Clinical Governance Procedures

PROCEDURE

1.1 Purpose

To establish a clear, accessible, and fair process for receiving, managing, and resolving complaints from clients (including NDIS participants) and other stakeholders in a manner that is respectful, timely, and promotes continuous improvement. This procedure operationalises the Behavioural Edge Psychology Feedback and Complaints Policy (Version 2.0) and should be read in conjunction with that policy, which contains the complaint-to-incident triage pathway, NDIS reportable incident procedures, and the independent complaints pathway for complaints about the Principal Psychologist.

1.2 Scope

This procedure applies to all complaints received about:

- Quality of psychological services provided
- Professional conduct and behaviour
- Communication and client interactions
- Administrative processes (billing, appointments, records)
- Breaches of confidentiality or privacy
- Any aspect of service delivery

1.3 Principles

Client-Cantered Approach:

- Complaints are treated seriously and with respect
- Complainants are not disadvantaged for making a complaint
- The complaints process is transparent and accessible
- Timely resolution is prioritised

Fair Process:

- Natural justice and procedural fairness are maintained
- Both the complainant and psychologist are treated fairly
- Decisions are based on evidence and consideration of all perspectives
- Bias and conflicts of interest are identified and managed

Cultural Safety:

- The complaints process is culturally safe and accessible
- Cultural support and interpreters are available when needed

- Aboriginal and Torres Strait Islander peoples receive culturally appropriate support
- Diversity in communication needs and preferences is accommodated

Learning and Improvement:

- Complaints are viewed as opportunities for improvement
- Systemic issues are identified and addressed
- Lessons learned inform practice changes
- Feedback contributes to quality improvement

1.4 Making Information Accessible

Information Provided to All Clients:

- Complaints information is provided in the Client Information and Consent document
- Information is available on the practice website
- Information is provided in plain language, free from jargon
- Information is available in accessible formats upon request, including Easy Read for NDIS participants. Assistance to lodge a complaint is available for anyone who needs it, including people with disability, communication support needs, or limited English proficiency

Content of Complaints Information:

- How to make a complaint
- What to expect from the complaints process
- Timeframes for acknowledgment and resolution
- Support available to complainants
- External complaint options (AHPRA, Health Complaints Commissioner, NDIS Quality and Safeguards Commission)
- Assurance that making a complaint will not affect the quality of care

1.5 Complaints Process

Step 1: Receipt of Complaint via

- In person during an appointment
- By telephone
- By email
- By written letter
- Through the practice website (if applicable)
- Through a third party, advocate, NDIS nominee, support coordinator, or family member (with client consent or within the scope of the nominee's appointment under the NDIS Act 2013)

Initial Response:

- Acknowledge receipt of complaint within 2 business days
- Thank the complainant for bringing the matter to attention
- Provide information about the complaints process and expected timeframes
- Offer support (interpreter, advocate, cultural support)
- Assign a reference number to the complaint

Documentation:

- Record all complaints in the Complaints Register
- Document: date received, complainant details (if provided), nature of complaint, preferred outcome, method of receipt
- Create a complaint file separate from clinical records
- Maintain confidentiality of complaint information

Step 2: Assessment and Triage

Immediate Risk Assessment:

- Assess whether the complaint involves immediate safety concerns
- Determine if urgent action is required to protect the client or others
- Implement immediate protective measures if needed
- Consider whether the matter requires notification to AHPRA, the NDIS Quality and Safeguards Commission, or other authorities. Where the complaint involves an NDIS participant, assess whether it constitutes a reportable incident under the NDIS (Reportable Incidents) Rules 2018 (including death, serious injury, abuse or neglect, unlawful sexual or physical contact, sexual misconduct, or unauthorised use of restrictive practices). If so, activate the complaint-to-incident triage pathway in the Feedback and Complaints Policy v2.0, Section 8, including mandatory notification to the NDIS Commission within 24 hours

Complaint Classification:

- **Level 1 - Minor:** Simple administrative issues, miscommunication, easily resolved matters
- **Level 2 - Moderate:** Service delivery concerns, professional conduct issues requiring investigation
- **Level 3 - Serious:** Significant professional misconduct, serious safety concerns, potential breach of the Psychology Board of Australia Code of Conduct

Complexity Assessment:

- Determine scope and complexity of investigation required
- Identify any conflicts of interest
- Consider whether external expertise or advice is needed
- Assess whether matter should be referred externally

Determine Response Pathway:

- Level 1: Direct resolution (target 5 business days)
- Level 2: Formal investigation (target 20 business days)
- Level 3: Comprehensive investigation with external advice (target 45 business days)
- Mandatory reporting: Immediate notification to AHPRA if required

Step 3: Investigation

Planning the Investigation:

- Define the scope of investigation
- Identify information and evidence required
- Determine who needs to be consulted
- Establish timeline for completion
- Consider whether independent review is needed

