[Service Letterhead]

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[Organisation Name]

Quality Improvement

Policy

Document Control

Policy Title	Quality Improvement Policy
Policy Number	P-XXX
Approval Date	DD/MM/YYYY
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Version Number	1.0
Responsible Officer	Chief Executive Officer, Quality & Compliance Lead
Accreditation Mapping Code	RACGP – Quality Improvement; Clinical Indicators; Clinical Risk Management; Practice Data; Patient Feedback; Clinical Governance NSQHS – Standard 1 Clinical Governance; Standard 2 Partnering with Consumers; quality improvement requirements across applicable clinical standards NSQPH – Clinical Governance; Partnering with Consumers; Clinical Safety; Quality Improvement QIC – Governance; Quality Improvement; Risk Management; Consumer and Community Engagement; Service Delivery

1. Purpose

The purpose of this policy is to establish the overarching system through which [Organisation Name] monitors, evaluates and continuously improves the quality, safety, effectiveness, cultural safety, accessibility and performance of its services and organisational systems.

Quality improvement is a core responsibility of the organisation and is integral to governance, clinical governance, strategic and operational planning, risk management and everyday service delivery. It provides a structured means of understanding how the organisation is performing, identifying where practice or systems can be strengthened, implementing improvement and determining whether changes have achieved and sustained the intended outcome.

This policy is intended to ensure that [Organisation Name]:

- maintains an organisation-wide and systematic approach to continuous quality improvement;
- establishes clear annual quality priorities and measurable objectives;
- uses reliable data and evidence to understand organisational and clinical performance;
- routinely audits clinical, operational, governance and administrative systems and practice;
- maintains a documented, risk-based audit program and annual audit schedule;
- identifies gaps, risks, inequities, variation and opportunities for improvement;
- prioritises improvement according to patient, community and organisational need and risk;
- involves Aboriginal and Torres Strait Islander people, patients, families, carers, community and the workforce in improvement;
- uses appropriate improvement methodologies to plan, test, implement and evaluate change;
- monitors clinical outcomes, service performance, patient experience, cultural safety, access and equity;
- compares performance against internal expectations, recognised standards, evidence and external benchmarks where appropriate;
- ensures findings from audits, incidents, complaints, risks, feedback, accreditation and other reviews result in appropriate action;
- verifies that corrective and improvement actions are implemented, effective and sustained;
- ensures overdue, repeated or ineffective actions are escalated according to risk;
- evaluates significant organisational and service changes;
- supports organisational learning, innovation and the sharing of successful improvement;
- provides the Board / Governing Body and leadership with appropriate assurance regarding organisational performance and improvement; and
- meets applicable legislative, regulatory, professional and accreditation requirements.

Quality improvement will be embedded within routine organisational practice and will not be undertaken solely for accreditation, compliance or external assessment purposes.

2. Scope

This policy applies across all areas of [Organisation Name] and to all persons involved in the governance, management, delivery, coordination, monitoring, evaluation or support of services provided by or on behalf of the organisation.

It applies to all clinical and non-clinical functions, programs, services, locations and models of care, including governance and corporate functions, primary healthcare, community programs, outreach, home visiting, telehealth and other services delivered or coordinated by [Organisation Name].

The policy applies to employees, Board / Governing Body members, healthcare practitioners, contractors, visiting practitioners, students, trainees and other persons undertaking work for or on behalf of the organisation.

Quality improvement under this policy includes both clinical and organisational quality and applies to the systems, processes, practices and outcomes that influence patient safety, health outcomes, cultural safety, patient and community experience, access, equity, service quality, organisational performance and compliance.

3. Definitions

Quality Improvement (QI) – A systematic and ongoing approach to identifying opportunities to improve services, systems, processes, outcomes or experiences and implementing, evaluating and sustaining changes intended to achieve better performance.

Continuous Quality Improvement (CQI) – An organisation-wide approach in which improvement is embedded into routine practice through ongoing measurement, review, learning and refinement.

Clinical Audit – A structured review of clinical practice, processes or outcomes against defined evidence-based criteria, standards, guidelines or expected practice to determine performance and identify opportunities for improvement.

Organisational Audit – A systematic examination of organisational, governance, operational, administrative or service systems against defined requirements, expectations, policies or standards.

Quality Indicator – A measurable element of structure, process, outcome or experience used to monitor and evaluate quality or performance.

Quality Objective – A defined and measurable organisational or service-level aim established to improve quality, safety, performance, patient experience, cultural safety, equity or outcomes.

Benchmarking – Comparison of organisational performance with previous organisational performance, targets, recognised standards or comparable external data to identify variation and opportunities for improvement.

PDSA Cycle – A Plan–Do–Study–Act improvement method used to test a change, examine its effect and determine whether it should be adopted, adapted or discontinued.

Corrective Action – Action taken to address an identified deficiency, non-conformance, risk or cause of an actual problem.

Preventive Action – Action intended to reduce the likelihood of an identified risk, deficiency or undesirable event occurring.

