

Domain 8: Continuous Improvement

We actively seek to improve what we do and can demonstrate progress over time.

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Why This Domain Matters

Quality is not a state that a practice achieves and then holds. It is a discipline - something that has to be actively maintained, regularly tested, and periodically reset against a changing external environment. A practice that completed an excellent self-assessment two years ago and has not revisited it since is not a quality practice. It is a practice that was organised two years ago.

Domain 8 is concerned with the mechanisms that keep quality alive over time: the processes by which a practice identifies what needs to improve, sets goals, takes action, reviews whether the action worked, and starts again. It covers internal audit, data use, peer review, and regulatory currency - and it covers the culture that makes all of those things possible.

This is also the domain that gives the Clinically Quality Framework its longitudinal value. A single self-assessment tells you where you are. A repeated self-assessment, tracked against an improvement plan with documented outcomes, tells a story of progress. That story is what distinguishes a practice that is genuinely committed to quality from one that treats frameworks as compliance exercises.

A practice that scores strongly in Domain 8 is one where improvement is expected, structured, and demonstrable - not because someone external is watching, but because the people who work there believe it matters.

Quality Statements

8.1 – Quality Improvement Planning

We have a structured, documented approach to identifying priorities and tracking improvement.

INDICATORS

- 8.1.1 The practice has a documented quality improvement plan that is reviewed at least annually
- 8.1.2 The improvement plan identifies specific goals, responsible persons, and target timeframes
- 8.1.3 The improvement plan is informed by the outcomes of the practice's self-assessment against this framework
- 8.1.4 Progress against improvement goals is reviewed at defined intervals (at least quarterly)
- 8.1.5 Completed improvement actions are documented and the outcomes recorded
- 8.1.6 Where an improvement action did not achieve its intended outcome, this is reviewed and a revised approach is documented
- 8.1.7 The improvement plan is accessible to relevant staff and is not held solely by a single individual
- 8.1.8 Quality improvement goals are prioritised by patient safety impact, not organisational convenience
- 8.1.9 The practice revisits its full self-assessment against this framework at least once every two years

8.2 – Internal Audit

We regularly review our own processes against defined standards and act on what we find.

INDICATORS

- 8.2.1 The practice conducts at least two internal audits per year
- 8.2.2 Internal audits are planned in advance and cover a mix of clinical and operational topics
- 8.2.3 Internal audit findings are documented and shared with relevant staff
- 8.2.4 Internal audits result in documented actions where gaps are identified
- 8.2.5 Audit topics are selected based on risk, prior incidents, or known areas of variability
- 8.2.6 At least one internal audit per year addresses a clinical process or outcome (not solely administrative topics)
- 8.2.7 Previous audit findings are reviewed in subsequent cycles to assess whether improvements have been sustained
- 8.2.8 The practice has conducted a medication management audit in the past two years (where medications are held or administered)
- 8.2.9 The practice has conducted an infection prevention and control audit in the past two years
- 8.2.10 The practice has conducted a health records audit in the past two years

8.3 – Data Use and Performance Monitoring

We collect, review, and act on data about our practice's performance.

INDICATORS

- 8.3.1 The practice has identified a small set of key performance indicators (KPIs) relevant to its operations
- 8.3.2 KPIs are reviewed at defined intervals by the principal practitioner(s) and practice manager
- 8.3.3 Waiting time data (time from referral to appointment) is monitored and reviewed
- 8.3.4 Did-not-attend (DNA) and cancellation rates are monitored and reviewed
- 8.3.5 Patient feedback data (see Domain 4) is reviewed in the context of quality improvement
- 8.3.6 Incident and near-miss data is reviewed in aggregate at least annually to identify patterns
- 8.3.7 Complaint data is reviewed in aggregate at least annually to identify patterns
- 8.3.8 Where available, clinical outcome data is reviewed by the principal practitioner(s) at least annually
- 8.3.9 Data review findings are connected to the improvement plan where action is indicated
- 8.3.10 The practice does not rely solely on absence of complaints as evidence of quality

8.4 — Learning from Incidents Near Misses and Complaints

We treat things that go wrong as opportunities to improve, not just problems to resolve.

