control basics, and hand hygiene
- Induction is documented with the staff member's name, date, and topics covered
- Refresher training is provided at least annually or when products, procedures, or standards change

MINIMUM FOR DEVELOPING

- Cleaning staff have been shown what to do but there is no documented induction or training record

EXCELLING

- Cleaning staff are included in the practice's infection control training program and participate in relevant updates (e.g., changes to disinfection protocols)

COMMON PITFALLS

- Cleaning contracted to an external company and the practice assumes the company has trained its staff in clinical cleaning - no verification has occurred
- High turnover of cleaning staff with no re-induction process, so new cleaners follow what the previous person did rather than the documented schedule

7.3.5 Enhanced cleaning is carried out after any contamination event

ESTABLISHED EVIDENCE

- A documented procedure for enhanced cleaning following blood or body fluid spills, infectious patient contact, or other contamination events
- The procedure specifies PPE requirements, products to use, and who is responsible
- A record is kept of contamination events and the cleaning response

MINIMUM FOR DEVELOPING

- Staff clean up spills when they occur but there is no documented procedure specifying the correct response

EXCELLING

- Contamination events are reviewed as part of the practice's incident management process, with root cause considered and cleaning procedures adjusted if needed

COMMON PITFALLS

- Using a standard mop and bucket for a blood spill rather than the correct product and PPE
- No spill kit available - staff improvise with whatever is in the cleaning cupboard

7.3.6 The practice has a documented process for pest management

ESTABLISHED EVIDENCE

- A pest management plan or contract with a licensed pest control provider, specifying inspection frequency and treatment methods
- Records of pest inspections and any treatments performed
- Food storage areas (staff kitchen) maintained to reduce pest attraction

MINIMUM FOR DEVELOPING

- Pest control is arranged reactively (i.e., when a problem is noticed) rather than on a planned preventive basis

EXCELLING

- Pest management is integrated into the practice's environmental management plan and reviewed annually, with no reactive call-outs in the past 12 months

COMMON PITFALLS

- No pest management arrangement at all - the issue is only addressed when a patient or staff member reports seeing a cockroach or rodent
- Practice in an older building with known pest issues but no preventive treatment schedule

7.3.7 Ventilation in consulting and procedure rooms is adequate and maintained

ESTABLISHED EVIDENCE

- Air conditioning and ventilation systems are serviced at manufacturer-recommended intervals (typically annually) with documented service records
- Filters are cleaned or replaced on schedule
- Procedure rooms where aerosol-generating procedures are performed have ventilation assessed against relevant guidelines (e.g., minimum air changes per hour)
- Temperature and humidity in clinical areas are maintained within a comfortable and clinically appropriate range

MINIMUM FOR DEVELOPING

- Air conditioning exists but service records are absent or the system has not been serviced in over 12 months

EXCELLING

- Ventilation adequacy has been formally assessed (e.g., by an HVAC engineer) for procedure rooms, and air change rates are documented and meet applicable standards

COMMON PITFALLS

- HVAC system filters not replaced in years, circulating dust and allergens through clinical areas
- Procedure rooms with no independent ventilation, relying on opening a window - not appropriate for aerosol-generating procedures

7.3.8 Waiting areas and reception are maintained to a clean and presentable standard

ESTABLISHED EVIDENCE

- Waiting area furniture is in good repair, clean, and wipeable (fabric-covered chairs in clinical settings are difficult to decontaminate)
- Floors, walls, and surfaces are clean and free from visible damage
- Reading materials, toys, or shared items (if provided) are cleaned regularly or are single-use
- The area is tidy and free from clutter

MINIMUM FOR DEVELOPING

- The waiting area is generally clean but furniture is worn or damaged, and there is no regular inspection or maintenance schedule

EXCELLING

- The waiting area is reviewed periodically from a patient experience perspective, with input from patient feedback, and improvements are implemented

COMMON PITFALLS

- Shared magazines and toys in the waiting room that are never cleaned - infection transmission risk, especially in paediatric settings
- Worn or stained seating that gives a poor first impression and raises questions about clinical hygiene standards

7.3.9 Physical hazards in the practice (e.g. trip hazards, trailing cables, unstable furniture) are identified and addressed

ESTABLISHED EVIDENCE

- A hazard inspection or walkthrough is conducted at defined intervals (e.g., quarterly) and documented
- Identified hazards are recorded, risk-rated, and addressed with a responsible person and target date
- Common hazards are checked: floor surfaces, cable management, furniture stability, door closers, mat edges, wet floor protocols
- Staff know how to report a hazard and reports are actioned promptly

MINIMUM FOR DEVELOPING

- Hazards are addressed when noticed but there is no systematic inspection process

EXCELLING

- Hazard inspections are integrated into the practice's WHS system, with trend analysis showing reduction in identified hazards over time

COMMON PITFALLS

- Trailing power cables across corridors because there are insufficient power outlets - a trip hazard that persists for years
- Mat edges curling up at the entrance, creating a trip hazard for elderly or vision-impaired patients

7.3.10 The practice complies with applicable work health and safety requirements in relation to the physical environment

ESTABLISHED EVIDENCE

- The practice has a WHS policy or statement that addresses the physical environment
- A risk register or risk assessment covers physical environment hazards (slips, trips, falls, manual handling, electrical safety)
- The practice holds current electrical test-and-tag records for portable appliances (where required by state/territory legislation)
- Fire extinguishers are serviced annually, and emergency lighting is tested at required intervals
- Workers' compensation reporting obligations are understood

MINIMUM FOR DEVELOPING

- The practice is aware of WHS obligations but has not conducted a formal risk assessment of the physical environment

EXCELLING

- WHS compliance is reviewed annually with input from staff, and the practice benchmarks against the relevant state/territory WHS code of practice for healthcare settings

COMMON PITFALLS

- No test-and-tag records for portable electrical appliances - common in practices that assume it is the building owner's responsibility
- Fire extinguishers present but last serviced three years ago

7.4 — Reusable Medical Device Reprocessing and Sterilisation

We reprocess reusable instruments in accordance with applicable standards and in a way that protects patient and staff safety.