Re-Audit – A repeat audit undertaken following improvement or corrective action to determine whether the required change has occurred and is effective.

Unwarranted Variation – Variation in practice or outcomes that cannot be adequately explained by patient needs, preferences, clinical circumstances or other appropriate factors and may indicate an opportunity to improve quality or safety.

Quality Improvement Register – The organisational record used to document, monitor and provide oversight of identified quality improvement activities and their progress, responsibilities, outcomes and status.

Quality Assurance – Activities undertaken to provide confidence that defined quality, safety, performance or compliance requirements are being met.

Thematic Analysis – Review of information from one or more sources to identify recurring themes, patterns, systemic issues or emerging risks.

Assurance – Evidence provided to governance and management that organisational controls, systems and improvement activities are operating as intended and achieving required outcomes.

4. Policy Statement

[Organisation Name] is committed to maintaining a culture in which quality, safety, cultural safety, learning and improvement are the responsibility of the whole organisation.

The organisation will maintain an integrated quality improvement system that enables the Board / Governing Body, management, workforce, patients and community to understand how services and systems are performing and where improvement is required.

Quality improvement will be informed by evidence rather than assumption. Decisions about improvement will draw on appropriate quantitative and qualitative information, including clinical and operational data, audits, health outcomes, incidents, risks, complaints, patient and community feedback, workforce feedback, accreditation findings, external reviews and emerging evidence.

[Organisation Name] will seek to understand not only whether required processes exist, but whether they are implemented, consistently followed and effective in achieving the intended outcome.

Quality improvement will be proportionate to organisational risk, responsive to community need and embedded within governance, clinical governance, risk management, service planning and routine work.

Compliance with legislation and accreditation requirements represents a minimum expectation. Where evidence identifies opportunities to further improve safety, quality, cultural safety, equity, patient experience, health outcomes or organisational effectiveness, [Organisation Name] will consider and implement appropriate improvement.

5. Policy

[Organisation Name] recognises that high-quality services require more than policies, procedures and accreditation compliance. The organisation must be able to demonstrate that its systems work effectively in practice, that performance is understood, that deficiencies are identified and addressed, and that improvement produces measurable and sustainable change.

Quality improvement will therefore operate as an ongoing cycle of identifying priorities, measuring current performance, understanding causes and contributing factors, implementing change, evaluating outcomes and sustaining or refining improvements.

5.1 Governance, Leadership and Accountability

The Board / Governing Body retains oversight of organisational quality and must receive sufficient information to understand significant quality, safety and performance issues and provide appropriate governance assurance.

Executive management is responsible for establishing and maintaining an effective organisation-wide quality improvement system and ensuring that appropriate resources, responsibilities, reporting pathways and oversight arrangements are in place.

Quality improvement responsibilities will be incorporated into relevant governance structures, committees, position descriptions, delegations, planning processes and reporting arrangements.

Quality and performance information provided to governance structures must be meaningful and sufficient to identify trends, significant risks, performance gaps and progress against organisational priorities.

Significant quality concerns, repeated deficiencies, deteriorating performance or improvement activities that are not progressing effectively must be escalated according to their level of risk.

Quality improvement priorities will align with the organisation's strategic direction, community needs, clinical governance arrangements, risk profile and service priorities.

5.2 Annual Quality Improvement Planning

[Organisation Name] will establish and maintain an annual Quality Improvement Plan, or equivalent documented set of organisation-wide quality priorities.

The plan will be informed by:

- strategic and operational priorities;
- organisational and clinical risk;
- community needs and priorities;
- audit findings;
- patient and community feedback;
- clinical and operational performance data;
- incidents and complaints;
- accreditation and external review findings;
- workforce feedback;
- legislative or regulatory changes; and
- emerging evidence and sector priorities.

The plan will identify significant quality priorities, intended outcomes, responsibilities, relevant indicators or measures and expected timeframes.

Progress against the annual Quality Improvement Plan will be monitored through appropriate management and governance structures.

Quality priorities may be revised during the year where emerging risk, performance concerns, community needs or significant organisational change requires a different or additional focus.

5.3 Organisation-Wide Quality Improvement System

[Organisation Name] will maintain a coordinated quality improvement system across clinical, operational, governance and administrative functions.

The system will provide mechanisms to:

- identify and prioritise opportunities for improvement;
- establish measurable improvement objectives;
- document improvement activities;
- assign responsibility and timeframes;
- monitor progress;
- evaluate outcomes;
- identify barriers to implementation;
- escalate overdue or ineffective actions;
- communicate learning; and
- sustain successful improvements.

Quality improvement will be integrated with strategic and operational planning, risk management, clinical governance, incident management, complaints management, workforce development, policy management, accreditation and service evaluation.

Improvement activities must be proportionate to the significance, complexity and risk of the issue being addressed.

5.4 Identification and Prioritisation of Improvement

Improvement opportunities may arise from any aspect of organisational activity.

