

Evidence Guide

Domain 4: Patient Experience and Engagement

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.

4.1 – Access and Responsiveness

Patients can contact our practice, book appointments, and access our services without unnecessary barriers.

- 4.1.1** The practice is contactable by phone during advertised business hours. Calls are answered or returned within a reasonable timeframe. If the practice uses a phone queue, voicemail, or callback system, patients are informed of expected response times.

ESTABLISHED EVIDENCE

- Phone system records or reports showing call answer rates during advertised business hours
- Where voicemail or callback systems are used, documented expected response times and evidence these are communicated to callers (e.g., recorded voicemail message script, hold message content)
- Patient feedback data that includes questions on phone accessibility, with results reviewed
- Staff roster or phone coverage plan that shows how calls are covered during lunch breaks, staff leave, and high-volume periods

MINIMUM FOR DEVELOPING

- The practice answers calls during business hours but has no data on call volumes, abandoned calls, or callback times
- Voicemail exists but the recorded message does not tell the caller when to expect a response

EXCELLING

- The practice tracks missed call rates and average callback times, and has set an internal benchmark (e.g., all voicemails returned within four business hours) that is reviewed quarterly
- Phone access data is included in practice performance reporting and discussed at team meetings

COMMON PITFALLS

- Phones ring out during lunch or after the receptionist leaves for the day, with no voicemail or recorded message directing patients to an alternative
- The practice assumes phones are being answered because no one has complained - but patients who cannot get through simply call another specialist

- 4.1.2** The practice offers appointment booking methods appropriate to its patient population. This may include phone, online, or patient portal booking. Whatever the method, the process is clear and does not require patients to navigate unreasonable complexity.

ESTABLISHED EVIDENCE

- Documentation of all available booking channels (phone, online portal, patient app, fax referral) and how each works
- Website or patient-facing materials clearly describe how to book an appointment
- If online booking is offered, it is tested periodically to confirm it works correctly and that appointment types, availability, and instructions are accurate
- The booking process does not require patients to complete unreasonable steps (e.g., faxing a form, calling only during a two-hour window)

MINIMUM FOR DEVELOPING

- Appointments can be booked by phone during business hours, but the practice has not reviewed whether additional channels would better serve its patient population
- The booking process works but is not documented or described on the website

EXCELLING

- The practice reviews its booking channels against patient demographics and feedback, and has made at least one change to improve accessibility (e.g., added online booking, extended phone hours, enabled SMS-based booking confirmation)

COMMON PITFALLS

- Online booking is offered but is broken, outdated, or shows no available appointments - giving patients the impression the practice is closed to new referrals
- The only way to book is by phone during hours that overlap with the patient's own working hours, creating a barrier for employed patients

- 4.1.3** The practice communicates realistic wait times to patients and referring practitioners at the time of booking. If wait times change significantly after booking, the patient is informed.

ESTABLISHED EVIDENCE

- Evidence that current wait times are communicated at the time of booking - in the referral acknowledgement letter, on the website, or verbally by reception staff
- Where wait times change significantly after booking, evidence that affected patients are contacted (e.g., template letter or SMS notifying patients of revised wait times)
- Referrer communication that includes expected wait time or appointment timeframe
- Wait time information on the practice website is reviewed and updated at least quarterly

MINIMUM FOR DEVELOPING

- Reception staff can tell patients the approximate wait when asked, but wait times are not proactively communicated in writing or on the website

EXCELLING

- The practice publishes current wait times on its website and in referral acknowledgement letters, and has a defined trigger (e.g., wait time increases by more than two weeks) that prompts patient notification
- Wait time trends are tracked and reported internally as a key practice metric

COMMON PITFALLS

- The website states "appointments available within two weeks" but the actual wait is three months - no one has updated the page since the practice opened
- Referrers are told one wait time but patients experience a significantly longer one, damaging the referral relationship

- 4.1.4** The practice has a process for accommodating urgent or semi-urgent appointments within clinically appropriate timeframes, separate from its routine waitlist.

ESTABLISHED EVIDENCE

- A documented process for triaging urgent and semi-urgent referrals, including who makes the triage decision (clinician or trained staff member) and the criteria used
- Evidence that the practice holds capacity for urgent cases - dedicated urgent slots, an overbook protocol, or a policy for fitting urgent patients into existing clinics
- Communication to referrers about how to flag a referral as urgent and what response time to expect

MINIMUM FOR DEVELOPING

- The specialist personally reviews urgent referrals on an ad-hoc basis but there is no written process, and reception staff are unsure how to handle an urgent referral when the specialist is unavailable

EXCELLING

- The practice has defined response time targets for urgent referrals (e.g., seen within 48 hours for category 1, within two weeks for category 2), tracks performance against these targets, and reviews the process at least annually

COMMON PITFALLS

- All referrals go into a single queue regardless of urgency - the GP who marks a referral "urgent" has no confidence it will be treated differently
- The triage decision is left entirely to reception staff without clinical oversight or guidelines

- 4.1.5** Appointment reminders are sent to patients in advance. The practice has a process for managing cancellations and rescheduling that minimises the impact on the patient and uses freed capacity efficiently.

ESTABLISHED EVIDENCE

- Appointment reminder system in operation - SMS, email, phone call, or patient portal notification - sent at least 24-48 hours before the appointment
- A documented process for managing cancellations, including how freed slots are reallocated (e.g., short-notice list, waitlist backfill)
- Rescheduling process that minimises patient effort - patients who cancel are offered an alternative appointment at the time of cancellation rather than being told to call back
- Data on DNA (did not attend) rates, reviewed periodically

MINIMUM FOR DEVELOPING

- Reminders are sent but there is no systematic process for filling cancelled slots - freed appointments are simply lost

EXCELLING

- The practice tracks DNA and late cancellation rates by clinician and appointment type, uses this data to identify patterns, and has implemented at least one initiative to reduce DNAs (e.g., double-reminder system, short-notice patient list, deposit for high-DNA appointment types)

COMMON PITFALLS

- Reminders are sent by SMS but the message does not include the date, time, location, or any instruction on how to cancel - patients ignore it because it lacks useful information
- Cancelled appointment slots go unfilled because staff only attempt to backfill at the end of the day rather than in real-time

- 4.1.6** The practice considers barriers to access for specific patient groups, including patients with physical disabilities, patients from culturally and linguistically diverse backgrounds, older patients, and patients in rural or remote areas (where telehealth may be appropriate).