Information Gathering:

- Review relevant clinical records
- Review correspondence and documentation
- Interview relevant parties (with consent)
- Gather physical evidence if applicable
- Consult with professional supervisor or peers (maintaining confidentiality)
- Seek advice from professional indemnity insurer if appropriate
- Consult AHPRA guidelines and Code of Conduct

Maintaining Objectivity:

- Approach investigation with open mind
- Consider all perspectives and evidence
- Avoid prejudgment or bias
- Document all steps of investigation
- Maintain separation between complaint handling and ongoing care provision

Ongoing Communication:

- Provide progress updates to complainant at agreed intervals (minimum every 10 business days)
- Advise of any delays and revised timeframes
- Keep complainant informed of investigation process

Step 4: Analysis and Decision Making

Analysis Framework:

- Review all evidence collected

- Consider relevant standards, policies, and guidelines
- Assess whether service delivery met professional standards
- Identify any systemic issues or contributing factors
- Consider whether Code of Conduct was breached
- Assess proportionality of response

Determining Outcomes:

- **Complaint Substantiated:** Evidence supports the complaint
- **Complaint Partially Substantiated:** Some aspects supported by evidence
- **Complaint Not Substantiated:** Evidence does not support the complaint
- **Insufficient Evidence:** Unable to determine outcome

Decision Considerations:

- Was there a breach of professional standards or Code of Conduct?
- What were the contributing factors?
- What is the appropriate response?
- What changes are needed to prevent recurrence?
- Is the complainant's desired outcome reasonable and achievable?

Step 5: Resolution and Response

Preparing the Response:

- Prepare written response within timeframe for complaint level
- Use clear, respectful, and empathetic language
- Explain investigation process undertaken
- State findings and rationale
- Address each aspect of the complaint
- Outline actions taken or to be taken
- Provide information about review options if dissatisfied

Components of Response:

- Acknowledgment of the complaint and impact on complainant
- Findings of investigation
- Explanation of decision-making
- Actions taken (if complaint substantiated):
    - Apology (when appropriate)
    - Explanation of what occurred
    - Changes to practice implemented
    - Training or professional development undertaken
    - System improvements made
- Information about external complaint options
- Invitation for further discussion if needed

Open Disclosure:

- When an adverse event has occurred, provide open and honest disclosure
- Apologise for harm or distress caused (noting apology laws protect such statements)
- Explain what happened and why
- Outline steps taken to prevent recurrence
- Offer to answer questions
- Provide ongoing support

Meeting with Complainant (if requested):

- Offer to meet in person or by video conference
- Allow complainant to bring support person
- Create a safe, respectful environment
- Listen to complainant's perspective
- Explain findings and actions
- Discuss resolution options
- Document meeting outcomes

Step 6: Follow-Up

Short-Term Follow-Up (1 week):

- Contact complainant to confirm receipt of response
- Answer any immediate questions
- Offer additional support if needed

Medium-Term Follow-Up (1 month):

- Check on implementation of agreed actions
- Assess complainant satisfaction with process
- Address any outstanding concerns

Long-Term Follow-Up (3-6 months):

- Review effectiveness of changes implemented
- Evaluate whether similar complaints have been received
- Assess sustainability of improvements

Care Continuity Considerations:

- Assess impact of complaint on therapeutic relationship
- Discuss options for continuing care
- Facilitate referral to another psychologist if appropriate
- Ensure smooth transition if client chooses to transfer care
- Document decisions regarding ongoing care

1.6 External Complaints

Information About External Options:

- **Australian Health Practitioner Regulation Agency (AHPRA):**
    - Website: www.ahpra.gov.au
    - Phone: 1300 419 495
    - Online notification form available
    - Manages complaints about registered health practitioners
    - Can investigate concerns about professional conduct
    - May impose conditions on registration or other regulatory action
- **Health Complaints Commissioner (Victoria):**
    - Website: www.hcc.vic.gov.au
    - Phone: 1300 582 113
    - Manages complaints about health service providers
    - Can investigate and conciliate complaints
    - Focus on resolution and system improvement

- **NDIS Quality and Safeguards Commission:**
    - Website: www.ndiscommission.gov.au
    - Phone: 1800 035 544
    - Manages complaints about NDIS supports and services, including quality, safety, and breaches of the NDIS Code of Conduct
    - NDIS participants can complain directly to the Commission at any time without needing to raise the complaint with us first

- **National Health Practitioner Ombudsman:**
    - Website: www.nhpo.gov.au
    - Manages complaints about AHPRA and National Boards
    - Reviews handling of complaints by AHPRA

Assistance Available:

- Provide contact information for external bodies
- Explain what each body can do
- Assist with understanding the external complaint process
- Do not discourage external complaints
- Continue to treat client professionally if external complaint made

1.7 Mandatory Notifications

When to Notify AHPRA (Immediate notification required if):