[Organisation Name] will consider information including:

- clinical and organisational audits;
- patient health outcomes;
- clinical indicators and practice data;
- service activity and access data;
- incidents, adverse events and near misses;
- organisational and clinical risk registers;
- complaints, compliments and feedback;
- patient experience;
- Aboriginal and Torres Strait Islander community feedback;
- workforce feedback and consultation;
- cultural safety and equity information;
- policy and procedure compliance;
- legislative and regulatory changes;
- accreditation findings;
- external reviews and assessments;
- benchmarking and comparative performance;
- changes in clinical evidence or recognised practice;
- workforce and competency information;
- service delivery and operational performance;
- population health information;
- emerging community needs; and
- identified variation in practice or outcomes.

Improvement priorities will be determined according to factors including actual or potential harm, clinical and organisational risk, community impact, frequency, severity, equity, cultural safety, regulatory obligations, strategic priorities, feasibility and the potential benefit of improvement.

High-risk or significant deficiencies must not be deferred solely because they are difficult or resource intensive to address.

5.5 Quality Objectives, Indicators and Performance Measures

[Organisation Name] will establish measurable quality objectives and indicators relevant to organisational priorities, service delivery and community need.

Measures may include clinical, operational, cultural safety, access, equity, patient experience, workforce, governance and service performance indicators.

Where appropriate, targets, thresholds or expected performance levels will be established to support meaningful monitoring.

Performance against relevant indicators will be reviewed at defined intervals and trends will be assessed over time.

Indicators that consistently demonstrate poor or deteriorating performance, significant variation or emerging risk will trigger further investigation, quality improvement or escalation as appropriate.

Quality indicators will be reviewed periodically to ensure they remain relevant, useful and proportionate to the organisation's services and priorities.

5.6 Quality Improvement Planning and Methodology

Improvement activities must be sufficiently structured to demonstrate what is being improved, why improvement is required and whether the intervention has been successful.

An improvement activity should, where appropriate, establish:

- the issue or opportunity being addressed;
- baseline performance;
- relevant evidence or expected standard;
- the intended outcome;
- actions or interventions;
- responsible person or team;
- required resources;
- measures of success;
- implementation timeframes;
- review points; and
- arrangements for evaluation and sustainability.

The organisation may use PDSA cycles, audit and feedback, root cause analysis, process mapping, benchmarking, co-design, service redesign or other recognised improvement approaches appropriate to the issue.

The methodology selected must be proportionate to the complexity and significance of the improvement.

Improvement activity must not be considered complete solely because an action has been undertaken. The organisation must, where reasonably practicable, determine whether the action produced the intended improvement.

5.7 Quality Improvement Register

[Organisation Name] will maintain a Quality Improvement / CQI Register or equivalent organisational system to provide oversight of significant improvement activities.

The register will record sufficient information to enable progress and outcomes to be monitored, including the identified issue, source, priority, planned action, responsible person, timeframe, status, outcome and evaluation.

Improvement actions arising from audits, incidents, complaints, risks, accreditation findings, service reviews and other sources should be linked or cross-referenced to relevant organisational records where appropriate.

The register will be reviewed routinely through designated management, quality, clinical or governance structures.

Overdue, repeatedly deferred, stalled or ineffective actions will be reviewed and escalated according to risk.

Where delays create a significant clinical, legal, regulatory, cultural safety or organisational risk, interim controls must be considered until permanent action is completed.

Completed activities will be closed only when appropriate evidence demonstrates that required actions have been implemented and, where applicable, evaluated.

5.8 Closing the Improvement Loop

[Organisation Name] will ensure that significant findings progress through a complete improvement cycle rather than being closed solely because an action has been assigned or undertaken.

The quality improvement cycle will, where appropriate, include:

identification → assessment → action planning → implementation → verification → evaluation or re-audit → closure → monitoring for sustainability.

Where verification demonstrates that the intended outcome has not been achieved, the activity must remain open or be returned for further action.

Where corrective action has reduced but not eliminated significant risk, the residual risk will be assessed and managed through appropriate organisational risk processes.

5.9 Organisational Audit Program and Annual Audit Schedule

[Organisation Name] will maintain a planned and risk-based audit program covering relevant clinical, governance, operational and administrative systems.

A documented Annual Audit Schedule will be maintained to identify planned audits, areas of focus, expected frequency, responsible persons and status.

The audit program and schedule will be reviewed through appropriate quality, management or governance structures.

Audits will be selected according to organisational risk, service activity, legislative and accreditation requirements, previous findings, patient and community priorities, clinical significance and identified performance concerns.

The audit schedule will be designed to ensure that the organisation's highest-risk and most significant systems are reviewed over an appropriate defined cycle and that lower-risk or easily audited activities do not displace areas requiring greater assurance.

The audit program may include scheduled, recurring, targeted and responsive audits.

Audit frequency will be proportionate to risk. Higher-risk activities, recurring deficiencies or areas of known concern may require more frequent review.