ESTABLISHED EVIDENCE

- Documentation of how the practice addresses physical access for patients with mobility impairments - ground-floor or lift access, accessible parking, accessible toilet, doorway widths sufficient for wheelchairs
- Evidence that telehealth is offered where clinically appropriate, particularly for patients in rural or remote areas or those with mobility limitations
- Consideration of patients from culturally and linguistically diverse backgrounds - interpreter services, translated appointment information, staff awareness of cultural access barriers
- Evidence that older patients or patients with low digital literacy are not excluded by technology-only booking or communication systems

MINIMUM FOR DEVELOPING

- The practice has not formally assessed physical access or considered non-physical access barriers, but has responded to individual patient requests when raised

EXCELLING

- The practice has conducted a formal access audit (or used a checklist) to identify and address barriers across physical, linguistic, digital, and geographic dimensions, with actions documented and reviewed

COMMON PITFALLS

- The practice is on the first floor with no lift and no one has considered this an access issue because "most of our patients are fine with stairs"
- Telehealth is technically available but not offered to patients who would benefit - it is only used when the clinician is away

4.2 — Financial Transparency

Patients know what our services will cost before they commit to treatment.

- 4.2.1** The practice provides clear fee information to patients before or at the time of booking. At a minimum, patients are told the consultation fee, the expected out-of-pocket cost (after Medicare and any private health insurance rebate), and whether the practice bulk-bills any services or patient categories.

ESTABLISHED EVIDENCE

- Written fee schedule or fee information that is provided to patients before or at the time of booking - in the booking confirmation email, on the website, or verbally by reception staff with a follow-up in writing
- Fee information includes the consultation fee, the Medicare rebate amount, and the expected out-of-pocket gap
- Where the practice bulk-bills certain services or patient groups (e.g., pensioners, children, initial consultations), this is clearly stated
- Reception staff are trained on current fees and can communicate them accurately to patients who call

MINIMUM FOR DEVELOPING

- Fees are communicated verbally when patients ask, but are not proactively provided before the appointment and are not available in writing

EXCELLING

- Fee information is published on the practice website with specific gap amounts for common consultation types, is included automatically in booking confirmations, and is reviewed whenever fees change to ensure all patient-facing materials are current

COMMON PITFALLS

- Reception staff say "there may be a gap" without quantifying it - the patient arrives expecting a small gap and is presented with a \$250 out-of-pocket charge at checkout
- Fee information on the website is two years out of date and understates the current gap

- 4.2.2** Fee information is available in at least one accessible format - on the practice website, in the booking confirmation, on a printed fee schedule in reception, or communicated verbally at the time of booking. The information is current and accurate.

ESTABLISHED EVIDENCE

- Fee schedule published in at least one patient-accessible format: practice website, printed schedule at reception, included in booking confirmation, or stated on the referral acknowledgement letter
- The information is current and matches the fees actually charged
- Where fees vary by service type (e.g., initial vs follow-up, standard vs extended consultation), each fee is listed separately

MINIMUM FOR DEVELOPING

- A printed fee schedule exists somewhere in the practice but is not prominently displayed or proactively given to patients

EXCELLING

- Fee information is available in multiple formats (website, printed, and verbal at booking) and is reviewed each time fees are updated, with a sign-off or version date on the document

COMMON PITFALLS

- The practice has a fee schedule on the website but it only lists item numbers and MBS fees without translating them into what the patient will actually pay
- The printed fee schedule in reception is in a drawer rather than on display, and staff do not offer it unless asked

- 4.2.3** For procedures, investigations, or treatments that involve additional costs (facility fees, anaesthetist fees, implant costs, pathology, imaging), the practice provides an estimate of total expected out-of-pocket costs before the patient consents to proceed. This estimate is documented.

ESTABLISHED EVIDENCE

- A written cost estimate template used for procedures, investigations, or treatments that involve additional costs beyond the consultation fee
- The estimate includes all anticipated components - surgeon fee, anaesthetist fee, facility/hospital fee, implant or prosthesis costs, pathology, imaging, and any other charges the patient may receive
- Evidence that estimates are provided to patients before they consent to proceed, with a copy retained in the patient record
- The estimate clearly states that it is an estimate and explains what may cause the final cost to differ

MINIMUM FOR DEVELOPING

- The specialist discusses costs verbally before a procedure but no written estimate is provided, and the conversation is not documented in the record

EXCELLING

- The practice uses a standardised informed financial consent form for all procedures above a defined cost threshold, provides a copy to the patient, retains a signed copy, and audits the accuracy of estimates against actual costs periodically

COMMON PITFALLS

- The surgeon provides their own fee estimate but no one tells the patient about the anaesthetist, facility, or implant costs - the patient receives multiple unexpected bills after the procedure
- Estimates are provided verbally in the consultation room but by the time the patient reaches reception, they cannot recall the figures

- 4.2.4** Where a patient's treatment plan changes during a consultation and additional costs will be incurred, the patient is informed and given the opportunity to agree before proceeding.

ESTABLISHED EVIDENCE

- A documented process or staff expectation that when a treatment plan changes during a consultation (e.g., additional investigation ordered, procedure scope expanded), the patient is told about any cost implications before proceeding
- Evidence in clinical records that cost discussions occurred when treatment plans changed - even a brief note such as "discussed additional cost of MRI, patient agreed to proceed"
- Patient consent forms or treatment plans that include a cost acknowledgement section

MINIMUM FOR DEVELOPING

- Clinicians are generally aware they should mention costs but there is no consistent practice, and cost discussions during consultations are rarely documented

EXCELLING

- The practice has a standard expectation that any change to the treatment plan that incurs additional out-of-pocket cost is discussed and documented, and this is audited as part of clinical record reviews

COMMON PITFALLS

- The specialist orders additional tests or extends a procedure without mentioning the cost impact - the patient discovers the additional charge only when they receive the bill
- The clinician assumes reception will explain the cost, and reception assumes the clinician already has

- 4.2.5** The practice complies with the Medical Board of Australia's guidance on informed financial consent and any relevant AMA or college position statements on fee transparency.