7.4.1 A documented reprocessing procedure exists for all reusable medical devices used in the practice

ESTABLISHED EVIDENCE

- Written procedures covering each step: pre-cleaning at point of use, transport to reprocessing area, manual cleaning, rinsing, drying, packaging, sterilisation, storage, and distribution
- Procedures are device-specific where the manufacturer requires particular handling (e.g., instruments with lumens, hinged instruments)
- Procedures are accessible to all staff who perform reprocessing
- Procedures reference the applicable standard (AS/NZS 4815 or AS/NZS 4187)

MINIMUM FOR DEVELOPING

- Some written guidance exists but it is generic and does not cover all instruments or all steps in the reprocessing cycle

EXCELLING

- Procedures are reviewed annually and updated when new instruments are introduced, when the applicable standard is updated, or following a reprocessing incident

COMMON PITFALLS

- A generic one-page "how to use the autoclave" document that does not address pre-cleaning, inspection, or packaging - the most critical steps in the cycle
- Procedures written at practice setup and never updated, despite changes in instruments or equipment

7.4.2 Reprocessing is conducted in accordance with AS/NZS 4815 (office-based healthcare) or AS/NZS 4187 (where a more complex procedure profile applies)

ESTABLISHED EVIDENCE

- The practice has identified which standard applies to its reprocessing activities based on its procedure profile
- Compliance with the applicable standard is documented - this includes water quality, detergent selection, rinse protocols, and drying requirements
- Where AS/NZS 4187 applies (e.g., practices performing complex invasive procedures), the practice meets the higher requirements for validation, water quality, and monitoring

MINIMUM FOR DEVELOPING

- Reprocessing occurs but the practice has not formally assessed its compliance against the applicable standard

EXCELLING

- An independent audit against the applicable standard has been conducted within the past two years, and recommendations have been implemented

COMMON PITFALLS

- Applying AS/NZS 4815 (the simpler standard) when the practice's procedure profile actually requires compliance with AS/NZS 4187
- Assuming that because the autoclave works, the overall reprocessing cycle is compliant - the standard covers far more than the sterilisation step

7.4.3 Reprocessing is conducted in a dedicated area with appropriate separation of clean and dirty workflow

ESTABLISHED EVIDENCE

- A dedicated reprocessing area with a clear physical or functional separation between the dirty (decontamination) side and the clean (packaging and storage) side
- Workflow flows in one direction - dirty instruments enter on one side and clean instruments exit on the other
- The area has adequate bench space, lighting, and ventilation
- Hand hygiene facilities and PPE are available in the reprocessing area

MINIMUM FOR DEVELOPING

- Reprocessing occurs in a defined area but clean and dirty workflow crosses over due to space constraints, and the practice has not documented how it manages the risk

EXCELLING

- The reprocessing area has been designed or retrofitted to meet the layout requirements of the applicable standard, with documented workflow and clear signage

COMMON PITFALLS

- Instruments cleaned in the tea room sink or a shared bathroom
- Dirty and clean instruments placed on the same bench because the area is too small, with no physical separation

7.4.4 Staff responsible for reprocessing have received documented training in the procedure

ESTABLISHED EVIDENCE

- Training records for each staff member who performs reprocessing, showing the date, content covered, and the trainer's credentials
- Training covers the full reprocessing cycle, use of PPE, chemical handling, equipment operation, and the applicable standard
- Competency assessment has been conducted (observation of the staff member performing the full cycle)
- Refresher training is provided at defined intervals (at least annually) or when procedures change

MINIMUM FOR DEVELOPING

- Staff have been shown how to use the autoclave but have not received formal training in the complete reprocessing cycle, and there are no training records

EXCELLING

- Staff have completed an accredited reprocessing course (e.g., through a state sterilising services body or registered training organisation) and competency is reassessed annually

COMMON PITFALLS

- Training limited to "watch someone else do it" with no documentation
- Locum or relief staff performing reprocessing without any training or competency verification - the single most common cause of reprocessing failures in specialist practices

7.4.5 Sterilisation equipment (autoclave) is tested, validated, and serviced in accordance with manufacturer instructions and applicable standards

ESTABLISHED EVIDENCE

- The autoclave has been validated (installation qualification, operational qualification, and performance qualification) in accordance with the applicable standard
- Routine monitoring includes daily Bowie-Dick or Helix test (for pre-vacuum autoclaves), chemical indicators in every load, and biological indicators at the frequency required by the standard
- The autoclave is serviced at manufacturer-recommended intervals, with service records retained
- Validation is repeated following relocation, major repairs, or at intervals specified by the standard

MINIMUM FOR DEVELOPING

- The autoclave is in use and appears to function correctly, but validation has never been performed or documentation cannot be located

EXCELLING

- Validation reports are current, monitoring results are reviewed monthly for trends, and any out-of-specification results trigger an immediate documented investigation

COMMON PITFALLS

- Autoclave purchased, installed, and used for years without ever being formally validated - this is the single most common sterilisation deficiency in Australian specialist practices
- Biological indicator testing not performed at all, or performed but results not reviewed before instruments are released for use

7.4.6 Sterilisation cycle records are maintained and include cycle parameters and load identification

ESTABLISHED EVIDENCE

- A log for every sterilisation cycle recording: date, cycle number, load contents (or load identifier), cycle parameters (temperature, pressure, time), chemical indicator result, and the operator's initials
- Printouts from the autoclave (if available) are retained and matched to the load record
- Records are retained for the period required by the applicable standard (typically a minimum of the shelf life of the sterilised items, and ideally longer)

MINIMUM FOR DEVELOPING

- The autoclave runs and produces printouts, but these are not matched to specific loads and no log is maintained

EXCELLING

- Cycle records are linked to individual instrument trays via a load tracking system, enabling traceability from patient to sterilisation cycle

COMMON PITFALLS

- Autoclave printouts accumulate in a pile but are not reviewed, dated, or matched to loads - they provide no usable traceability
- Cycle parameters recorded but never reviewed - a gradual drift in performance goes unnoticed until a failure occurs

7.4.7 Instrument packaging is inspected prior to use and out-of-date or damaged items are removed from circulation

ESTABLISHED EVIDENCE

- A defined shelf life or event-related expiry system is in place for sterilised instrument packs
- Instrument packs are inspected before each use for packaging integrity (tears, moisture, seal failure) and expiry
- Expired, damaged, or compromised packs are returned for reprocessing before use
- Storage conditions protect packs from contamination, moisture, and damage

MINIMUM FOR DEVELOPING

- Packs are inspected visually before use but there is no defined shelf life or systematic expiry process

EXCELLING

- A stock rotation system (first in, first out) is in place, pack integrity failures are recorded and analysed for trends, and storage conditions are monitored

COMMON PITFALLS

- Instrument packs stored in open drawers or on shelves where they are handled repeatedly, compromising the packaging
- No expiry date on packs - instruments sterilised months ago used without any assessment of packaging integrity

7.4.8 Single-use devices are not reused

ESTABLISHED EVIDENCE

- The practice maintains a list of single-use devices used in the practice
- Packaging and manufacturer instructions are checked for single-use labelling (the "do not reuse" symbol)
- A clear policy prohibits the reprocessing or reuse of single-use devices
- All staff involved in instrument handling and setup are aware of the policy

MINIMUM FOR DEVELOPING

- Staff generally understand the principle but there is no written policy, and single-use status is not always verified for every device

EXCELLING

- The single-use device register is reviewed when new products are introduced, and any ambiguity is resolved with the manufacturer before the device is used