The audit program will include sufficient breadth to provide assurance regarding how the organisation operates in practice and must not be limited to reviewing whether documents exist.

Audits may assess whether:

- required systems and controls are implemented;
- policies and procedures are being followed;
- clinical practice aligns with evidence and recognised standards;
- records and documentation meet required standards;
- legislative, regulatory and accreditation requirements are met;
- risk controls are effective;
- workers understand and fulfil relevant responsibilities;
- service processes are timely, reliable and effective; and
- intended patient, community or organisational outcomes are being achieved.

5.10 Conduct of Audits

Audits must have a clearly defined purpose, scope, criteria and methodology appropriate to the matter being reviewed.

Audit criteria should be based on applicable legislation, recognised standards, clinical guidelines, organisational policies, approved procedures, contractual requirements or other defined expectations.

Where sampling is used, the sample should be sufficient and appropriate to provide meaningful information about the area being examined.

Persons conducting audits must have appropriate knowledge or capability relevant to the audit. Where specialist clinical interpretation is required, appropriately qualified clinical personnel must be involved.

Audit findings must be documented objectively and supported by appropriate evidence.

Audits must protect patient privacy, confidentiality, cultural safety and information security.

5.11 Audit Independence and Objectivity

Audits will be conducted in a manner that supports objective and reliable findings.

For routine internal audits, independence may be proportionate to the risk and complexity of the activity.

Where an audit concerns a high-risk, sensitive or significant matter, [Organisation Name] will consider whether the audit should be undertaken or reviewed by a person sufficiently independent of the activity being examined.

Greater independence may be required for matters involving significant clinical risk, governance, privacy, controlled medicines, financial controls, credentialing, serious complaints, conflicts of interest, alleged misconduct or repeated systemic failure.

Where complete independence is not practicable, potential conflicts or limitations will be identified and appropriate safeguards applied.

5.12 Audit Findings, Corrective Action and Re-Audit

Audit findings will be reviewed according to their significance and risk.

Identified deficiencies will result in proportionate action, which may include immediate correction, further investigation, education, process redesign, policy or procedure amendment, system changes, risk treatment or formal quality improvement activity.

Significant findings will have clearly assigned actions, responsible persons and completion timeframes.

Where an audit identifies immediate or significant risk to patient safety, legal compliance or organisational operations, the issue must be escalated promptly and managed through relevant clinical, risk or governance processes.

Completion of an action does not, by itself, demonstrate that a deficiency has been resolved.

Re-audit, follow-up review, performance monitoring or another suitable verification method will be used where appropriate to determine whether corrective action has been implemented effectively and the improvement sustained.

Repeated findings must be examined for underlying systemic causes rather than repeatedly addressed as isolated events.

5.13 Clinical Quality Improvement and Clinical Audit

Clinical quality improvement will form an integral component of the organisation's clinical governance system.

Clinical audits and reviews will be used to evaluate whether care is consistent with recognised evidence, clinical guidance, organisational requirements and expected standards of practice.

Clinical quality activities may examine areas including:

- preventive healthcare;
- chronic disease management;
- clinical documentation;
- medication safety;
- diagnostic testing and results management;
- referrals and follow-up;
- recall and reminder systems;
- infection prevention and control;
- immunisation;
- emergency preparedness;
- clinical handover;
- clinical equipment;
- scope of practice;
- clinical outcomes;
- access and continuity of care; and
- other areas identified through clinical risk or service priorities.

Clinical audit findings will be reviewed with relevant practitioners and clinical leaders.

Clinical quality improvement will support practitioners to reflect on and strengthen practice and must not be used solely as a punitive performance-management mechanism.

Where an audit identifies a serious clinical safety concern, professional performance concern or significant departure from expected clinical practice, the matter must be escalated through appropriate clinical governance processes.

5.14 Clinical Indicators and Health Outcomes

[Organisation Name] will identify and monitor clinical indicators relevant to the services provided and the health needs of the community.

Indicators should be selected where they provide meaningful information about the safety, effectiveness, appropriateness, timeliness, continuity or outcomes of care.

Clinical data will be reviewed over time to identify trends, gaps in care, population health needs and opportunities to strengthen preventive and chronic disease care.

Where appropriate, clinical performance will be compared with recognised targets, guidelines, benchmarks or comparable data.

Clinicians will be provided with appropriate information about relevant clinical performance and outcomes to support professional reflection and improvement.

5.15 Variation in Practice and Outcomes

[Organisation Name] will use available data, audits and clinical review to identify significant variation in practice or outcomes.

Variation will not automatically be considered inappropriate. The organisation will seek to understand whether variation reflects legitimate differences in patient needs, preferences, clinical circumstances, community context or service delivery.

Where variation cannot be adequately explained and may affect quality, safety, equity or outcomes, further review will occur.

Identified unwarranted variation will inform quality improvement, clinical review, education, risk management or other appropriate action.

Significant risks arising from unwarranted variation will be incorporated into organisational risk management processes where appropriate.