- Practitioner has placed public at risk of substantial harm through impairment, intoxication, or significant departure from professional standards
- Practitioner has engaged in sexual misconduct in connection with practice
- Practitioner has been charged with or convicted of an offense that may be grounds for disciplinary action

Notification Process:

- Submit notification to AHPRA within 24 hours of forming reasonable belief. Where the matter involves an NDIS participant and constitutes a reportable incident, also submit initial notification to the NDIS Quality and Safeguards Commission within 24 hours via the NDIS Commission portal, with a detailed report within 5 business days
- Use AHPRA online notification form
- Provide all relevant information
- Document rationale for making notification
- Seek advice from professional indemnity insurer

1.8 Record Keeping

Complaints Register:

- Maintain confidential register of all complaints
- Record: date, nature of complaint, classification, timeframes, outcome, actions taken
- De-identified data used for quality improvement
- Store securely and separately from clinical records

Complaint Files:

- Create separate file for each complaint
- Include: initial complaint, correspondence, investigation notes, evidence, response, follow-up
- Maintain for minimum 7 years
- Store securely with restricted access
- Mark as confidential

Clinical Records:

- Note in clinical records that complaint was received (if relevant to care)
- Do not include complaint details in clinical records
- Maintain separation between complaint process and clinical documentation
- Document any impact on care provision

1.9 Learning and Improvement

- Reflect on each complaint and learning opportunities
- Identify personal development needs
- Discuss in clinical supervision
- Implement practice changes
- Update policies and procedures as needed. Ensure alignment with the Feedback and Complaints Policy (v2.0), Privacy Policy (v2.0), OHS Policy (v3.0), and Clinical Governance Policy (v2.0)

Monitoring Effectiveness:

- Track complaint numbers and types
- Monitor resolution timeframes
- Assess complainant satisfaction
- Evaluate effectiveness of changes implemented
- Include in annual practice review

1.10 Support for Practitioner

- Acknowledge that receiving complaints can be stressful
- Seek support from supervisor, peers, or mental health professional
- Contact professional indemnity insurer for advice
- Access professional association support services
- Engage in self-care practices
- Maintain perspective and professionalism

Professional Support Resources:

- Clinical supervisor
- Professional peer consultation
- Practitioner Health programs
- Professional indemnity insurer
- Professional association (APS)
- Private psychological support

1.11 Review and Evaluation

Annual Review:

- Review complaints management procedure annually
- Assess effectiveness of process
- Identify improvements needed
- Update procedure as required
- Ensure alignment with current regulations

Evaluation Criteria:

- Accessibility of complaints process
- Timeliness of responses
- Fairness and objectivity
- Complainant satisfaction
- Learning and improvement outcomes
- Compliance with regulatory requirements

2. CONFLICT OF INTEREST MANAGEMENT PROCEDURE

2.1 Purpose

To establish a transparent and systematic approach to identifying, disclosing, and managing conflicts of interest to protect client welfare, maintain professional integrity, and uphold public trust.

2.2 Scope

This procedure applies to all potential, perceived, and actual conflicts of interest that may arise in professional psychological practice, including:

- Financial interests
- Professional relationships
- Personal relationships
- Multiple relationships (dual relationships)
- Gifts and benefits
- Commercial activities
- External commitments

2.3 Definition of Conflict of Interest

What is a Conflict of Interest? A conflict of interest occurs when a psychologist's private interests (financial, professional, or personal) could inappropriately influence, or appear to influence, their professional judgment and decisions regarding client care.

Financial Conflicts:

- Pecuniary interest in companies, products, or services recommended to clients
- Financial benefit from referrals to specific providers or services
- Ownership or investment in healthcare businesses
- Payment or gifts from pharmaceutical or medical device companies
- Financial arrangements with third parties (insurers, lawyers, organisations)

Professional Conflicts:

- Multiple roles with same client (therapist and assessor)
- Professional relationships with clients outside therapy
- Competing professional obligations
- Research or teaching involving clients
- Media or expert witness work involving clients

Personal Conflicts:

- Pre-existing personal relationships with clients
- Social connections with clients
- Romantic or sexual attraction to clients
- Treating family members or friends

- Shared community or social networks

2.4 Identifying Conflicts of Interest

Regular Self-Assessment:

- Conduct quarterly conflict of interest review
- Consider potential conflicts when accepting new clients
- Assess conflicts before making referrals
- Review when circumstances change
- Document self-assessment in professional log

Prompts for Identification:

- Do I have any financial interest in this recommendation?
- Would I benefit financially from this decision?
- Do I have any personal relationship with this client?
- Am I being asked to serve multiple roles?
- Could my judgment be influenced by factors other than client welfare?
- Would a reasonable person perceive a conflict?
- Am I uncomfortable with this situation?