ESTABLISHED EVIDENCE

- The practice can demonstrate awareness of and compliance with Medical Board of Australia guidance on informed financial consent
- Relevant AMA or specialist college position statements on fee transparency have been reviewed and are reflected in practice policy
- Staff involved in communicating fees and collecting payments are trained on the practice's obligations around informed financial consent
- The practice's informed financial consent process has been reviewed in the last two years

MINIMUM FOR DEVELOPING

- The practice provides fee information but has not formally reviewed its obligations under Medical Board or AMA guidance on informed financial consent

EXCELLING

- The practice has a written informed financial consent policy that references the relevant Medical Board and college guidance, is reviewed annually, and is included in staff onboarding

COMMON PITFALLS

- The practice relies on a generic consent form that does not include financial information, assuming that "consent" refers only to clinical consent
- Staff are unaware that the Medical Board has specific guidance on this topic and believe informed financial consent is optional

- 4.2.6** The practice has a clear policy on payment terms, overdue accounts, and any fees charged for missed appointments or late cancellations. These are communicated to patients before they apply.

ESTABLISHED EVIDENCE

- A written policy covering payment terms (when payment is due, accepted payment methods), overdue account management (follow-up process, debt recovery), and any fees for missed appointments or late cancellations
- This policy is communicated to patients before it applies - on the website, in the new patient registration pack, or verbally at booking with written confirmation
- The cancellation fee policy states the notice period required, the fee amount, and any exceptions (e.g., medical emergencies)
- Staff consistently apply the policy rather than enforcing it selectively

MINIMUM FOR DEVELOPING

- Payment is expected on the day but terms are not written down, and the cancellation fee is mentioned verbally only after a patient has missed an appointment

EXCELLING

- The payment and cancellation policy is published on the website, included in booking confirmations, acknowledged by the patient in the registration form, and reviewed annually for fairness and compliance

COMMON PITFALLS

- A cancellation fee is charged without prior notice - the patient was never told the policy existed, creating complaints and reputational damage
- The policy exists but is enforced inconsistently - some patients are charged and others are not, depending on which receptionist is on duty

4.3 – Respectful and Person-Centred Care

We treat every patient as an individual and provide care that respects their values, preferences, and circumstances.

- 4.3.1** Patients are greeted respectfully and addressed by their preferred name. The practice has a process for recording and using preferred names, titles, and pronouns.

ESTABLISHED EVIDENCE

- The practice management system has fields for preferred name, title, and pronouns, and these are populated during patient registration
- New patient intake forms include a question about preferred name and preferred form of address
- Staff consistently use the preferred name and title when greeting and calling patients - not just in the clinical record
- Evidence that the process is communicated to all staff, including reception, nursing, and allied health

MINIMUM FOR DEVELOPING

- Patients can request a preferred name but the practice does not proactively ask, and there is no dedicated field in the patient record

EXCELLING

- The practice audits whether preferred names are being used consistently, includes this in staff orientation, and has updated its intake forms and system configuration to support pronouns

COMMON PITFALLS

- The intake form asks for preferred name but the information is not transferred to the appointment screen - reception calls out the patient's legal name in the waiting room
- Staff default to "Mr" or "Mrs" without checking, which can be distressing for transgender or non-binary patients

- 4.3.2** Clinicians explain findings, diagnoses, and treatment options in language the patient can understand. Medical jargon is avoided or explained. Patients are given the opportunity to ask questions and are not made to feel rushed.

ESTABLISHED EVIDENCE

- Patient feedback that specifically addresses communication quality (e.g., survey questions on whether the clinician explained things clearly and gave time for questions)
- Patient information materials (leaflets, post-consultation summaries, consent forms) are written in plain English and have been reviewed for readability
- Evidence that clinicians summarise key points for patients at the end of a consultation, or provide written take-home summaries

MINIMUM FOR DEVELOPING

- Clinicians generally communicate well but the practice has no patient feedback data on communication quality and has not reviewed its written materials for readability

EXCELLING

- The practice uses a post-consultation summary (written or verbal) as standard, has tested its patient materials against a readability standard (e.g., Grade 8 reading level), and includes communication skills in clinician peer review or appraisal

COMMON PITFALLS

- The specialist assumes the patient understood because they nodded - but the patient leaves confused and calls the GP to ask what the specialist said
- Consent forms are written in dense medical-legal language that patients sign without understanding

- 4.3.3** The practice supports shared decision-making. Patients are involved in decisions about their care to the extent they wish to be, and their preferences - including the option to decline treatment - are respected and documented.

ESTABLISHED EVIDENCE

- Evidence in clinical records that treatment options were discussed with the patient, including the option to decline or defer treatment, and that the patient's preference was recorded
- Use of decision aids, written option summaries, or structured consent discussions for significant treatment decisions
- Patient feedback that includes questions on whether they felt involved in decisions about their care
- Clinicians allow adequate consultation time for discussion rather than presenting a single recommended option

MINIMUM FOR DEVELOPING

- Clinicians discuss treatment options verbally but do not routinely document the discussion or the patient's stated preference

EXCELLING

- The practice uses structured decision aids for common treatment decisions (e.g., surgery vs conservative management), documents the decision-making conversation, and has examples of clinical records where patients chose a different option from the clinician's initial recommendation

COMMON PITFALLS

- The consultation is structured as "here is what we are going to do" rather than "here are the options and what matters to you" - patients feel they were told, not consulted
- Shared decision-making is confused with informed consent - they overlap but are not the same thing

- 4.3.4** The practice considers the needs of patients who may require additional support during consultations, including patients with hearing or vision impairment, cognitive impairment, intellectual disability, mental health conditions, or high anxiety levels.