5.16 Data Quality, Measurement and Analysis

Quality improvement decisions must be based on information that is sufficiently accurate, relevant and reliable for its intended purpose.

[Organisation Name] will support appropriate systems for the collection, validation, interpretation and reporting of quality and performance information.

Measures may include structure, process, outcome, experience, equity and balancing measures.

Where possible, baseline information will be established before significant changes are implemented to enable the organisation to determine whether improvement has occurred.

Data will be examined over time where appropriate rather than relying solely on isolated results.

The limitations of available data, including small sample sizes, incomplete data or limitations in comparability, will be considered when interpreting findings.

5.17 Quality Improvement Data Governance

Access to patient, workforce or organisational information for quality improvement or audit purposes must be authorised and proportionate to the activity being undertaken.

Only information reasonably necessary for the quality activity should be accessed, used or disclosed.

Where practicable, information used for reporting, presentation or broader analysis will be de-identified or aggregated.

Quality improvement information must be stored, transmitted, retained and disposed of in accordance with organisational privacy, records management and information security requirements.

Access to sensitive quality information will be restricted to persons with a legitimate organisational need.

Quality improvement activities involving the use of data must respect cultural safety, confidentiality and the appropriate interpretation of Aboriginal and Torres Strait Islander data.

5.18 Benchmarking and External Comparison

Where meaningful and appropriate, [Organisation Name] will compare its performance against recognised external standards, evidence, clinical guidelines, peer services, population data, accreditation expectations or other relevant benchmarks.

Benchmarking will be used to understand performance and identify opportunities for improvement rather than to pursue numerical targets without regard to community context or patient need.

Where performance differs significantly from expected or comparable performance, the organisation will seek to understand the reasons for the difference and determine whether improvement is required.

5.19 Trend and Thematic Analysis

[Organisation Name] will periodically analyse quality information across multiple sources to identify patterns that may not be apparent when information is reviewed separately.

This may include collective review of:

- audit findings;
- incidents and near misses;
- complaints and compliments;
- risk information;
- patient and community feedback;
- workforce feedback;
- clinical indicators;
- service performance;
- accreditation findings; and
- external review information.

Recurring themes, clusters, repeated deficiencies or deterioration across several sources will be considered potential indicators of systemic risk.

Where systemic issues are identified, the organisation will undertake appropriate investigation, improvement, risk treatment or governance escalation.

5.20 Patient, Family and Community Involvement

[Organisation Name] recognises that quality cannot be understood solely through organisational or clinical data.

Patients, families, carers and community members have direct knowledge of how services are experienced and whether they are accessible, respectful, culturally safe and responsive.

Patient and community experience will therefore inform quality improvement priorities and service evaluation.

The organisation will provide meaningful opportunities for consumers and community to contribute to improvement through mechanisms appropriate to the organisation and community.

This may include feedback, surveys, consultation, advisory mechanisms, community engagement, yarning, co-design, complaints information and participation in relevant quality activities.

Information obtained through engagement will be considered alongside clinical, operational and performance data when evaluating service quality.

5.21 Community-Controlled Quality Improvement

[Organisation Name] recognises that, as an Aboriginal Community Controlled Health Service, quality improvement must remain responsive to the priorities, experiences and expectations of the Aboriginal community it serves.

Community priorities, cultural knowledge and lived experience will inform the identification, design, implementation and evaluation of quality improvement where appropriate.

The organisation's understanding of quality will not rely solely on mainstream clinical, accreditation or performance measures.

Measures of quality and success may also include:

- cultural safety;
- accessibility;
- trust;
- continuity and relationships;
- community experience;
- self-determination;
- responsiveness to community priorities;
- equity;
- engagement; and
- outcomes valued by Aboriginal and Torres Strait Islander people.

Quality improvement information will be communicated through appropriate governance and community accountability mechanisms.

Improvement activity will remain consistent with the principles of Aboriginal community control and the organisation's accountability to the community it serves.

5.22 Aboriginal and Torres Strait Islander Health Equity

Quality improvement within [Organisation Name] will explicitly consider Aboriginal and Torres Strait Islander health outcomes, cultural safety, access, equity and community priorities.

The organisation will seek to identify whether systems, processes or models of care create or contribute to barriers, inequity or culturally unsafe experiences.

Where data are available and appropriate, quality analysis will consider differences in access, experience, outcomes or service use that may indicate inequity.

Improvement strategies affecting Aboriginal and Torres Strait Islander people should be informed by appropriate community knowledge, lived experience and cultural expertise.

Measures of success will not be limited to clinical outcomes and may include cultural safety, trust, accessibility, continuity, engagement and community experience.

5.23 Incidents, Risks, Complaints and Feedback as Sources of Improvement

Incidents, near misses, risks, complaints and feedback will be treated as important sources of organisational learning.

These sources will not be reviewed only as individual events. [Organisation Name] will periodically analyse information collectively to identify recurring themes, systemic issues and emerging risks.

Where patterns or significant concerns are identified, appropriate quality improvement activity will be initiated.