Specific Scenarios Requiring Assessment:

- Providing therapy to friends, family, or colleagues
- Accepting clients who are employees of organisations where I have financial interests
- Recommending products or services in which I have financial interests
- Accepting gifts from clients
- Social media connections with clients
- Treating clients with whom I share community connections
- Providing services to someone I know through other contexts
- Accepting clients referred by family members or friends

2.5 Disclosure Requirements

Duty to Disclose:

- All actual, potential, and perceived conflicts must be disclosed
- Disclosure must occur as soon as conflict is identified
- Disclosure must be clear, specific, and understandable
- Written documentation of disclosure must be maintained

To Whom Disclosure is Made:

- Primary disclosure to client (or guardian if client is minor)
- Documentation in clinical records

- Disclosure to referrer if relevant
- Notification to supervisor or professional consultant
- Disclosure to professional indemnity insurer if significant
- Disclosure to third parties as required (with consent)

What to Disclose:

- Nature of the conflict of interest
- How the conflict might influence judgment or decisions
- Steps taken to manage the conflict
- Alternative options available to client
- Client's right to seek second opinion or alternative provider
- Process for ongoing monitoring of conflict

Disclosure Documentation:

- Complete Conflict of Interest Disclosure Form
- Obtain client acknowledgment of disclosure
- Store in client file
- Update when circumstances change
- Include in informed consent documentation

2.6 Assessment of Conflicts

Risk Assessment Framework: Assess each identified conflict using the following criteria:

Severity Assessment:

- **Low Risk:** Minimal potential to influence judgment, easily managed
- **Moderate Risk:** Some potential for influence, requires active management
- **High Risk:** Significant potential to compromise judgment, may preclude proceeding

Assessment Factors:

1. **Client Vulnerability:**
   - Client's capacity to make autonomous decisions
   - Power differential in relationship
   - Client's dependency on psychologist
   - Client's ability to provide informed consent
2. **Potential for Harm:**
   - Impact on therapeutic relationship
   - Effect on treatment decisions
   - Financial implications for client
   - Emotional or psychological impact
   - Potential for exploitation

3. **Professional Standards:**
   - Consistency with Code of Conduct
   - Alignment with professional competencies
   - Precedent in professional guidelines
   - Peer perspective on acceptability
4. **Public Perception:**
   - Would a reasonable person view this as problematic?
   - Does this undermine public trust?
   - How would this appear if publicly disclosed?
5. **Manageability:**
   - Can the conflict be effectively managed?
   - Are management strategies realistic?
   - Can client welfare be fully protected?

2.7 Managing Conflicts of Interest

Strategy 1: Avoidance (Preferred for High-Risk Conflicts)

- Decline to provide services
- Do not accept referral
- Divest financial interest
- Terminate personal relationship (if possible and appropriate)
- Decline the role or opportunity creating conflict

When to Use:

- Sexual or romantic attraction to client
- Close personal relationships
- Significant financial conflicts
- Multiple roles that cannot be reconciled
- Client cannot provide fully informed consent

Strategy 2: Modification

- Restructure financial arrangements
- Limit scope of service
- Engage independent third party for specific decisions
- Time-separate conflicting roles
- Reduce extent of financial interest

When to Use:

- Moderate risk conflicts
- Conflict can be substantially reduced
- Client welfare can still be protected
- Professional standards can be maintained

Strategy 3: Disclosure and Monitoring (for Lower-Risk Conflicts)

- Full disclosure to client
- Obtain informed consent
- Document conflict and management plan
- Regular review in supervision
- Establish monitoring procedures
- Maintain heightened awareness

When to Use:

- Low-risk conflicts
- Avoidance would disadvantage client
- Conflict is unavoidable (e.g., small community)
- Client benefits outweigh risks
- Strong management plan in place

Strategy 4: Third-Party Oversight

- Consultation with supervisor or peer consultant
- Engage independent reviewer for specific decisions
- Seek second opinion on treatment decisions
- Involve ethics consultant
- Request oversight from professional body

When to Use:

- Moderate to high-risk conflicts
- Complex decision-making required
- Independent judgment needed
- Accountability required
- Additional safeguards necessary

Strategy 5: Client Empowerment

- Provide client with full information
- Explain alternative options
- Support client to seek second opinions
- Facilitate referral to another provider if preferred
- Ensure client has genuine choice

When to Use:

- All conflict situations
- Client has capacity for autonomous decision-making
- Multiple options available
- Client preference is paramount

2.8 Specific Conflict Scenarios

Multiple Relationships (Dual Relationships)

Definition: Multiple relationships occur when the psychologist serves in more than one role with the same person or has a relationship with someone closely associated with the client.