ESTABLISHED EVIDENCE

- A process for identifying patients who may need additional support before they arrive - flags in the booking system, intake form questions, or referral letter review
- Evidence of reasonable adjustments made for patients with hearing impairment (e.g., written instructions, hearing loop), vision impairment (e.g., large print materials, verbal guidance), cognitive impairment (e.g., longer appointments, carer involvement), or high anxiety (e.g., quiet waiting area, pre-visit phone call)
- Staff training or awareness on communicating with patients with disabilities, dementia, or mental health conditions
- Consultation rooms can accommodate a support person or carer

MINIMUM FOR DEVELOPING

- Staff respond to additional needs when they become apparent during the visit, but there is no proactive process for identifying needs before the appointment

EXCELLING

- The practice has a documented register of adjustments it can offer, proactively asks about additional needs at booking, and includes accessibility and additional needs in staff orientation

COMMON PITFALLS

- The practice assumes patients with additional needs will disclose them - many will not, either because they do not want to be a burden or because they do not know adjustments are available
- Standard 15-minute appointment slots are used for patients with cognitive or communication difficulties, leaving no time for the consultation to proceed at an appropriate pace

- 4.3.5** The practice has a process for identifying and responding to patients who may need interpreter services, including Auslan. Interpreter services are offered rather than relying on family members to interpret clinical information.

ESTABLISHED EVIDENCE

- A documented process for identifying patients who need interpreter services - at referral triage, at booking, or on the intake form
- Access to a professional interpreter service (on-site, phone, or video) and evidence of its use - booking records, invoices, or interpreter service account details
- Staff are trained not to rely on family members (including children) to interpret clinical information, and understand why this matters for accuracy and consent
- Information about interpreter availability is communicated to patients who may need it, in their own language where possible

MINIMUM FOR DEVELOPING

- Interpreter services are available but are rarely used because staff default to family members or assume the patient's English is "good enough" for the consultation

EXCELLING

- The practice tracks interpreter use against the proportion of CALD patients in its population, has Auslan interpreter access for Deaf patients, and includes interpreter booking as a standard step in the appointment preparation workflow

COMMON PITFALLS

- A child or teenage family member is used to interpret a cancer diagnosis or a discussion about intimate symptoms - this is inappropriate, inaccurate, and potentially harmful to the family member
- The practice has an interpreter service account but no one knows how to book an interpreter, so it is never used

- 4.3.6** Patients attending sensitive or distressing consultations (e.g., diagnosis of a serious condition, discussion of prognosis, examination of intimate body areas) are treated with particular care. The clinician checks the patient's emotional state, offers a support person where appropriate, and considers whether the patient is safe to leave the practice.

ESTABLISHED EVIDENCE

- Clinicians have a process for checking a patient's emotional state before delivering significant news (e.g., asking who is with them, whether they have driven themselves, whether they would like a support person present)
- For examinations of intimate body areas, a chaperone is offered (cross-reference with 4.5.4), the patient's comfort is checked during the examination, and the clinician explains each step
- Evidence that clinicians check whether a patient is safe to leave after a distressing consultation - do they have transport home, do they have someone to call, are they at risk of self-harm
- Follow-up is arranged before the patient leaves, rather than asking a distressed patient to call and book their own follow-up

MINIMUM FOR DEVELOPING

- Clinicians are generally sensitive but there is no standard process - it depends on the individual clinician's judgement and style

EXCELLING

- The practice has a protocol for delivering significant diagnoses or bad news (e.g., based on the SPIKES framework or similar), includes it in clinician onboarding, and reception staff are trained to recognise and respond to visibly distressed patients leaving the consulting room

COMMON PITFALLS

- A patient receives a cancer diagnosis and is then sent to reception to make a follow-up appointment and pay the bill - no one checks whether they are okay to drive home
- Intimate examinations are conducted without offering a chaperone, closing the door properly, or explaining what is about to happen

4.4 — Cultural Safety

Our practice is culturally safe for Aboriginal and Torres Strait Islander peoples and for patients from all cultural backgrounds.

- 4.4.1** The practice acknowledges the Traditional Custodians of the land on which it operates. This is displayed in the practice (e.g., an Acknowledgement of Country in reception or on the website) and reflected in the practice's approach to care.

ESTABLISHED EVIDENCE

- A visible Acknowledgement of Country in the practice - in the waiting area, on the website, or in patient-facing materials
- The acknowledgement names the specific Traditional Custodians of the land on which the practice is located (not a generic statement)
- The acknowledgement is reflected in the practice's broader approach, not displayed as a token gesture

MINIMUM FOR DEVELOPING

- The practice has a generic Acknowledgement of Country on the website but it does not name the specific Traditional Custodians and is not displayed in the physical practice

EXCELLING

- The Acknowledgement of Country is visible in the waiting area and on the website, names the correct nation or people, and is accompanied by Aboriginal and Torres Strait Islander artwork, flags, or health resources appropriate to the patient population

COMMON PITFALLS

- The acknowledgement names the wrong Traditional Custodians because it was copied from another organisation's website without checking
- The practice displays an acknowledgement but staff are unable to explain its significance or pronounce the name of the Traditional Custodians correctly

- 4.4.2** Staff have undertaken cultural safety training or awareness education relevant to the patient populations they serve. For practices that see Aboriginal and Torres Strait Islander patients, this includes training specific to the health needs and experiences of First Nations peoples.

ESTABLISHED EVIDENCE

- Training records showing that clinical and non-clinical staff have completed cultural safety or cultural awareness training - certificates, attendance records, or e-learning completion reports
- Training is specific to the populations the practice serves - for practices seeing Aboriginal and Torres Strait Islander patients, this includes First Nations-specific cultural safety training (not generic diversity training)
- Training has been completed within the last three years and is refreshed periodically
- New staff complete cultural safety training as part of their orientation

MINIMUM FOR DEVELOPING

- Some staff have completed training individually (e.g., through CPD) but it has not been provided practice-wide and is not part of orientation

EXCELLING

- All staff have completed cultural safety training within the last two years, the practice has a training schedule for refreshers, and training is delivered by an Aboriginal Community Controlled Health Organisation (ACCHO) or equivalent provider where possible

COMMON PITFALLS

- The practice counts a single one-hour online module completed five years ago as "cultural safety training" - genuine cultural safety is ongoing, not a box to tick
- Training is limited to clinical staff, but reception staff are the first point of contact and most likely to create or prevent a culturally unsafe experience

- 4.4.3** The practice considers cultural factors that may affect the patient experience, including preferences around gender of the treating clinician, the role of family in decision-making, cultural or religious observances that affect scheduling or treatment, and health literacy.