COMMON PITFALLS

- Reusing devices marked as single-use to save cost - this creates regulatory, insurance, and patient safety exposure
- Ambiguity about whether a device is single-use or reusable because the packaging has been discarded and the manufacturer's instructions are not retained

7.4.9 The practice has a defined process for managing a reprocessing failure or instrument recall

ESTABLISHED EVIDENCE

- A documented procedure for responding to a reprocessing failure (e.g., failed biological indicator, load recall, contaminated load discovery) including: quarantine of affected instruments, notification of clinicians, patient notification if instruments were used, root cause investigation, and corrective action
- The procedure identifies who is responsible for each step and the timeframes for action
- The procedure addresses manufacturer instrument recalls (identifying affected instruments, removing from circulation, notifying the TGA if required)

MINIMUM FOR DEVELOPING

- No documented procedure - staff would "figure it out" if a failure occurred

EXCELLING

- The practice has conducted a tabletop exercise or drill simulating a reprocessing failure, and the procedure has been tested and refined based on the findings

COMMON PITFALLS

- A failed biological indicator is re-run rather than investigated - "it was probably a faulty indicator" is not an acceptable first response
- No patient notification procedure - if a contaminated instrument was used on a patient, the practice has no plan for how to contact them or what to say

7.4.10 Where reprocessing is outsourced, the provider's credentials and compliance are verified and documented

ESTABLISHED EVIDENCE

- A current contract or service agreement with the external reprocessing provider
- Evidence that the provider holds appropriate accreditation or certification (e.g., compliance with AS/NZS 4187, state health department licensing)
- The practice has verified the provider's quality monitoring processes (e.g., biological indicator testing, load traceability)
- Delivery and return processes maintain the sterile chain (instruments transported in sealed containers)

MINIMUM FOR DEVELOPING

- Reprocessing is outsourced but the practice has not verified the provider's credentials or quality processes

EXCELLING

- The practice conducts annual reviews of the outsourced provider's compliance, including requesting copies of their most recent audit results or accreditation certificate

COMMON PITFALLS

- Outsourcing to a provider chosen on price without verifying their compliance with the applicable standard
- No documentation of the arrangement - if the provider has a failure, the practice cannot demonstrate it exercised due diligence in selecting them

7.5 — Waste Management

We manage clinical and general waste safely, lawfully, and in a way that protects staff, patients, and the environment.

7.5.1 Clinical, sharps, pharmaceutical, and general waste streams are clearly separated and labelled

ESTABLISHED EVIDENCE

- Separate, correctly colour-coded bins for general waste, clinical waste (yellow), and cytotoxic waste (purple, where applicable) are present in clinical areas
- Sharps containers comply with AS 4031 and are clearly labelled
- A pharmaceutical waste container or defined collection point is in place for expired or unwanted medications
- Bins are labelled with pictograms and text to aid correct segregation

MINIMUM FOR DEVELOPING

- Sharps containers and clinical waste bins are present but other waste streams (pharmaceutical, cytotoxic) are not clearly separated

EXCELLING

- Waste segregation is audited periodically (e.g., quarterly visual inspection of bin contents) and non-compliance is addressed through staff education

COMMON PITFALLS

- General waste placed in clinical waste bins - increasing disposal costs significantly and indicating poor staff understanding of segregation
- No dedicated pharmaceutical waste stream - expired medications placed in general waste or clinical waste inappropriately

7.5.2 Waste management procedures are documented and followed by all clinical and cleaning staff

ESTABLISHED EVIDENCE

- A written waste management procedure covering segregation rules, handling, storage, collection schedules, spill management, and staff responsibilities
- The procedure identifies applicable state/territory waste legislation and EPA requirements
- The procedure is accessible to all staff who handle waste, including cleaning contractors
- Staff sign-off confirms they have read and understood the procedure

MINIMUM FOR DEVELOPING

- Waste is managed but procedures are not written down - staff follow verbal instructions or habit

EXCELLING

- Waste management procedures are reviewed annually and updated when waste regulations change or when new waste streams are introduced (e.g., new pharmaceutical products)

COMMON PITFALLS

- Procedures exist but cleaning contractors have never been shown them and follow their own methods
- The procedure does not address spill management - staff improvise when a clinical waste bag leaks

7.5.3 Sharps containers are approved, correctly labelled, not overfilled, and disposed of via a licensed contractor

ESTABLISHED EVIDENCE

- Sharps containers are AS 4031 compliant and bear the biohazard symbol and practice identification
- Containers are assembled correctly (base locked, lid functioning) and positioned securely on a stable surface or wall bracket
- Fill level does not exceed the marked fill line
- Disposal is via a licensed clinical waste contractor, with collection records retained

MINIMUM FOR DEVELOPING

- Sharps containers are present and used but fill levels are not monitored systematically, and disposal records are incomplete

EXCELLING

- Sharps container fill levels are checked on a defined schedule (e.g., weekly), and the practice tracks sharps injury incidents with sharps container usage patterns

COMMON PITFALLS

- Sharps containers overfilled to the point where sharps protrude from the opening - a needlestick injury waiting to happen
- Containers placed on the floor where they can be knocked over, or on high shelves requiring staff to reach above shoulder height to dispose of sharps

7.5.4 Clinical waste (including pathological waste) is collected by a licensed clinical waste contractor at appropriate intervals

ESTABLISHED EVIDENCE

- A current contract with a licensed clinical waste collection contractor
- Collection frequency is appropriate to the volume of waste generated - waste does not accumulate or overflow between collections
- Waste is stored in a secure, designated area between collections (not in corridors, consulting rooms, or public areas)
- Collection consignment notes are retained for the required period under state/territory legislation

MINIMUM FOR DEVELOPING

- Clinical waste is collected but the arrangement is informal, collection frequency is irregular, and consignment notes are not consistently retained

EXCELLING

- The practice monitors waste volumes and adjusts collection frequency proactively, and reviews the contractor's compliance annually

COMMON PITFALLS

- Clinical waste bags stored in a staff kitchen or corridor between collections because there is no designated storage area
- Collection lapses (e.g., contractor missed a pickup) not followed up, leading to waste accumulating beyond safe limits

7.5.5 Waste disposal documentation (including contractor consignment notes) is retained for the required period

ESTABLISHED EVIDENCE

- Consignment notes or waste transfer documents from the licensed waste contractor are filed and retained for the period required by state/territory legislation (typically 3-5 years)
- Records include the date of collection, type and quantity of waste, the contractor's details, and the disposal destination
- Records are accessible for inspection by the relevant environmental authority if requested

MINIMUM FOR DEVELOPING

- Some consignment notes are retained but the filing is incomplete - notes from earlier periods are missing or cannot be located

EXCELLING

- A digital register of all waste collections is maintained, with consignment notes scanned and filed, enabling quick retrieval for audits or regulatory inquiries