- Treating a friend, colleague, or family member
- Social relationships with current clients
- Business relationships with clients
- Professional training relationships with clients (supervisor/supervisee)
- Providing therapy and conducting assessments for same client

Management:

- Generally, avoid multiple relationships where possible
- If unavoidable (e.g., rural/remote areas), implement rigorous safeguards:
    - Comprehensive disclosure
    - Written agreement on boundaries
    - Clear delineation of roles
    - Regular supervision
    - Documentation of rationale
    - Contingency plans for managing complications
    - Enhanced informed consent

Financial Interests

Pecuniary Interest in Recommendations:

- Must disclose any financial interest in recommended products/services
- Disclosure must be made before recommendation
- Client must be informed of alternatives without financial interest
- Document all disclosures
- Ensure recommendation is based on clinical merit

Referral Arrangements:

- Never accept payment for referrals (illegal and unethical)
- Disclose any relationship with referred providers
- Provide multiple referral options
- Base referrals on client needs, not financial benefit
- Document referral rationale

Gifts from Clients

Small, Unsolicited Gifts:

- May accept small tokens of appreciation (under $50 value)
- Consider cultural context
- Document receipt and rationale for acceptance
- Discuss in supervision if any concerns

Substantial or Repeated Gifts:

- Generally, decline
- Explain professional boundaries
- Document offer and refusal
- Consider impact on therapeutic relationship
- Discuss in supervision

Social Media and Electronic Communications

Client Connections:

- Do not accept friend/follow requests from current clients
- Maintain professional boundaries online
- Use separate professional and personal accounts
- Explain social media policy to clients
- Document policy in informed consent

Incidental Online Encounters:

- Do not search for clients online
- If inadvertently discover client information, do not use in therapy without disclosure
- Maintain same confidentiality standards online

Community Relationships (Small or Specialised Communities)

Unavoidable Multiple Relationships:

- Common in rural, remote, or specialised communities
- Anticipate and discuss boundary issues proactively
- Establish clear agreements about managing community contacts
- Create protocol for chance encounters
- Maintain professional boundaries despite social overlap
- Seek external supervision when possible

Management Strategies:

- Comprehensive informed consent about dual relationship
- Explicit discussion of boundaries
- Agreement on managing community encounters
- Client empowered to raise concerns
- Regular review of boundary management

- Documentation of agreements

2.9 Documentation Requirements

Conflict of Interest Register:

- Maintain register of all identified conflicts
- Record: date identified, nature of conflict, assessment, management strategy, review dates
- Update as circumstances change
- Review quarterly
- Store securely

Individual Conflict Files:

- Disclosure documents
- Risk assessment
- Management plan
- Client consent/acknowledgment
- Supervision notes
- Review documentation
- Correspondence

Clinical Records:

- Note existence of conflict and management approach
- Document informed consent discussions
- Record ongoing monitoring
- Update when circumstances change

2.10 Review and Monitoring

Ongoing Monitoring:

- Review all conflicts quarterly minimum
- Assess effectiveness of management strategies
- Adjust strategies as needed
- Document reviews in professional log
- Discuss in supervision

Indicators Requiring Reassessment:

- Change in client circumstances
- Change in personal/financial circumstances
- Therapeutic relationship changes
- Concerns raised by client
- Concerns identified in supervision

- Boundary violations or near-misses

Red Flags:

- Difficulty maintaining boundaries
- Minimising significance of conflict
- Reluctance to discuss in supervision
- Client expressing concerns about conflict
- Increased secrecy or discomfort
- Rationalisation of boundary crossings

2.11 Consultation and Supervision

Mandatory Consultation:

- All moderate and high-risk conflicts
- Any conflict involving personal attraction
- Situations where judgment may be impaired
- When unsure about appropriate management
- When client raises concerns

Supervision Discussion:

- Present conflicts in regular supervision
- Seek guidance on management strategies
- Discuss effectiveness of interventions
- Explore personal biases or blind spots
- Maintain accountability

2.12 Training and Competence

- Maintain knowledge of conflict-of-interest management
- Attend training on boundary management
- Stay current with Code of Conduct updates
- Engage in reflective practice
- Learn from case studies and peer experiences

3. CLINICAL EMERGENCY MANAGEMENT PROCEDURE

3.1 Purpose

To establish clear protocols for identifying, assessing, and responding to clinical emergencies to ensure client safety and appropriate crisis intervention.