ESTABLISHED EVIDENCE

- Evidence that the practice asks about and records cultural preferences relevant to care - gender preference for treating clinician, role of family in decision-making, dietary or religious observances affecting treatment, cultural practices around health and illness
- Appointment scheduling accommodates cultural or religious observances where known (e.g., avoiding booking appointments during Ramadan fasting hours for patients who fast, being aware of Sorry Business for Aboriginal patients)
- Health literacy is assessed informally and communication is adjusted accordingly - not assumed based on cultural background

MINIMUM FOR DEVELOPING

- Cultural preferences are accommodated when a patient raises them, but the practice does not proactively ask about cultural needs during intake

EXCELLING

- The intake form includes questions about cultural preferences, staff are trained to ask sensitively, and the practice has documented examples of adjustments made for cultural needs

COMMON PITFALLS

- The practice assumes that because it treats "everyone the same," cultural safety is addressed - equal treatment is not the same as equitable treatment
- Cultural factors are only considered for patients who are visibly from a non-Anglo background, missing the needs of patients whose cultural identity is not immediately apparent

- 4.4.4** The practice does not tolerate discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, gender identity, disability, or socioeconomic status. This expectation is communicated to staff and reflected in practice culture.

ESTABLISHED EVIDENCE

- A written anti-discrimination policy or code of conduct that explicitly states the practice does not tolerate discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, gender identity, disability, or socioeconomic status
- The policy is communicated to all staff during onboarding and is accessible (e.g., in the staff handbook or intranet)
- Evidence that the policy is enforced - staff understand how to report discriminatory behaviour from colleagues or patients, and there is a process for responding to reports
- The practice culture visibly reflects the policy - LGBTIQ+ inclusive language on forms, diverse representation in patient materials, welcoming environment for all patients

MINIMUM FOR DEVELOPING

- Staff generally behave respectfully but there is no written anti-discrimination policy and no formal process for reporting or responding to discriminatory behaviour

EXCELLING

- The practice reviews its anti-discrimination policy annually, includes it in staff performance discussions, and has taken visible steps to create an inclusive environment (e.g., gender-neutral intake forms, inclusive imagery, rainbow or safe space signage where appropriate)

COMMON PITFALLS

- The practice has a policy document but no one has read it and it is not reflected in daily practice - forms still only offer "Male" and "Female," and staff make assumptions about patients' partners or family structures
- Discriminatory comments from patients towards staff (or between staff) are tolerated because "that's just how some patients are"

- 4.4.5** Where the practice identifies that it serves a significant population from a specific cultural or linguistic background, it considers whether targeted measures - such as translated materials, bilingual staff, or community engagement - would improve access and outcomes.

ESTABLISHED EVIDENCE

- The practice has identified the main cultural and linguistic groups in its patient population (from demographic data, postcode analysis, or referral patterns)
- Where a significant population is identified, targeted measures are in place - translated patient information sheets, bilingual staff, community engagement activities, or partnerships with multicultural health services
- Evidence that these measures have improved access or experience - patient feedback, appointment uptake, or interpreter use data

MINIMUM FOR DEVELOPING

- The practice knows it serves patients from diverse backgrounds but has not analysed its patient demographic data or implemented any targeted measures

EXCELLING

- The practice reviews its patient demographics annually, has translated its most-used patient information materials into the top two or three languages spoken by its patients, and engages with local multicultural health or community organisations

COMMON PITFALLS

- The practice is located in a highly multicultural area but all patient materials are in English only, and no one has checked whether patients are disengaging from care due to language barriers
- Translated materials exist but are out of date or use overly formal language that does not match how patients actually speak

4.5 — Privacy and Dignity

We protect patient privacy and dignity at every point of contact with our practice.

- 4.5.1** Consulting rooms are designed and managed so that conversations cannot be easily overheard from the waiting area, corridor, or adjacent rooms. Where soundproofing is limited, staff are aware and take reasonable steps to protect confidentiality.

ESTABLISHED EVIDENCE

- A privacy assessment of consulting rooms has been conducted - either formal (acoustic assessment) or practical (staff member stands in the waiting area while a conversation occurs at normal volume in the consulting room and reports whether it is audible)
- Where soundproofing is inadequate, documented mitigation measures are in place - background music in the waiting area, white noise machines, staff speaking at lower volume near shared walls, or scheduling sensitive consultations in better-insulated rooms
- The layout of consulting rooms means patients are not walking past open doors of rooms where other consultations are in progress

MINIMUM FOR DEVELOPING

- Staff are aware that conversations can sometimes be heard but no assessment or mitigation has been undertaken

EXCELLING

- The practice has conducted a formal privacy walkthrough, documented the findings, implemented mitigations, and repeats the assessment when the fitout changes or a new room is added

COMMON PITFALLS

- Thin walls between consulting rooms mean patients can hear the clinician discussing another patient's diagnosis in the next room - staff have become so accustomed to it they no longer notice
- The consulting room door does not close properly or staff leave it ajar during consultations

- 4.5.2** Patient information is not visible to other patients - including on computer screens at reception, on paperwork left in common areas, or on whiteboards or schedules visible from public spaces.

ESTABLISHED EVIDENCE

- Computer screens at reception face away from patient-accessible areas, or privacy screens are fitted
- Patient files, pathology results, and printed documents are not left on the reception desk, in printer trays, or on surfaces visible from the waiting room
- Whiteboards, scheduling boards, or patient lists are not visible from public areas - if used in back-of-house areas, they are behind closed doors
- Staff have been briefed on the importance of not leaving identifiable patient information visible

MINIMUM FOR DEVELOPING

- Screens face away from patients but printed documents are sometimes left in view, and staff have not been formally reminded about information visibility

EXCELLING

- The practice has conducted a "patient line of sight" audit - walking through the practice from the patient's perspective to identify every point where patient information might be visible - and addressed all issues found

COMMON PITFALLS

- The reception screen is angled so that the next patient in line can see the current patient's name, date of birth, and appointment reason on screen
- Day lists or theatre lists are pinned to a noticeboard in a corridor that patients walk through

- 4.5.3** Patients are offered privacy during examinations and procedures. Gowns or drapes are provided where appropriate, and patients are not left undressed longer than necessary. Staff knock before entering rooms where patients may be undressed.