Actions arising from these sources will be monitored to determine whether identified problems have been addressed and recurrence reduced.

5.24 Accreditation and External Review

Accreditation, certification, regulatory review and other external assessment processes will be used as opportunities to strengthen organisational systems.

Findings, recommendations, observations and identified non-conformities will be reviewed, prioritised and incorporated into relevant improvement plans or registers.

The organisation will not rely solely on accreditation assessment to determine whether its systems are effective.

Readiness for accreditation will be maintained through routine quality assurance, audit, monitoring and improvement rather than short-term preparation immediately before assessment.

5.25 Policy and Procedure Compliance

[Organisation Name] will monitor whether key policies, procedures, protocols and organisational controls are implemented and effective.

High-risk policies and processes will be prioritised for periodic compliance review or audit.

Where workers are not consistently following an organisational requirement, the organisation will consider contributing factors including clarity of the requirement, education, workflow, resources, technology, supervision, service design and whether the requirement remains appropriate.

Repeated non-compliance must not be addressed solely through repeated instruction where underlying system factors contribute to the problem.

Findings may result in education, system redesign, policy amendment, risk treatment, performance management or other proportionate action.

5.26 Evaluation Following Significant Organisational Change

Significant changes to services, systems or models of care will be subject to appropriate post-implementation monitoring and evaluation.

This may apply to changes including:

- new clinical or community services;
- new or relocated facilities;
- new clinical or administrative software;
- significant digital health or technology implementation;
- new models of care;
- significant changes to staffing or workforce models;
- major policy or procedural changes;
- changes to clinical pathways; and
- significant changes arising from regulatory or accreditation requirements.

Evaluation will consider whether the change achieved its intended objective and whether unintended risks, service impacts, inequities or adverse consequences have emerged.

Where evaluation identifies deficiencies or new risks, appropriate corrective or quality improvement action will occur.

5.27 Quality Assurance and Organisational Assurance

[Organisation Name] will maintain different levels of assurance proportionate to organisational risk.

Assurance may include:

- routine operational monitoring;
- supervisor or manager review;
- internal audit;
- clinical review;
- quality and compliance review;
- governance reporting;
- independent internal review; and
- external accreditation, certification, audit or specialist review.

Higher-risk systems and significant organisational concerns may require stronger or more independent forms of assurance.

Governance bodies will receive sufficient evidence to distinguish between actions that have merely been reported as complete and systems that have been verified as effective.

5.28 Workforce Participation and Improvement Capability

All workers have a role in identifying opportunities to improve quality.

Workers will be encouraged to raise concerns, identify inefficiencies, suggest improvements and participate in quality activities relevant to their roles.

[Organisation Name] will support workforce capability in quality improvement through appropriate orientation, education, resources, data access, supervision and opportunities to participate in improvement activity.

Quality improvement should be incorporated into routine team and service discussions rather than being viewed solely as the responsibility of quality, compliance or management personnel.

Leaders will promote an environment in which workers can identify problems and opportunities for improvement without unreasonable fear of blame or reprisal.

5.29 Quality Improvement and Research

[Organisation Name] recognises that routine audit and quality improvement activities are generally undertaken to evaluate and improve existing organisational practice.

Where an activity is designed to generate new or generalisable knowledge, departs substantially from routine quality improvement, involves additional intervention or risk to participants, or otherwise meets requirements for research or ethical review, appropriate governance and ethics requirements must be considered before the activity commences.

Where there is uncertainty about whether an activity constitutes routine quality improvement, evaluation or research, advice will be sought through appropriate organisational or external governance channels.

5.30 Evaluation and Sustainability of Improvement

Improvement activity must include consideration of whether the intended outcome has been achieved.

Evaluation may include re-audit, repeated measurement, data analysis, patient or workforce feedback, observation, review of incidents or another appropriate method.

Where an improvement has not achieved the intended outcome, the organisation will review why and determine whether the intervention should be modified, replaced or discontinued.

Where improvement has been demonstrated, [Organisation Name] will consider what is required to sustain the change, including incorporation into policies, procedures, workflows, information systems, training, induction, position responsibilities, monitoring or routine audit.

Where successful improvement may benefit other programs or locations, opportunities to spread the improvement across the organisation will be considered.

5.31 Reporting and Organisational Assurance

Quality and performance information will be reported through appropriate organisational and governance structures.

Reporting will be proportionate to the responsibilities of the recipient and may include:

- quality indicators and trends;
- significant clinical and organisational audit findings;
- patient and community experience;
- clinical outcomes;
- incidents, complaints and risk trends;
- progress against annual quality priorities;
- progress against improvement plans;
- overdue or ineffective improvement actions;
- accreditation and regulatory findings;
- significant variation in practice or outcomes;
- systemic themes identified across multiple information sources; and

- evidence regarding whether improvements have been achieved and sustained.

The Board / Governing Body will receive sufficient information to provide oversight of significant quality issues and assurance regarding the effectiveness of the organisation's quality improvement system.