3.2 Scope

This procedure covers management of:

- Suicidal ideation, intent, and attempts
- Self-harm behaviours
- Risk of harm to others
- Medical emergencies during sessions
- Acute psychotic episodes
- Severe dissociation or trauma responses
- Domestic violence disclosures requiring immediate action
- Child safety concerns requiring immediate action

3.3 Principles

Client Safety Priority:

- Client safety is the paramount concern
- Immediate action taken to prevent harm
- Err on the side of caution when assessing risk
- Balance autonomy with duty of care

Collaborative Approach:

- Work with client whenever possible
- Involve support systems with consent
- Coordinate with other services (including NDIS support coordinators, plan managers, and nominees where relevant)
- Maintain therapeutic alliance while ensuring safety

Evidence-Based Response:

- Use validated risk assessment tools
- Follow best practice protocols
- Base decisions on clinical evidence
- Document decision-making rationale

Least Restrictive Intervention:

- Use least restrictive effective intervention
- Respect client autonomy to greatest extent possible
- Only escalate when necessary for safety
- Provide explanation and support throughout

3.4 Emergency Contacts and Resources

Emergency Services:

- **Emergency (Police/Ambulance/Fire):** 000
- **Police Assistance Line (VIC):** 131 444
- **Ambulance (non-urgent):** 1300 360 391

Crisis Support Lines:

- **Lifeline:** 13 11 14 (24/7 crisis support and suicide prevention)
- **Suicide Call Back Service:** 1300 659 467 (24/7)
- **Beyond Blue:** 1300 22 4636 (24/7)
- **Kids Helpline:** 1800 55 1800 (5-25 years, 24/7)
- **MensLine Australia:** 1300 78 99 78 (24/7)
- **1800RESPECT (Domestic/Family Violence):** 1800 737 732 (24/7)
- **QLIFE (LGBTIQA+):** 1800 184 527
- **13YARN (Aboriginal & Torres Strait Islander):** 13 92 76

Local Mental Health Crisis Services (Victoria):

- **Mental Health Triage (Victoria):** Local area health service number
- **Centre Against Sexual Assault (CASA):** 1800 806 292
- **Safe Steps (Family Violence Response):** 1800 015 188

Other Resources:

- Local hospital emergency department contact
- Client's GP contact (with consent)
- Client's psychiatrist (if applicable, with consent)

3.5 Prevention and Preparedness

Risk Screening:

- Conduct suicide risk screening at intake using validated tool
- Regular ongoing risk assessment throughout treatment
- Heightened vigilance during high-risk periods:
    - Treatment transitions
    - Discharge from hospital
    - Major life stressors
    - Relationship breakdowns
    - Anniversary dates of trauma
    - After sentinel events

Early Warning Signs:

- Changes in mood or behaviour
- Withdrawal or isolation
- Giving away possessions
- Talking about death or suicide
- Hopelessness or helplessness
- Increased substance use
- Reckless behaviour
- Sudden calmness after depression

Proactive Planning:

- Develop Safety Plan with all clients at risk
- Regular review and update of Safety Plans
- Ensure clients have crisis contact information
- Establish emergency contact protocols
- Practice scenario planning

Practice Preparedness:

- Keep emergency contact list updated and accessible
- Ensure phone is fully charged and functional
- Know location of nearest hospital
- Maintain first aid kit
- Know practice address for emergency services
- Have emergency protocols readily accessible

3.6 Suicide Risk Assessment and Management

Initial Assessment

Screening Questions: Use standardised screening tool (e.g., PHQ-9 Item 9, Columbia-Suicide Severity Rating Scale)

If Positive Response, Conduct Detailed Assessment:

1. Ideation Assessment:

- Frequency and duration of thoughts
- Intensity of thoughts
- Content of thoughts (passive vs. active)
- Triggers for thoughts

2. Intent Assessment:

- Current intention to act on thoughts
- Desire to die vs. escape pain
- Ambivalence about living
- Reasons for living vs. dying

3. Plan Assessment:

- Specificity of plan
- Lethality of intended method
- Availability of means
- Preparation or rehearsal
- Timeline (immediate vs. future)

4. Capability Assessment:

- Prior suicide attempts (number, recency, lethality)
- History of self-harm
- Impulsivity
- Substance use
- Access to lethal means
- Knowledge of lethal methods

5. Risk Factors:

- Mental health diagnosis (depression, psychosis, PTSD)
- Substance use disorder
- Chronic pain or physical illness
- Recent significant losses
- Social isolation
- Financial or legal problems
- History of trauma or abuse
- Family history of suicide
- Recent discharge from psychiatric care

6. Protective Factors:

- Reasons for living
- Future orientation
- Social support
- Coping skills
- Help-seeking behaviour
- Treatment engagement
- Cultural or religious beliefs
- Responsibility to others

7. Warning Signs:

- Talking about death, dying, or suicide
- Seeking means
- Giving away possessions
- Saying goodbye
- Withdrawal
- Sudden mood improvement (may indicate decision made)

Risk Categorisation

Low Risk:

- Thoughts of death but no suicidal ideation
- OR passive ideation without intent or plan
- No prior attempts

- Good protective factors
- No substance abuse
- Strong support system

Moderate Risk:

- Suicidal ideation with plan but no intent
- OR intent without specific plan
- Prior attempts (not recent)
- Some protective factors
- Willingness to engage in safety planning
- Support available

High Risk:

- Suicidal ideation with specific plan and intent
- Access to means
- Recent attempt or multiple prior attempts
- Few protective factors
- Impulsivity or agitation
- Psychosis or severe mental illness
- Substance intoxication
- Unwilling to engage in safety planning