COMMON PITFALLS

- Consignment notes handed to the cleaner at the time of collection and never seen again
- The practice assumes the waste contractor retains all necessary records - they may, but the practice has a separate obligation to retain its own copies

7.5.6 Pharmaceutical waste (including expired medications) is disposed of via appropriate channels and not placed in general waste

ESTABLISHED EVIDENCE

- Expired or unwanted medications are collected in a designated container and disposed of via a pharmaceutical waste program (e.g., Return Unwanted Medicines - RUM - for Schedule 2-4 medications, or via a licensed pharmaceutical waste contractor for Schedule 8 and cytotoxic medications)
- Controlled substance destruction is witnessed and documented in accordance with state/territory requirements
- Staff are trained to identify pharmaceutical waste and segregate it from other waste streams

MINIMUM FOR DEVELOPING

- Expired medications are not placed in general waste but disposal is ad hoc - there is no defined process or designated collection point

EXCELLING

- Pharmaceutical waste disposal is integrated into the practice's medication management process, with regular stock reviews identifying items approaching expiry before they become waste

COMMON PITFALLS

- Expired medications thrown into the general waste bin - a regulatory breach and a potential environmental or safety hazard
- Schedule 8 medications disposed of without proper documentation or witnessing, creating a discrepancy in the drug register

7.5.7 The practice complies with applicable state or territory waste regulations

ESTABLISHED EVIDENCE

- The practice has identified the applicable waste legislation for its state or territory (e.g., Protection of the Environment Operations Act in NSW, Environment Protection Act in Victoria)
- The practice is registered or licensed as required for clinical waste generation in the relevant jurisdiction
- Waste management practices align with the relevant EPA guidelines for clinical and related waste
- Compliance is reviewed when regulations change or when the practice's waste profile changes

MINIMUM FOR DEVELOPING

- The practice manages waste responsibly but has not confirmed which specific regulations apply or whether it holds any required registrations

EXCELLING

- The practice subscribes to regulatory updates from the relevant EPA or health department and adjusts its waste practices proactively when requirements change

COMMON PITFALLS

- Assuming that waste compliance is the contractor's problem - the generator of clinical waste has primary legal responsibility for its safe management
- Operating across state borders (e.g., a practice with locations in NSW and ACT) without recognising that waste regulations differ by jurisdiction

7.5.8 Staff are trained in waste segregation and the management of contamination incidents

ESTABLISHED EVIDENCE

- Training records showing that all clinical and cleaning staff have been trained in waste segregation rules, safe handling, PPE use, and the procedure for managing a spill or contamination incident
- Training is provided at induction and refreshed at least annually
- Training covers sharps injury management, including first aid and reporting requirements

MINIMUM FOR DEVELOPING

- Staff have been verbally instructed on waste segregation but there are no training records and no formal contamination management training has been provided

EXCELLING

- Staff training includes practical scenarios (e.g., simulated spill response), and the practice reviews sharps injury and contamination incidents as part of its incident management process to identify training gaps

COMMON PITFALLS

- Cleaning staff assumed to know waste segregation because they work in healthcare - without specific training, cross-contamination of waste streams is common
- Sharps injury response not covered in training - staff do not know the post-exposure protocol or who to report an injury to

7.6 — IT Infrastructure and Cybersecurity

Our IT systems are fit for purpose, kept up to date, and protected against foreseeable threats.

7.6.1 Clinical and administrative software is licenced, current, and supported by the vendor

ESTABLISHED EVIDENCE

- A register of all software used in the practice (clinical, billing, accounting, communication, document management) showing licence status, version, and vendor support expiry
- All software is within the vendor's active support lifecycle - receiving updates and patches
- Licence compliance is verified (correct number of seats or users for the number of staff using the software)

MINIMUM FOR DEVELOPING

- Software is in use and appears to work but there is no register, and the practice is unsure whether all licences are current or whether the vendor still supports the version in use

EXCELLING

- Software inventory is reviewed at least annually, with upcoming end-of-support dates identified and migration plans in place before support expires

COMMON PITFALLS

- Running an outdated version of the practice management system because "the update might break something" - unsupported versions do not receive security patches
- Using unlicensed copies of office productivity software, creating compliance and security exposure

7.6.2 Operating systems on all practice devices are within vendor support lifecycle (no end-of-life OS in use on clinical devices)

ESTABLISHED EVIDENCE

- A device register listing all computers, tablets, and servers used in the practice, with the operating system version for each
- All operating systems are within the vendor's support lifecycle (e.g., Windows 10 support end date is October 2025 - devices must be upgraded before then)
- A plan exists for upgrading or replacing devices approaching end-of-support

MINIMUM FOR DEVELOPING

- Most devices run supported operating systems but a few legacy devices remain on unsupported versions

EXCELLING

- The practice maintains a forward-looking device lifecycle plan, budgeting for replacements 12 months before end-of-support dates

COMMON PITFALLS

- A reception PC or clinical workstation still running Windows 7 or an unsupported macOS version - no longer receiving security patches and vulnerable to known exploits
- Assuming that end-of-life devices are safe because they are "behind the firewall" - internal network attacks are a real and growing threat

7.6.3 Automatic security updates and patches are applied to all devices and systems

ESTABLISHED EVIDENCE

- Automatic updates are enabled on all workstations, servers, and network devices (or updates are managed centrally via a patch management system)
- Critical security patches are applied within 48 hours of release (or as recommended by the ACSC)
- Update status is verified periodically (e.g., monthly check that all devices are current)

MINIMUM FOR DEVELOPING

- Automatic updates are enabled on most devices but some are deferred or disabled, and there is no process for verifying that updates have been applied

EXCELLING

- A managed patch management solution is in place, with reporting that confirms patch compliance across all devices, and exceptions are documented and risk-assessed

COMMON PITFALLS

- Updates disabled on clinical workstations because "they cause the system to restart during consultations" - the risk of an unpatched vulnerability is far greater than a restart
- Network devices (routers, switches, firewalls) not included in the update process - these are common attack vectors

7.6.4 Antivirus or endpoint protection software is installed and active on all practice devices

ESTABLISHED EVIDENCE

- Endpoint protection software is installed on all workstations, laptops, and servers used in the practice
- The software is active, up to date, and configured to perform regular scans
- Alerts from the endpoint protection software are monitored and responded to

MINIMUM FOR DEVELOPING

- Antivirus software is installed on most devices but it is unclear whether it is current or whether all devices are covered

EXCELLING

- The practice uses a managed endpoint detection and response (EDR) solution with centralised monitoring and alerting, and the IT support provider reviews threat reports regularly

COMMON PITFALLS

- Free consumer antivirus installed years ago and never updated - it provides minimal protection against current threats
- Endpoint protection disabled by a user because it slowed their computer, and nobody noticed