Significant deterioration, emerging risk or failure of key controls must be escalated outside routine reporting cycles where necessary.

5.32 Organisational Learning, Recognition and Sharing Improvement

[Organisation Name] will promote organisational learning by communicating relevant findings, lessons and successful improvements to workers, patients, community and governance structures as appropriate.

Learning from one incident, audit, complaint, service or location will be considered for its relevance elsewhere in the organisation.

Where improvement identifies a need to change organisational practice, relevant policies, procedures, education, systems, resources or service models will be updated.

Successful improvement practices should be embedded into routine organisational systems so that gains are maintained beyond the individual project or person responsible for initiating them.

The organisation will, where appropriate, recognise the contribution of individuals, teams and community members who support meaningful quality improvement.

Successful improvement may be shared across teams, services and relevant sector networks where this supports broader learning and does not compromise privacy or confidentiality.

5.33 Quality Improvement as Routine Practice

Quality improvement will be embedded into everyday organisational activity and will not operate as a separate or episodic compliance function.

Managers, clinical leaders and teams will routinely consider performance, risk, feedback, data and opportunities for improvement as part of service management and clinical practice.

Improvement activity will be incorporated, where appropriate, into team meetings, clinical meetings, management reviews, planning processes, supervision, performance discussions and governance reporting.

The organisation will seek to develop a culture in which asking "How do we know this is working?" and "How can this be improved?" forms part of routine decision-making.

6. Roles and Responsibilities

Role	Responsibilities
Board / Governing Body	Provides governance oversight of organisational quality and performance; endorses strategic quality priorities; reviews significant quality, safety, audit and improvement information; and seeks assurance that improvement systems are effective.
Chief Executive Officer / Executive Management	Ensures organisation-wide quality improvement systems, resources, responsibilities and reporting arrangements are established and maintained and significant quality issues are appropriately addressed.
Clinical Lead / Senior Clinician	Provides clinical leadership for clinical audit and improvement, supports review of clinical performance and variation, and oversees significant clinical quality concerns.
Managers / Service Leads	Implement quality systems within their areas, monitor performance, support audits and improvement activities, address identified deficiencies and ensure actions are completed and evaluated.
Quality / Compliance / Accreditation Personnel	Coordinate quality systems, annual quality planning, audit schedules, CQI registers, improvement methodologies, reporting and accreditation activities and support teams to implement and evaluate improvement.
Healthcare Practitioners	Participate in clinical audit and improvement, use data and evidence to review practice, respond to identified gaps and contribute to safe, effective and culturally safe care.
All Workers	Comply with quality requirements, participate in relevant audits and improvement activities, identify opportunities for improvement and report risks, deficiencies or concerns.

7 . Cultural Considerations

[Organisation Name] recognises that quality improvement within an Aboriginal Community Controlled Health Service must reflect Aboriginal and Torres Strait Islander understandings of health, community priorities and the principle of Aboriginal community control.

Quality cannot be determined solely through mainstream clinical or operational measures. Assessment of quality must also consider whether services are culturally safe, equitable,

accessible, respectful and responsive to Aboriginal and Torres Strait Islander people, families and communities.

Quality improvement activities will:

- recognise Aboriginal and Torres Strait Islander cultures, identities, strengths, knowledge and ways of knowing, being and doing;
- value community knowledge and lived experience as legitimate evidence for improvement;
- consider the impacts of racism, discrimination, trauma and systemic barriers on access, experience and outcomes;
- seek meaningful patient and community involvement where improvement affects service experience or delivery;
- use culturally appropriate engagement methods;
- consider family, kinship and community contexts where appropriate;
- examine whether organisational systems unintentionally create barriers or inequity;
- protect the privacy, dignity and cultural safety of people whose information contributes to audit or quality activities; and
- ensure that data concerning Aboriginal and Torres Strait Islander people are interpreted responsibly and in context.

Quality improvement affecting other culturally and linguistically diverse communities will similarly consider cultural identity, communication, health literacy, accessibility and individual needs.

The organisation will seek improvement that strengthens not only compliance and clinical outcomes, but also community trust, cultural safety, patient experience, equity and self-determination.

8. Related Policies & Documents

- Clinical Governance Policy
- Organisational Governance Policy
- Risk Management Policy
- Incident Management Policy
- Feedback and Complaints Management Policy
- Cultural Safety Policy
- Patient Rights and Person-Centred Care Policy
- Access and Continuity of Care Policy
- Health Information Management Policy
- Medication Management Policy
- Infection Prevention and Control Policy
- Clinical Audit Procedure
- Quality Improvement / CQI Framework
- Annual Quality Improvement Plan
- Quality Improvement / CQI Register
- Annual Audit Schedule
- Risk Register
- Incident Register
- Feedback and Complaints Register
- Strategic Plan
- Operational Plan
- Results and Follow-Up Policy

9. Monitoring & Review

[Organisation Name] will monitor the implementation and effectiveness of this policy through governance, clinical governance, quality improvement, risk management and performance monitoring systems.