ESTABLISHED EVIDENCE

- Gowns or drapes are available in all consulting rooms where examinations occur, and are offered to patients routinely
- Staff knock and wait before entering any room where a patient may be undressed - this is a stated and observed practice standard
- Patients are given time and privacy to dress and undress - the clinician steps out or a curtain/screen is provided
- Examination areas are not visible from corridors or other rooms when doors are opened

MINIMUM FOR DEVELOPING

- Gowns are available but not routinely offered - patients are sometimes examined in their underwear without being given an alternative

EXCELLING

- The practice has a written standard for examination privacy, includes it in staff and clinician orientation, and audits compliance through patient feedback or observation

COMMON PITFALLS

- Staff enter the room without knocking while the patient is undressed - particularly common in busy procedural practices where staff move quickly between rooms
- The consulting room layout means a partially undressed patient is visible momentarily each time the door opens

- 4.5.4** Chaperones are offered for examinations of intimate body areas, consistent with Medical Board of Australia guidance. The offer and the patient's response are documented in the clinical record.

ESTABLISHED EVIDENCE

- A written chaperone policy consistent with Medical Board of Australia guidance, specifying when a chaperone is offered (at minimum, for examinations of intimate body areas)
- The offer of a chaperone and the patient's response (accepted or declined) are documented in the clinical record for every relevant examination
- Chaperones are trained staff members - not family members or other patients - and understand their role
- The chaperone policy is communicated to patients (e.g., displayed in consulting rooms or included in patient information)

MINIMUM FOR DEVELOPING

- Chaperones are available if a patient requests one, but the offer is not routinely made by the clinician and not documented in the record

EXCELLING

- Chaperone offers are documented consistently, the practice audits documentation compliance, and reception staff are prepared to arrange a chaperone when scheduling appointments for examinations that typically require one

COMMON PITFALLS

- The clinician does not offer a chaperone because "the patient didn't ask" - the Medical Board guidance is that the practitioner should offer, not wait to be asked
- Chaperone offers are made but never documented - if a complaint arises, there is no evidence the offer was made

- 4.5.5** Conversations about clinical or financial matters between reception staff and patients are managed to minimise the risk of being overheard by other patients in the waiting area.

ESTABLISHED EVIDENCE

- The reception area is designed or managed so that conversations about clinical or financial matters are not easily overheard by other patients - a lowered voice, a private window or counter, or the option to step to a separate area
- Staff are trained to recognise when a conversation should be moved to a private space (e.g., discussing test results, explaining a large bill, taking sensitive medical history)
- Signage or layout encourages patients to maintain distance from the reception desk while another patient is being served

MINIMUM FOR DEVELOPING

- Staff are generally discreet but there is no dedicated private area and no formal process for handling sensitive conversations at reception

EXCELLING

- The practice has a dedicated private area near reception for sensitive conversations, staff are trained to use it proactively, and the layout includes a visual cue (e.g., a floor marker or sign) asking patients to wait at a distance

COMMON PITFALLS

- The receptionist reads out the patient's diagnosis or reason for visit at the front desk while other patients are standing within earshot
- Financial conversations about overdue balances or large gap payments are conducted at the main reception counter

- 4.5.6** The practice has a process for managing requests from third parties (employers, insurers, lawyers, family members) for patient information, consistent with the Australian Privacy Principles and the patient's consent.

ESTABLISHED EVIDENCE

- A documented process for handling requests for patient information from third parties - insurers, employers, lawyers, family members, other practitioners
- The process requires verification of the requester's identity and authority, confirmation of the patient's written consent (or a valid legal basis for disclosure without consent), and documentation of what was released and to whom
- Staff understand that family members - including spouses and adult children - do not have automatic access to patient information without the patient's consent
- The process is consistent with the Australian Privacy Principles and any applicable state/territory health records legislation

MINIMUM FOR DEVELOPING

- Requests are handled on a case-by-case basis but there is no written process, and staff are unsure of their obligations under privacy legislation

EXCELLING

- The practice maintains a log of third-party information releases, audits compliance with its own process, and has sought legal or privacy advice on complex requests (e.g., subpoenas, coronial requests)

COMMON PITFALLS

- A family member calls and is given clinical information over the phone without verifying whether the patient has consented to the disclosure
- An insurer sends a broad request for "all records" and the practice releases the entire file without considering whether the scope of the request is proportionate or whether the patient has authorised it

4.6 — Patient Feedback

We actively seek patient feedback and use it to improve.

- 4.6.1** The practice has a method for collecting patient feedback on a regular basis. This may include patient satisfaction surveys, online review monitoring, feedback cards, post-consultation SMS surveys, or a visible suggestion mechanism. The method is proportionate to the size and resources of the practice.

ESTABLISHED EVIDENCE

- A functioning patient feedback mechanism proportionate to the size of the practice - patient satisfaction survey (paper or electronic), post-consultation SMS survey, feedback cards in the waiting room, online feedback form, or active monitoring of review platforms
- Evidence that the mechanism is in active use - completed surveys, response rates, or a summary of feedback received over a defined period
- Patients are made aware that feedback is welcome - signage in the waiting room, a link on the website, or a prompt in the post-consultation communication
- The feedback method captures both positive and negative feedback, not just complaints

MINIMUM FOR DEVELOPING

- The practice has a suggestion box or email address for feedback but receives very little input and has not actively promoted the mechanism to patients

EXCELLING

- The practice uses a structured feedback tool (e.g., a validated patient experience survey), achieves a meaningful response rate, and collects feedback continuously rather than as a one-off exercise

COMMON PITFALLS

- The practice installed a feedback tablet in the waiting room two years ago and no one has checked the results since - the device is now out of battery or disconnected
- Feedback is only collected from patients who are already satisfied (e.g., handed a survey at checkout after a good experience), biasing the results

- 4.6.2** Feedback is reviewed by the practice manager and, where relevant, the clinical governance lead. Both positive and negative feedback are considered.