7.6.5 Practice Wi-Fi separates clinical and administrative networks from patient guest access

ESTABLISHED EVIDENCE

- Separate wireless networks (SSIDs) for clinical/administrative use and patient guest access
- The guest network is isolated from the clinical network at the router or access point level (VLAN segmentation or equivalent)
- The guest network has a password that is changed periodically, or uses a captive portal
- The clinical network uses WPA3 or WPA2-Enterprise encryption

MINIMUM FOR DEVELOPING

- A single Wi-Fi network is used for all purposes, but the practice is aware of the risk and considering segmentation

EXCELLING

- Network segmentation has been verified by the IT provider (e.g., a penetration test or network audit confirms that guest devices cannot access clinical systems), and the configuration is reviewed annually

COMMON PITFALLS

- One Wi-Fi network shared by clinical systems and patient guest access - a compromised guest device could access clinical data
- Guest Wi-Fi password printed on a sign in the waiting room and never changed

7.6.6 Multi-factor authentication (MFA) is enabled for access to clinical software, email, and remote access systems

ESTABLISHED EVIDENCE

- MFA is enabled for all users on the practice management system, email, cloud storage, and any remote access tools (VPN, remote desktop)
- MFA methods used are robust (authenticator app, hardware token) rather than SMS-only where possible
- MFA is enforced by policy - individual users cannot opt out

MINIMUM FOR DEVELOPING

- MFA is enabled on some systems (e.g., email) but not yet on the practice management system or remote access tools

EXCELLING

- MFA is enforced across all systems with access to patient data, and the practice has adopted passwordless or phishing-resistant MFA methods where available

COMMON PITFALLS

- MFA enabled but not enforced - some users have not completed setup and access systems without it
- MFA using SMS only, which is vulnerable to SIM-swap attacks - an authenticator app is significantly more secure

7.6.7 Access to clinical systems is role-based and user accounts are deactivated promptly when staff leave

ESTABLISHED EVIDENCE

- Clinical system access is configured by role (e.g., clinician, nurse, receptionist, billing) with permissions limited to what each role requires
- A documented process exists for creating, modifying, and deactivating user accounts
- User accounts are deactivated on the staff member's last day (or before, if the departure is involuntary)
- A periodic review (at least annually) of active user accounts is conducted to identify orphaned or unnecessary accounts

MINIMUM FOR DEVELOPING

- Role-based access exists in principle but permissions have not been reviewed, and some former staff members may still have active accounts

EXCELLING

- Access reviews are conducted at least every six months, account deactivation is included in the offboarding checklist and verified by the practice manager, and elevated access (e.g., system administrator) is limited to the minimum number of staff necessary

COMMON PITFALLS

- A former staff member's account still active months after they left - a security and privacy breach waiting to happen
- All staff given full administrator access because "it's easier" - this eliminates the purpose of role-based access control

7.6.8 Passwords are managed in accordance with current guidance (minimum complexity requirements; not shared between systems; not written on physical notes near devices)

ESTABLISHED EVIDENCE

- A password policy specifying minimum length (at least 12 characters recommended by the ACSC), complexity requirements, and prohibition on password reuse across systems
- Passwords are not shared between staff members
- No passwords written on sticky notes, under keyboards, or on monitors
- A password manager is recommended or provided for staff to manage their credentials

MINIMUM FOR DEVELOPING

- Staff have individual passwords but there is no formal password policy, and some password sharing or reuse is likely occurring

EXCELLING

- The practice provides a password manager to all staff, conducts periodic awareness reminders about password hygiene, and has implemented single sign-on where available to reduce password fatigue

COMMON PITFALLS

- The practice management system password shared between all reception staff - no individual accountability and no audit trail
- Passwords written on a sticky note attached to the monitor - visible to patients, cleaners, and anyone who enters the room

7.6.9 Patient data is not stored on personal devices unless encrypted and subject to a documented access policy

ESTABLISHED EVIDENCE

- A policy addressing the use of personal devices (BYOD) for accessing or storing patient data
- If personal devices are permitted, they must have full-disk encryption enabled, a passcode or biometric lock, and remote wipe capability
- Patient data is not stored locally on personal devices - access is via secured clinical systems only
- The policy is acknowledged by all staff who use personal devices for work purposes

MINIMUM FOR DEVELOPING

- Staff occasionally access patient data on personal devices (e.g., email on a personal phone) but there is no BYOD policy and no encryption verification

EXCELLING

- The practice uses a mobile device management (MDM) solution to enforce encryption, passcodes, and remote wipe on all devices that access practice systems, and personal device access is reviewed annually

COMMON PITFALLS

- Clinicians storing patient photos on personal mobile phones - unencrypted, unmanaged, and not backed up to a secure location
- Practice email (containing patient data) accessible on personal devices without a passcode or biometric lock

7.6.10 The practice has a documented cybersecurity incident response procedure

ESTABLISHED EVIDENCE

- A written procedure covering the response to common cybersecurity incidents: ransomware, data breach, phishing compromise, unauthorised access, and lost or stolen devices
- The procedure specifies immediate actions (isolate affected systems, preserve evidence), communication steps (notify IT support, practice manager, principal clinician), and regulatory notification requirements (OAIC under the Notifiable Data Breaches scheme, ACSC for significant incidents)
- Contact details for the IT support provider, OAIC, and ACSC are included in the procedure
- The procedure is accessible offline (printed copy or accessible from a device not connected to the practice network)

MINIMUM FOR DEVELOPING

- Staff are aware they should "call IT" if something goes wrong, but there is no documented procedure and no clarity on regulatory notification obligations

EXCELLING

- The practice has conducted a tabletop exercise simulating a cybersecurity incident (e.g., ransomware scenario), and the procedure has been tested and refined based on the findings

COMMON PITFALLS

- The incident response procedure is stored on the practice server - if the server is encrypted by ransomware, the procedure is inaccessible
- No mention of OAIC notification obligations - the practice may not realise it has 30 days to assess and notify following an eligible data breach

7.6.11 Staff have received cybersecurity awareness training in the past 24 months

ESTABLISHED EVIDENCE

- Training records showing all staff (clinical and administrative) have completed cybersecurity awareness training within the past 24 months
- Training covers: phishing recognition, safe email and internet practices, password management, reporting suspicious activity, and the practice's incident response procedure
- Training is provided at induction and refreshed at least every two years

MINIMUM FOR DEVELOPING

- Some staff have received informal guidance but there is no documented training and not all staff have been covered

EXCELLING

- The practice uses simulated phishing exercises to test staff awareness, reviews results, and provides targeted follow-up training for staff who engage with simulated phishing emails

COMMON PITFALLS

- Training provided only to administrative staff - clinicians excluded because "they're too busy" - but clinicians are equally targeted by phishing attacks
- One-off training at practice setup with no refresher - threats evolve rapidly and training becomes outdated within 12 months