Monitoring may include:

- progress against the Annual Quality Improvement Plan;
- completion of the Annual Audit Schedule;
- clinical and non-clinical audit findings;
- quality objectives, indicators and performance trends;
- clinical and patient outcomes;
- CQI register activity and completion;
- effectiveness and sustainability of improvement actions;
- overdue, repeated or ineffective actions;
- incidents, risks, complaints and feedback trends;
- thematic analysis across multiple quality information sources;
- patient and community experience;
- cultural safety, access and equity measures;
- policy and procedure compliance;
- accreditation and external review findings;
- workforce participation in improvement;
- post-implementation evaluation of significant organisational changes;
- re-audit results; and
- Board / Governing Body quality reporting and assurance.

The organisation will periodically evaluate the quality improvement system itself to determine whether:

- appropriate priorities are being identified;
- the audit program provides adequate coverage of organisational risk;
- corrective and improvement actions are completed within appropriate timeframes;
- quality information is reaching appropriate decision-makers;
- patient and community perspectives are informing improvement;
- actions are being evaluated rather than simply recorded as complete;
- improvements are producing measurable outcomes; and
- successful changes are being sustained.

Findings will be reported through appropriate governance structures and significant deficiencies will result in corrective or improvement action.

This policy will be reviewed every two years, or earlier where changes to legislation, accreditation standards, evidence, organisational services or strategic priorities occur, or where audits, incidents, risks, feedback or evaluation identify a need for review.

10. Breach of Policy

Failure to comply with this policy may result in quality, safety, performance or compliance deficiencies remaining unidentified or unresolved and may compromise patient care, community outcomes or organisational obligations.

Actual or suspected significant non-compliance must be reported and managed according to the nature and level of risk.

Where an audit, review or quality activity identifies an immediate or significant risk to patient safety, cultural safety, legal compliance or organisational operations, appropriate action must be taken and the matter promptly escalated.

Failure to implement, monitor or appropriately escalate significant corrective actions may itself constitute a breach of this policy.

Non-compliance may result in corrective action, education, additional monitoring, re-audit, risk management, clinical review, system redesign or, where serious or repeated, performance or disciplinary action.

Identified breaches and system deficiencies will be reviewed for organisational learning and used to strengthen future quality and improvement systems.

11. Appendix

Referenced Documents and Resources

The following external and internal resources have informed the development of this policy:

Document Title	Type	Location / Access
Australian Commission on Safety and Quality in Health Care – Clinical Governance Standard	External	Clinical Governance Standard (Safety and Quality in Health Care)
Australian Commission on Safety and Quality in Health Care – 2026 National Model for Clinical Governance	External	2026 National Model for Clinical Governance (Safety and Quality in Health Care)

[Service Letterhead]

Document Title	Type	Location / Access
Australian Commission on Safety and Quality in Health Care – Practical Guide to the 2026 National Model for Clinical Governance	External	Practical Guide to Implementation (Safety and Quality in Health Care)
National Safety and Quality Health Service Standards	External	NSQHS Standards (Safety and Quality in Health Care)
National Safety and Quality Primary and Community Healthcare Standards	External	Primary and Community Healthcare Standards (Safety and Quality in Health Care)
RACGP Standards for General Practices – 6th Edition	External	RACGP Standards for General Practices (RACGP)
RACGP – Quality Improvement Resources	External	Quality Improvement Module (RACGP)
National Guide to Preventive Healthcare for Aboriginal and Torres Strait Islander People	External	National Guide (RACGP)
Australian Charter of Healthcare Rights	External	Australian Charter of Healthcare Rights
AHPRA – Codes, Guidelines and Professional Standards	External	AHPRA Codes and Guidelines
NSW Health – Clinical Governance, Safety and Quality	External	NSW Health – Clinical Excellence Commission
Quality Improvement / CQI Framework	Internal	Internal Document
Annual Quality Improvement Plan	Internal	Internal Document
Clinical Governance Policy / Framework	Internal	Internal Document
Clinical Audit Procedure	Internal	Internal Document
Annual Audit Schedule	Internal	Internal Document
Quality Improvement / CQI Register	Internal	Internal Document
Risk Management Policy and Risk Register	Internal	Internal Document
Incident Management Policy and Incident Register	Internal	Internal Document

Document Title	Type	Location / Access
Feedback and Complaints Management Policy	Internal	Internal Document
Strategic Plan and Operational Plan	Internal	Internal Document

Legislative and Standards Currency

Legislation, professional standards, accreditation requirements and quality improvement guidance may change over time. [Organisation Name] will refer to the current applicable version when reviewing or applying this policy.

Where an external requirement changes and creates a conflict with this policy, the applicable legislative, regulatory or professional requirement will take precedence and this policy will be reviewed accordingly.

12. Version History

Version	Date	Author	Change Summary
1.0	DD/MM/YYYY	[Your Name]	Initial draft