INDICATORS

- 8.4.1 A documented process exists for reviewing incidents and near misses for learning, separate from the initial response process
- 8.4.2 Significant incidents are subject to a structured review (e.g. case discussion, root cause analysis) within a defined timeframe
- 8.4.3 Learning identified from incident reviews is translated into documented changes to policy, process, or training
- 8.4.4 Changes made in response to incidents are communicated to relevant staff
- 8.4.5 Complaints are reviewed for themes and patterns at least annually (see also Domain 1)
- 8.4.6 Learning from complaints is connected to the improvement plan where systemic issues are identified
- 8.4.7 The practice monitors external safety alerts, recalls, and clinical advisories relevant to its specialty and acts on them promptly
- 8.4.8 Near misses are treated with the same learning intent as incidents that caused harm
- 8.4.9 Staff feel safe to report incidents and near misses without fear of blame (see also Domain 6)
- 8.4.10 The practice can demonstrate at least one documented improvement that originated from an incident or complaint in the past two years

8.5 — Peer Review and External Benchmarking

We look outside our own practice to test and calibrate the quality of what we do.

INDICATORS

- 8.5.1 The principal practitioner(s) participate in at least one form of structured peer review, case discussion, or clinical audit activity annually
- 8.5.2 Peer review activity is documented (including the nature of the activity and any learning identified)
- 8.5.3 Where the practice's specialty college or professional association offers clinical audit or benchmarking programs, the practice has considered participation
- 8.5.4 The practice is aware of relevant national or state-based clinical registries in its specialty and has considered participation where applicable
- 8.5.5 Findings from peer review or benchmarking activities are connected to the practice improvement plan where relevant
- 8.5.6 Where the practice participates in clinical training (students, registrars, or fellows), feedback from supervisory bodies is reviewed and acted on

8.6 — Regulatory Currency and Awareness

We stay current with our legal obligations, relevant standards, and evolving clinical guidance.

INDICATORS

- 8.6.1** A named person in the practice is responsible for monitoring changes to regulation, standards, and guidelines relevant to the practice
 - 8.6.2** The practice has a defined process for reviewing and acting on updates to relevant legislation (including the Privacy Act, Work Health and Safety Act, and applicable state health legislation)
 - 8.6.3** The practice monitors updates from AHPRA and relevant specialist college(s) and acts on guidance relevant to its operations
 - 8.6.4** Clinical policies and procedures are reviewed at defined intervals (at least every two years) and updated to reflect current standards
 - 8.6.5** The practice has reviewed its obligations under the Australian Privacy Principles in the past two years
 - 8.6.6** The practice is aware of current mandatory reporting obligations (AHPRA, child protection) and reviews these at staff induction and at least biennially thereafter
 - 8.6.7** The practice monitors safety alerts and product recalls from the TGA and other relevant bodies
 - 8.6.8** Relevant changes to regulation or standards are communicated to affected staff promptly
 - 8.6.9** Policy updates triggered by regulatory change are documented with the reason for the update and the effective date
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8.7 – Improvement Culture

Our leadership actively creates the conditions for improvement to happen.

INDICATORS

- 8.7.1** The principal practitioner(s) visibly champion quality improvement within the practice
 - 8.7.2** Quality improvement is a standing agenda item at practice meetings
 - 8.7.3** Staff at all levels are encouraged to identify improvement opportunities and their suggestions are taken seriously
 - 8.7.4** Staff who identify problems or raise concerns are thanked, not managed
 - 8.7.5** The practice celebrates and communicates improvements that have been achieved
 - 8.7.6** Time and resource are allocated (however modestly) to quality improvement activity - it is not expected to happen in staff members' personal time
 - 8.7.7** New staff are introduced to the practice's quality framework and improvement approach during induction
 - 8.7.8** The practice manager has access to professional development relevant to healthcare quality and governance
 - 8.7.9** The practice does not treat this framework as a compliance exercise - it can articulate at least two specific improvements made as a result of using it
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This document is part of the Specialist Practice Quality Framework (SPQF). Visit spqf.au for the full framework, evidence guides, and self-assessment tools.