ESTABLISHED EVIDENCE

- A defined process for who reviews patient feedback, how often, and what happens with the results - the practice manager reviews feedback weekly or monthly, and shares themes with the clinical governance lead or principal clinician
- Both positive and negative feedback are reviewed - positive feedback is shared with the team, negative feedback is assessed for patterns or systemic issues
- Meeting minutes or reports that reference patient feedback themes

MINIMUM FOR DEVELOPING

- The practice manager reads feedback when it comes in but does not compile it, share it with others, or track themes over time

EXCELLING

- Patient feedback is a standing agenda item at practice meetings, data is trended over time to identify patterns, and the review includes a comparison against previous periods

COMMON PITFALLS

- Only complaints are reviewed - positive feedback is ignored, missing an opportunity to reinforce what the practice does well
- Feedback reaches the practice manager but never the clinicians - the clinician whose communication style generates consistent negative feedback is never told

- 4.6.3** The practice responds to negative feedback constructively. Where a specific concern is raised that does not constitute a formal complaint, the practice considers whether a direct response to the patient is appropriate and whether the issue points to a systemic problem.

ESTABLISHED EVIDENCE

- A documented process for responding to negative feedback, including who is responsible, the expected timeframe for response, and how the practice determines whether a direct response to the patient is appropriate
- Examples of responses to negative feedback - acknowledging the concern, explaining what action was taken, or inviting the patient to discuss the matter further
- Where negative feedback reveals a systemic issue, evidence that the issue was investigated and addressed (e.g., a change to a process, additional staff training, or a revision to a policy)

MINIMUM FOR DEVELOPING

- Negative feedback is acknowledged internally but the practice does not respond directly to patients who raise concerns, and no systemic analysis of negative feedback themes has been conducted

EXCELLING

- The practice has a tiered response framework - minor concerns are acknowledged and logged, significant concerns trigger a direct response and investigation, and recurring themes are escalated to a quality improvement action

COMMON PITFALLS

- Negative feedback is treated as a personal attack on the clinician rather than a data point about the patient experience - defensive responses escalate rather than resolve concerns
- The practice responds to the individual complaint but does not step back to ask whether the issue is systemic

- 4.6.4** The practice monitors its online reputation (Google reviews, Healthshare, Whitecoat, or equivalent platforms) and has a process for responding to public reviews in a manner that is professional and does not breach patient confidentiality.

ESTABLISHED EVIDENCE

- The practice regularly monitors its reviews on Google, Healthshare, Whitecoat, or other relevant platforms - at least monthly
- A process exists for responding to public reviews that is professional, does not breach patient confidentiality, and is consistent in tone
- The person responsible for responding to reviews is identified and trained on what can and cannot be said publicly (e.g., never confirming that a reviewer is a patient)
- Both positive and negative reviews are monitored - positive reviews can be acknowledged, negative reviews are responded to constructively

MINIMUM FOR DEVELOPING

- The practice is aware it has online reviews but does not monitor them regularly and has never responded to one

EXCELLING

- The practice tracks its online ratings over time, has a templated but personalised response approach for common review themes, and uses review content as an input into quality improvement (alongside formal feedback mechanisms)

COMMON PITFALLS

- The clinician personally responds to a negative Google review with identifiable clinical details, breaching the patient's confidentiality in a public forum
- The practice has a 2.8-star Google rating and no one has noticed because no one has looked

- 4.6.5** Patient feedback data - including themes and trends - is reviewed periodically (at least annually) and used to inform quality improvement activities. The practice can demonstrate at least one change it has made in response to patient feedback.

ESTABLISHED EVIDENCE

- A periodic review (at least annually) of patient feedback data - including survey results, complaint themes, online review themes, and informal feedback - compiled into a summary or report
- Evidence that at least one quality improvement action has been taken in response to patient feedback, with documentation of the change and its rationale
- The link between feedback and action is explicit - not just "we got feedback" but "we changed X because patients told us Y"
- Feedback trends are compared over time to assess whether changes have had an impact

MINIMUM FOR DEVELOPING

- Feedback is collected but has not been analysed for themes or used to drive any specific change

EXCELLING

- Patient feedback is formally integrated into the practice's quality improvement plan, with feedback-driven actions tracked alongside other QI initiatives, and patients are informed (e.g., via a "you said, we did" display or communication) about changes made in response to their feedback

COMMON PITFALLS

- The practice collects feedback diligently but it sits in a spreadsheet that no one analyses - data without analysis is just noise
- Changes are made in response to feedback but are not documented, so the practice cannot demonstrate the link when asked

4.7 — Waiting Room and Patient Journey

The patient's experience in our practice - from arrival to departure - is considered, comfortable, and respectful of their time.

- 4.7.1** The waiting area is clean, comfortable, and appropriate for the patient population. Seating is adequate for the typical number of patients waiting, and the space considers the needs of patients with mobility aids, wheelchairs, or prams.

ESTABLISHED EVIDENCE

- The waiting area is visibly clean, well-maintained, and comfortable - adequate seating for the typical number of patients waiting, appropriate lighting, and a reasonable temperature
- The space accommodates patients with mobility aids, wheelchairs, and prams - there is sufficient room to manoeuvre, and at least some seating does not have fixed armrests (which prevent transfer from a wheelchair)
- A cleaning schedule is in place for the waiting area, including touch surfaces such as door handles, chairs, and shared reading materials
- The waiting area is appropriate for the patient population - paediatric practices have child-friendly elements, practices seeing elderly patients have firm seating at an appropriate height

MINIMUM FOR DEVELOPING

- The waiting area is clean but has not been assessed for accessibility or comfort from the patient's perspective

EXCELLING

- The practice has sought patient feedback specifically on the waiting area, has made changes in response, and periodically reassesses the space against accessibility and comfort standards

COMMON PITFALLS

- The waiting area has low, soft couches that elderly patients or patients with hip or knee conditions cannot get out of - no one has considered this because the furniture looks good
- The waiting room is cramped during peak times, with patients standing or sitting in the corridor, and this is accepted as normal rather than addressed

- 4.7.2** Patients are informed of expected waiting times on arrival. If delays exceed fifteen minutes beyond the scheduled appointment time, patients are proactively updated and offered the option to reschedule if the delay is significant.