7.6.12 The practice is enrolled in My Health Record and meets its obligations for secure messaging in accordance with the Australian Digital Health Agency standards (where applicable)

ESTABLISHED EVIDENCE

- The practice is registered as a participating healthcare organisation with the My Health Record system
- The practice management system is configured to upload and view My Health Record documents in accordance with ADHA specifications
- Secure messaging (e.g., discharge summaries, referral letters, pathology results) is configured and used in accordance with ADHA standards (e.g., SMD, HL7 messaging)
- Staff are trained in their obligations under the My Health Record Act (e.g., access controls, not accessing records without clinical need)

MINIMUM FOR DEVELOPING

- The practice is registered for My Health Record but it is not actively used, or secure messaging is not yet configured

EXCELLING

- The practice monitors its My Health Record upload rates, actively contributes specialist letters and event summaries, and has integrated secure messaging into its standard workflow for all outgoing clinical correspondence

COMMON PITFALLS

- Registered for My Health Record but no staff member knows how to use it, and the integration with the PMS has never been configured
- Secure messaging installed but not used - all correspondence still sent by fax, negating the security benefit

7.6.13 The practice has considered and documented its obligations under the Notifiable Data Breaches scheme

ESTABLISHED EVIDENCE

- The practice has documented its obligations under Part IIIC of the Privacy Act 1988 (the Notifiable Data Breaches scheme), including what constitutes an eligible data breach, the assessment timeframe (30 days), and notification requirements
- The practice's data breach response plan references the OAIC's published guidance
- Staff are aware that a suspected breach must be reported internally so that the assessment process can begin
- The assessment and notification process is included in the cybersecurity incident response procedure

MINIMUM FOR DEVELOPING

- The practice is aware that data breach notification requirements exist but has not documented its obligations or established an internal reporting process

EXCELLING

- The practice has completed a privacy impact assessment identifying its highest-risk data holdings and the breach scenarios most likely to trigger notification, and has tested its breach response procedure

COMMON PITFALLS

- Assuming the Notifiable Data Breaches scheme only applies to cyberattacks - sending a referral letter to the wrong address or emailing a patient list to the wrong recipient can also trigger notification obligations
- Not starting the 30-day assessment clock because the practice is "still looking into it" - the clock starts when the practice becomes aware of reasonable grounds to suspect a breach

7.7 — Clinical and Administrative System Reliability

We manage system disruptions in a way that maintains continuity and patient safety.

7.7.1 A documented data backup procedure exists and is tested at defined intervals

ESTABLISHED EVIDENCE

- A written backup procedure specifying what is backed up (clinical data, financial records, documents, system configurations), how often (at least daily for clinical data), the backup method (local, cloud, or both), and who is responsible
- Backup completion is verified (not just assumed) - automated backup reports are reviewed
- Backup restoration is tested at defined intervals (at least annually) to confirm that data can actually be recovered
- A record of backup tests and their outcomes is maintained

MINIMUM FOR DEVELOPING

- Backups run automatically but no one verifies whether they complete successfully, and restoration has never been tested

EXCELLING

- Backup and restoration testing includes a full recovery drill (restoring the entire system to a test environment) at least annually, with documented results and any issues addressed

COMMON PITFALLS

- The backup has been "running" for years but nobody has checked the logs - when restoration is attempted, the backups are incomplete or corrupted
- Backups verified but restoration never tested - the practice discovers the backup is useless only when it is needed

7.7.2 Backups are stored in a location separate from primary systems (including at least one offsite or cloud-based copy)

ESTABLISHED EVIDENCE

- At least one backup copy is stored offsite (physically or via cloud storage) so that a local disaster (fire, flood, theft) does not destroy both the primary data and the backup
- The offsite backup is encrypted in transit and at rest
- The offsite location or cloud provider meets the practice's requirements for data sovereignty (data stored in Australia)
- Backup frequency to the offsite location is documented

MINIMUM FOR DEVELOPING

- Backups exist but are stored on a device in the same room as the server (e.g., an external hard drive on the server rack)

EXCELLING

- The practice uses the 3-2-1 backup strategy (three copies of data, on two different media types, with one copy offsite) and has verified that the offsite backup can be restored independently of the primary systems

COMMON PITFALLS

- Backup to an external hard drive that sits on top of the server - if the server room floods or the building burns, both are lost
- Cloud backups assumed to be secure, but the cloud account has no MFA and uses a shared password

7.7.3 The practice has a documented downtime procedure for when the practice management system is unavailable

ESTABLISHED EVIDENCE

- A written downtime procedure that covers: how to access the day's appointment list (printed or alternative system), how to record clinical notes during the outage (paper templates), how to process payments, how to contact the IT support provider, and how to communicate with patients about delays
- Paper-based templates for clinical notes, prescriptions, and pathology requests are available and stored in an accessible location
- The procedure includes criteria for when to cancel or redirect patients versus continuing with reduced capability

MINIMUM FOR DEVELOPING

- Staff have an informal understanding of what they would do ("we'd use paper") but there is no written procedure and no paper templates are pre-prepared

EXCELLING

- The downtime procedure has been tested (e.g., a simulated outage during a low-volume period) and refined based on what was learned, and all staff have participated in the test

COMMON PITFALLS

- No printed appointment list available - the practice cannot identify which patients are expected that day
- The downtime procedure is stored on the server that is unavailable - it needs to be printed and stored in a known physical location

7.7.4 Staff are aware of the downtime procedure and know where to find it

ESTABLISHED EVIDENCE

- All clinical and administrative staff have been briefed on the downtime procedure and know the location of the printed copy
- The procedure is included in staff induction
- A brief refresher or reminder is provided at least annually (e.g., at a staff meeting)

MINIMUM FOR DEVELOPING

- The downtime procedure exists but only one or two staff members know about it or where it is located

EXCELLING

- The practice conducts an annual downtime drill or walkthrough so that all staff, including new team members, are confident in the procedure

COMMON PITFALLS

- The practice manager wrote the procedure and it is in their desk drawer - nobody else knows it exists
- Staff trained once at induction but never reminded - when a downtime event occurs two years later, no one remembers the procedure

7.7.5 Clinical notes can be accessed (in read-only mode at minimum) during a system outage

ESTABLISHED EVIDENCE

- A mechanism exists to access critical clinical information during an outage - e.g., a recent backup accessible on a separate device, a cloud-based system with independent access, or printed summaries for patients with complex needs or scheduled procedures that day
- The mechanism does not rely on the same infrastructure as the primary system (e.g., if the server is down, access must be via a different pathway)
- The access method has been tested and is known to work

MINIMUM FOR DEVELOPING

- The practice acknowledges the risk but has no mechanism for accessing clinical notes during an outage - it relies on clinician memory and patient-reported history

EXCELLING

- The practice maintains a near-real-time replicated copy of clinical data accessible from an independent system, or has a cloud-based PMS with a guaranteed uptime SLA and failover capability