ESTABLISHED EVIDENCE

- A defined process for informing patients when the clinic is running more than fifteen minutes behind schedule - reception staff proactively approach waiting patients, update them on the expected wait, and offer the option to reschedule
- The update includes an estimated additional wait time, not just "the doctor is running behind"
- Evidence that this process is followed - patient feedback on communication about delays, or staff training on the expectation
- Where delays are communicated, the tone is respectful and apologetic rather than dismissive

MINIMUM FOR DEVELOPING

- Staff inform patients of delays when asked, but do not proactively communicate running delays unless a patient complains

EXCELLING

- The practice uses a real-time system to track running times and proactively contacts patients before they arrive if the clinic is significantly behind (e.g., SMS or phone call offering to reschedule or arrive later)

COMMON PITFALLS

- Patients sit in the waiting room for 40 minutes past their appointment time with no communication from staff - they feel ignored and disrespected
- The receptionist says "it shouldn't be too much longer" repeatedly without providing a specific estimate, which erodes trust each time

- 4.7.3** The practice monitors and manages running times. Chronic over-running of appointments is addressed as a practice management issue, not accepted as inevitable. Strategies may include adjusted appointment scheduling, buffer slots, or review of consultation length templates.

ESTABLISHED EVIDENCE

- The practice tracks appointment running times - through the practice management system, a manual log, or periodic audit - and knows which clinicians or clinic sessions consistently run over time
- Strategies are in place to address chronic over-running: adjusted appointment length templates, buffer slots between appointments, limits on the number of complex patients per session, or structured clinic start and end times
- Running time data is discussed at practice meetings or in clinician performance conversations, and over-running is treated as a practice management issue, not an immutable personal style

MINIMUM FOR DEVELOPING

- Staff know which clinicians run late but there is no data, no formal discussion, and no strategies in place to manage it

EXCELLING

- The practice analyses running time data by clinician, clinic type, and day of week, has implemented scheduling changes based on the data, and can demonstrate a measurable improvement in punctuality over time

COMMON PITFALLS

- Running late is accepted as part of specialist practice culture - "he always runs an hour behind, that's just how he is" - and the impact on patients is not acknowledged
- The appointment schedule allocates 15 minutes for every consultation regardless of complexity, guaranteeing that complex new patients will cause a cascade of delays

- 4.7.4** The waiting area provides basic amenities - at a minimum, access to drinking water and toilet facilities. For practices with longer expected waiting times or that see paediatric patients, additional amenities may be appropriate.

ESTABLISHED EVIDENCE

- Drinking water is available in the waiting area - a water cooler, dispenser, or cups and a tap within easy reach
- Toilet facilities are accessible to patients, clearly signposted, clean, and include at least one accessible toilet for patients with disabilities
- For practices with typically longer waiting times (e.g., surgical practices, infusion centres), additional amenities are considered - phone charging, Wi-Fi access, reading materials, or a television
- For practices seeing paediatric patients, age-appropriate entertainment or a play area is provided

MINIMUM FOR DEVELOPING

- Toilets are available but water is not offered in the waiting area, and amenities have not been assessed against the typical wait duration

EXCELLING

- The practice has assessed its amenities against patient expectations and wait times, made improvements based on patient feedback, and ensures all amenities are maintained and functional (e.g., the water cooler is not empty, the Wi-Fi password is displayed)

COMMON PITFALLS

- The water cooler has been empty for weeks and no one has refilled it - small details signal whether the practice respects patients' time and comfort
- The children's play area has broken toys and out-of-date magazines, giving an impression of neglect

- 4.7.5** The practice manages the flow of patients through the practice to avoid unnecessary waiting at check-out, billing, or results collection. The departure process is considered, not just the consultation.

ESTABLISHED EVIDENCE

- The practice has considered the full patient journey from arrival to departure - not just the consultation - and has designed the departure process to be efficient and respectful
- Patients are not left waiting at reception for extended periods after their consultation to pay, collect results, or book follow-up appointments
- The billing and checkout process is clear and efficient - staff know the fee, process payment promptly, and provide receipts and Medicare claim lodgement without unnecessary delay
- Follow-up appointments are booked before the patient leaves (where appropriate), rather than asking the patient to call back

MINIMUM FOR DEVELOPING

- The departure process works but has not been reviewed - patients occasionally wait at reception because staff are busy with phone calls or other patients

EXCELLING

- The practice has mapped the full patient journey (arrival to departure), identified bottlenecks, and implemented changes to improve flow - for example, staggered checkout times, a dedicated checkout staff member during busy clinics, or pre-prepared invoices

COMMON PITFALLS

- The patient finishes a difficult consultation and then has to wait ten minutes at reception to pay a \$350 bill while other patients watch - the departure experience undermines the consultation experience
- Follow-up appointments cannot be booked at checkout because the clinician's diary is not available to reception staff, so patients leave without a booking and are lost to follow-up

- 4.7.6** Patients who are visibly distressed, unwell, or in pain while waiting are identified and attended to by staff. There is a process for prioritising patients in the waiting room whose condition may have changed.

ESTABLISHED EVIDENCE

- Reception or nursing staff are trained to observe patients in the waiting room and identify those who are visibly distressed, unwell, or in pain
- There is a process for responding - offering a private area, alerting the clinician, providing basic first aid, or escalating if the patient's condition appears to have deteriorated
- Staff know how to escalate if a patient in the waiting room becomes acutely unwell - who to call, what to do, and where to take the patient
- Patients who become distressed after a consultation (e.g., crying after receiving a diagnosis) are approached by staff and offered support rather than being left alone in the waiting room

MINIMUM FOR DEVELOPING

- Staff would respond if a patient collapsed or was clearly in distress, but there is no defined process and no training on recognising deterioration or emotional distress

EXCELLING

- The practice includes waiting room observation in reception staff duties, has a documented escalation pathway for deteriorating patients, and has trained reception staff in psychological first aid or basic emotional support for distressed patients

COMMON PITFALLS

- A patient sits in the waiting room in visible pain for 30 minutes and no one checks on them because "they're waiting for the doctor" - reception staff do not see patient welfare as part of their role
- A patient leaves the consulting room in tears after a diagnosis and walks straight past reception and out the door - no one notices or intervenes

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