COMMON PITFALLS

- Assuming that "the cloud PMS never goes down" - every system can experience an outage, and the practice needs a plan for when it does
- The backup is accessible but nobody knows how to open or navigate it without the primary system's interface

7.7.6 The practice has a documented process for restoring normal operations and reconciling data following a downtime event

ESTABLISHED EVIDENCE

- A written procedure for post-downtime recovery that includes: restoring systems, entering any clinical notes or data recorded on paper during the outage, reconciling appointments and billing, verifying data integrity, and communicating with staff that normal operations have resumed
- The procedure assigns responsibility for data reconciliation and sets a timeframe for completion
- A post-incident review is conducted after each significant downtime event to identify what worked, what did not, and what should be improved

MINIMUM FOR DEVELOPING

- Normal operations resume after an outage but paper records from the downtime period are not reconciled - they sit in a pile and some are never entered

EXCELLING

- Post-downtime reconciliation is completed within a defined timeframe (e.g., 24 hours for clinical notes, 48 hours for billing), and every downtime event triggers a documented debrief

COMMON PITFALLS

- Paper notes written during the outage are lost, illegible, or incomplete and cannot be reconciled with the electronic record
- No post-incident review - the same issue recurs because the root cause was never investigated

7.7.7 Hardware failures and system outages are logged and reviewed for patterns

ESTABLISHED EVIDENCE

- A log of all hardware failures and system outages, recording the date, time, duration, affected systems, cause (if identified), impact on operations, and resolution
- The log is reviewed periodically (at least quarterly) to identify recurring issues or trends
- Review findings inform equipment replacement or IT infrastructure upgrade decisions

MINIMUM FOR DEVELOPING

- Major outages are remembered but not formally recorded - there is no log and no systematic review

EXCELLING

- Outage data is used to calculate system availability metrics, and the practice has set a target for maximum acceptable downtime per quarter, with action taken when the target is exceeded

COMMON PITFALLS

- Repeated short outages (e.g., 15-minute freezes) not logged because they are individually minor - but collectively they indicate a hardware failure approaching
- Outages logged but never reviewed - the log is a compliance exercise rather than a management tool

7.7.8 The practice has identified its IT support provider and has a current support contract or arrangement in place

ESTABLISHED EVIDENCE

- A current contract or service agreement with an IT support provider, specifying response times, scope of support, and contact details
- The IT provider is familiar with healthcare-specific requirements (data security, clinical system support, ADHA compliance)
- Contact details for the IT provider are accessible during and outside business hours
- The practice has a clear escalation path if the IT provider does not respond within the agreed timeframe

MINIMUM FOR DEVELOPING

- The practice uses an IT provider on an ad hoc basis but there is no formal agreement, response time commitment, or documented contact details

EXCELLING

- The IT support contract includes proactive monitoring (not just break-fix), the provider conducts regular health checks of practice systems, and the practice reviews the provider's performance annually

COMMON PITFALLS

- No IT support arrangement at all - the practice relies on "the partner's son who is good with computers"
- IT support contract with a residential provider who has no healthcare experience and no understanding of clinical system requirements or privacy obligations

7.8 — Business Continuity Planning

We have plans to maintain safe operations and protect patient welfare when normal operations are disrupted.

7.8.1 A documented business continuity plan (BCP) exists for the practice

ESTABLISHED EVIDENCE

- A written business continuity plan that is specific to the practice (not a generic template with the practice name inserted)
- The BCP covers the practice's key functions: clinical operations, patient communication, staff management, IT systems, and premises access
- The plan has a version date, an owner (named person responsible for maintaining it), and a review schedule

MINIMUM FOR DEVELOPING

- The practice has thought about business continuity informally but nothing is documented

EXCELLING

- The BCP is integrated with the practice's risk register and is treated as a living document, updated after every significant event or change to the practice

COMMON PITFALLS

- A generic BCP template downloaded from the internet with placeholder text still visible - it has never been customised to the practice's actual circumstances
- The BCP exists but is filed away and nobody apart from the person who wrote it knows where it is

7.8.2 The BCP identifies credible disruption scenarios relevant to the practice (e.g. extended power outage, premises unavailability, key staff absence, major system failure, natural disaster)

ESTABLISHED EVIDENCE

- The BCP includes a risk assessment identifying the disruption scenarios most likely to affect the practice, based on its location, infrastructure, staffing model, and service type
- Scenarios cover a range of disruptions: infrastructure (power, water, internet), premises (flood, fire, building damage), personnel (key staff incapacitation), technology (PMS failure, ransomware), and external events (pandemic, natural disaster)
- Each scenario includes an assessment of likelihood and impact

MINIMUM FOR DEVELOPING

- The BCP lists some scenarios but the selection is not based on a risk assessment of the practice's specific circumstances

EXCELLING

- The scenario list is reviewed annually and updated based on emerging risks (e.g., increasing frequency of extreme weather events, new cybersecurity threat landscape)

COMMON PITFALLS

- The BCP addresses "natural disaster" generically without considering the specific risks for the practice's location (e.g., flood zone, bushfire-prone area, cyclone region)
- Key staff absence not addressed - the plan assumes the principal clinician and practice manager are always available

7.8.3 The BCP assigns clear roles and responsibilities for each scenario

ESTABLISHED EVIDENCE

- Each scenario in the BCP has a named person responsible for activating the response, and a deputy if that person is unavailable
- Roles include decision-making authority (who decides to close the practice, cancel patients, or relocate), communication (who contacts patients, staff, and external parties), and operations (who manages IT recovery, premises access, or temporary arrangements)
- Responsibilities are understood by the people assigned to them - not just written in the document

MINIMUM FOR DEVELOPING

- The BCP exists but roles are vague (e.g., "the practice manager will manage the situation") without specifying what that means in each scenario

EXCELLING

- Role assignments include alternates and succession planning, and staff have confirmed their understanding of their responsibilities in a documented briefing or drill

COMMON PITFALLS

- All responsibilities assigned to the practice manager - if the practice manager is the one who is unavailable, the plan fails
- Roles assigned on paper but the named individuals have never been told they have those responsibilities

7.8.4 The BCP includes procedures for contacting and managing patients affected by a disruption

ESTABLISHED EVIDENCE

- The BCP includes a patient communication procedure: how patients with upcoming appointments will be contacted (phone, SMS, email), who is responsible for making those calls, what message they will receive, and how urgent clinical needs will be triaged and redirected
- The procedure addresses patients with time-critical needs (e.g., patients on treatment protocols, post-operative patients, patients awaiting urgent results)
- An alternative communication method is identified in case the primary system (e.g., PMS, email) is unavailable

MINIMUM FOR DEVELOPING

- Staff would contact patients if the practice closed unexpectedly, but there is no documented procedure and no pre-prepared communication templates

EXCELLING

- The practice maintains the ability to send bulk SMS or email communications independently of the PMS (e.g., via a separate communication platform), and has pre-prepared templates for common disruption scenarios

COMMON PITFALLS

- Patient contact details only accessible via the PMS - if the PMS is down, the practice cannot contact anyone
- No process for triaging patients with urgent needs - all patients are simply told "we are closed today, we will call you to reschedule"

7.8.5 The BCP includes procedures for maintaining access to patient records during a disruption

ESTABLISHED EVIDENCE

- The BCP addresses how patient records will be accessed if the primary system is unavailable - this may include offsite backup access, cloud-based failover, or printed summaries for patients with complex needs
- The procedure is consistent with the practice's backup and downtime procedures (7.7.1–7.7.6) and links to those documents
- Access to records during a disruption maintains privacy and security requirements - e.g., printed records are secured, temporary access does not bypass normal access controls

MINIMUM FOR DEVELOPING

- The BCP mentions record access but defers to "IT will sort it out" without specifying what the actual fallback mechanism is

EXCELLING

- The practice has tested access to patient records under disruption conditions (e.g., accessing the offsite backup or cloud failover) and confirmed that clinically useful information can be retrieved within a defined timeframe

COMMON PITFALLS

- Assuming that the IT provider will restore access quickly - without a tested procedure, restoration can take days
- No consideration of privacy during a disruption - patient records accessed from an insecure location or printed and left unsecured

7.8.6 The BCP is reviewed at least annually and following any significant disruption event

ESTABLISHED EVIDENCE

- The BCP has a documented review date and the most recent review occurred within the past 12 months
- Reviews are documented, noting what was assessed, what changes were made, and who conducted the review
- The BCP is also reviewed and updated following any actual disruption event, incorporating lessons learned

MINIMUM FOR DEVELOPING

- The BCP was written at some point but has not been reviewed since, and its content may no longer reflect the practice's current circumstances

EXCELLING

- BCP review is a standing item on the practice's annual governance calendar, and post-disruption reviews include input from all staff who were involved in the response

COMMON PITFALLS

- The BCP was written three years ago and still references a phone number for a staff member who left two years ago
- A disruption event occurred but the BCP was not updated afterwards - the same gaps will exist next time

7.8.7 The practice has tested at least one element of the BCP (e.g. data restoration, downtime procedure) in the past 12 months

ESTABLISHED EVIDENCE

- A documented record of a BCP test or drill conducted within the past 12 months
- The test covered at least one practical element (e.g., restoring data from backup, running the downtime procedure, contacting patients using the alternative communication method)
- Findings from the test are documented, including what worked, what did not, and what changes were made to the BCP as a result

MINIMUM FOR DEVELOPING

- No formal testing has been conducted, but the practice intends to and has identified which element to test first

EXCELLING

- The practice tests different elements of the BCP on a rotating basis so that all key components are tested over a defined cycle (e.g., three years), and tests include realistic scenarios with staff participation

COMMON PITFALLS

- Testing limited to "we checked that the backup runs" - this does not test restoration, usability, or the broader response procedure
- A test was conducted but findings were not documented or acted upon

7.8.8 Contact details for essential services (IT support, utilities, building manager, clinical waste contractor, locum agencies) are documented and accessible without relying on systems that may be affected by the disruption

ESTABLISHED EVIDENCE

- A printed contact list including: IT support provider, electricity and water utilities, building manager or landlord, clinical waste contractor, locum agencies, key suppliers, insurance broker, OAIC, relevant professional colleges, and emergency services contacts specific to the building
- The list is stored in a physical location known to all staff (e.g., laminated and posted in the staff room, stored in the emergency kit)
- A copy is held by the practice manager and principal clinician outside the practice (e.g., on a personal device or at home)
- The list is reviewed and updated at least every six months

MINIMUM FOR DEVELOPING

- Key contact details exist in various places (emails, phone contacts, contracts) but there is no consolidated list, and it is not accessible if the practice's systems are down

EXCELLING

- The contact list is maintained in multiple formats (printed, stored securely on a personal device, and in a cloud-accessible location independent of the practice network) and is tested periodically to confirm numbers are still correct

COMMON PITFALLS

- All contact details stored in the PMS or on the office server - if those systems are down, the contacts are inaccessible
- The contact list includes the main switchboard number for the IT provider but not the direct line or after-hours support number

7.8.9 The practice has considered its obligations to patients with ongoing clinical needs in the event of an extended closure

ESTABLISHED EVIDENCE

- The BCP addresses the practice's duty of care to patients with ongoing treatment needs (e.g., patients on immunosuppressive therapy, post-surgical patients requiring follow-up, patients awaiting urgent results, patients mid-investigation pathway)
- The plan identifies how these patients would be triaged, communicated with, and transferred to alternative care if necessary
- Arrangements with neighbouring practices, hospital outpatient departments, or the relevant specialist college for patient transfer or coverage have been considered (even if not formalised)

MINIMUM FOR DEVELOPING

- The practice acknowledges the obligation but has not documented how patients with ongoing needs would be managed during an extended closure

EXCELLING

- The practice has discussed reciprocal coverage arrangements with one or more colleague practices, and the process for transferring care (including medical record access) is documented

COMMON PITFALLS

- The plan addresses short-term disruptions (a day or two) but not an extended closure (weeks or months) - the clinical risk to patients on active treatment is significant
- No consideration of patients awaiting time-sensitive results (e.g., biopsy results) - these patients may not know who to contact if the practice is unreachable

7.8.10 Critical physical infrastructure (power, heating/cooling, water) is assessed for risk and mitigation options are documented

ESTABLISHED EVIDENCE

- The BCP includes an assessment of the practice's dependence on critical infrastructure: mains power (including impact on clinical equipment, cold chain, IT systems), heating and cooling (patient and staff comfort, medication storage), and water supply (hand hygiene, reprocessing)
- Mitigation options are documented: e.g., uninterruptible power supply (UPS) for IT equipment, backup generator assessment, alternative water supply for hand hygiene, temperature management for medication storage during power outage
- The assessment considers the building's infrastructure as well as the practice's - e.g., whether the building has a backup generator, how long the UPS will sustain operations

MINIMUM FOR DEVELOPING

- The practice is aware that power and water outages would disrupt operations but has not documented the specific impacts or mitigation options

EXCELLING

- The practice has invested in mitigation measures (e.g., UPS for servers and critical equipment, portable cooling for medication fridge during power outage) and has tested them to confirm they work as expected

COMMON PITFALLS

- A UPS installed for the server but it provides only 10 minutes of runtime - enough to save data but not to continue clinical operations; this limitation is not documented or communicated
- No assessment of what happens to temperature-sensitive medications during a prolonged power outage - vaccines and biologics may be lost without a mitigation plan

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