Imminent Risk:

- Current intent to act immediately
- Access to means
- Stating will attempt upon leaving
- Preparing to act
- Agitated or unable to collaborate
- Recent serious attempt
- Requires immediate intervention

Management Based on Risk Level

LOW RISK - Outpatient Management

Immediate Actions:

1. Acknowledge and validate client's distress
2. Explore thoughts and feelings
3. Develop or review Safety Plan
4. Assess and enhance protective factors
5. Provide crisis resources
6. Schedule next appointment within 1 week
7. Consider more frequent appointments
8. Encourage connection with supports

Safety Planning:

- Collaboratively develop a safety plan in writing
- Review warning signs
- Identify coping strategies
- List support contacts
- Identify professional contacts
- Discuss reducing access to means
- Client keeps copy of plan

Follow-Up:

- Appointment within 7 days
- Brief check-in call within 48 hours (if agreed)
- Encourage client to contact if situation worsens

Documentation:

- Risk assessment findings
- Risk level determination
- Safety Plan developed
- Client's agreement to plan
- Follow-up arrangements

MODERATE RISK - Intensive Outpatient Management

Immediate Actions:

1. Conduct thorough risk assessment
2. Develop detailed safety plan
3. Increase session frequency
4. Consider medication referral if not already in place
5. Involve support system (with consent)
6. Identify 24/7 support arrangements
7. Agree on clear criteria for when to go to ED

Consultation:

- Discuss with supervisor
- Consider consulting with psychiatrist (with consent and if applicable)
- Notify GP (with consent)

Follow-Up:

- Appointment within 3-5 days
- Daily brief phone contact (if agreed)
- Monitoring of warning signs
- Review of safety plan effectiveness

Documentation:

- Comprehensive risk assessment
- Risk level and contributing factors
- Consultation and collaboration on safety plan
- Client's capacity and willingness to engage
- Family/support involvement (if applicable)

HIGH RISK - Urgent Intervention Required

Immediate Actions:

1. Do not leave client alone
2. Comprehensive risk assessment
3. Consider immediate hospitalisation
4. Contact emergency services if client at imminent risk
5. Involve support system immediately (with or without consent if life-threatening)
6. Remove access to means
7. Consider mental health crisis team

Decision Tree:

Can client safety be assured in community?

YES - with intensive support:

- Daily contact or multiple times per day
- 24/7 supervision by family/supports
- Crisis team involvement
- Immediate psychiatric consultation
- All means removed from environment
- Client commits to Safety Plan and contacting before acting
- Next appointment within 24-48 hours

NO - hospitalisation required:

- Voluntary admission preferred
- Support client to present to ED
- Accompany or arrange accompaniment
- Provide information to ED staff
- Arrange follow-up post-discharge

Documentation:

- Detailed risk assessment
- Clinical reasoning for decision
- All interventions attempted
- Client and family involvement

- Hospitalisation arrangements or intensive community plan. For NDIS participants: assess whether the event constitutes a reportable incident and activate the complaint-to-incident triage pathway if required; notify the participant's nominee, guardian, or support coordinator as appropriate
- Follow-up plans

IMMINENT RISK - Emergency Response

Immediate Actions:

1. Call 000 (emergency services)
2. Stay with client - do not leave alone
3. Remove any means of harm from immediate environment
4. Keep client and self safe
5. Speak calmly and supportively
6. Contact support person
7. Provide information to emergency responders
8. Accompany to hospital if possible

If Client Leaves Session Before Emergency Services Arrive:

- Do not physically restrain (unless trained and safe to do so)
- Call emergency services immediately
- Provide client description, direction, and risk information
- Contact nominated emergency contact
- Document all actions taken
- Follow up to confirm client safety

Documentation:

- Time and nature of crisis
- Risk assessment
- All actions taken
- Emergency service involvement
- Outcome
- Follow-up arrangements

3.7 Self-Harm Management

Assessment:

- Distinguish suicidal from non-suicidal self-harm
- Assess frequency, methods, and severity
- Understand function of self-harm
- Assess risk of accidental lethality
- Identify triggers and patterns

Immediate Management:

- Ensure medical attention if needed for injuries
- Assess current urges and risk
- Develop harm reduction strategies
- Identify alternative coping skills
- Create Safety Plan specific to self-harm

Harm Reduction Approach:

- Delay: strategies to delay acting on urge
- Distract: alternative activities
- Substitute: intense but non-harmful sensory alternatives (e.g., holding something very cold, vigorous exercise, strong flavours, drawing on skin with red marker). Note: Strategies involving physical pain or discomfort (e.g., rubber bands, ice directly on skin) are not recommended as they may reinforce self-destructive patterns
- Express: safe ways to express emotion
- Seek support: people to contact

Treatment Planning:

- Address underlying issues (trauma, emotion regulation)
- Teach coping and emotion regulation skills
- Process function of self-harm
- Gradual reduction approach
- Regular monitoring

3.8 Risk of Harm to Others

Assessment:

- Specific threats or intent
- Access to intended victim
- History of violence
- Substance use
- Psychosis or delusional beliefs
- Impulsivity
- Access to weapons

Management:

LOW RISK:

- Explore thoughts and feelings
- Assess precipitants
- Develop anger management strategies
- Address underlying issues
- Monitor in ongoing treatment

MODERATE RISK:

- Detailed assessment
- Consider psychiatric referral
- Increase session frequency
- Involve appropriate others (with caution regarding confidentiality)
- Document decision-making
- Consult supervisor

HIGH RISK:

- Duty to warn potential victim if specific threat
- Contact police if imminent danger
- Consider involuntary hospitalisation
- Document thoroughly including legal and ethical considerations
- Seek legal advice if needed
- Notify professional indemnity insurer

Duty to Warn Considerations:

- Is threat specific and serious?
- Is victim identifiable?
- Is threat imminent?
- Balance confidentiality with duty to protect
- Document decision-making thoroughly
- Seek consultation

3.9 Acute Psychosis Management

Recognition:

- Hallucinations (auditory, visual)
- Delusions
- Disorganised thinking or speech
- Grossly disorganised behaviour
- Flat or inappropriate affect
- Paranoia or agitation

Immediate Management:

1. Ensure safety of client and self
2. Remain calm and non-threatening
3. Use simple, clear language
4. Avoid arguing about delusions
5. Assess risk to self and others
6. Assess substance intoxication
7. Assess need for emergency services

Risk Assessment:

- Command hallucinations (especially to harm self/others)
- Paranoid delusions
- Level of insight
- Agitation or aggression
- Ability to care for self

Intervention:

If Client Cooperative and Low Risk:

- Contact psychiatrist (if applicable)
- Involve support system
- Ensure psychiatric follow-up within 24 hours
- Ensure safe environment and supervision
- Medication compliance check

If Client High Risk or Uncooperative:

- Call emergency services (000)
- Do not leave client alone if safe to stay
- Provide information to emergency responders

3.10 Medical Emergencies

Recognition:

- Chest pain
- Difficulty breathing
- Loss of consciousness
- Seizure
- Severe allergic reaction
- Severe injury

Immediate Response:

1. Call 000
2. Follow emergency operator instructions
3. Provide first aid if trained and safe
4. Stay with client
5. Contact emergency contact person
6. Document incident

First Aid:

- Maintain current First Aid certification
- Keep first aid kit accessible and stocked

- Know CPR if certified
- Know location of nearest AED (if applicable)

3.11 Severe Dissociation or Trauma Response

Recognition:

- Disconnection from present
- Flashbacks
- Altered state of consciousness
- Unresponsive to environment
- Panic or freeze response

Grounding Interventions:

1. Speak calmly and gently
2. Use grounding techniques:
   - Orient to present (date, location, safety)
   - 5-4-3-2-1 sensory grounding
   - Physical grounding (feet on floor, holding object)
   - Breathing exercises
3. Do not touch without permission and warning
4. Allow time and space
5. Stay present and supportive

Post-Episode:

- Process experience
- Assess safety
- Identify triggers
- Plan prevention strategies
- Consider trauma-informed treatment

3.12 Domestic and Family Violence

Recognition:

- Physical injuries
- Fear of partner/family member
- Controlling relationship patterns
- Isolation from supports
- Financial control
- Escalating pattern

Immediate Safety Assessment:

- Is client safe to return home today?

- Are children at risk?
- Is there immediate danger?
- Does client have safe place to go?

Intervention:

- Believe and validate client
- Collaboratively engage in safety planning and document this
- Provide information about services
- Offer to call services with/for client
- Respect client autonomy and timing
- Document concerns (separate from client-accessible records if safety concern)

Resources:

- Safe Steps (VIC): 1800 015 188
- 1800RESPECT: 1800 737 732
- Police: 000 (if immediate danger)
- Local family violence service
- Crisis accommodation services

Mandatory Reporting:

- Report if children at risk
- Follow mandatory reporting procedure

3.13 Child Safety Concerns

Recognition:

- Disclosure of abuse or neglect
- Indicators of abuse (physical, sexual, emotional, neglect)
- Concerns about child's safety

Immediate Response:

1. Listen and believe child
2. Do not investigate - not psychologist's role
3. Ensure child's immediate safety
4. Follow mandatory reporting obligations
5. Document carefully and objectively

Mandatory Reporting:

- Report to Child Protection or Police (Victoria)
- Report when form reasonable belief child at risk of significant harm
- Cannot be delegated
- Cannot wait for proof

- Make report immediately

Victoria Contacts:

- Child Protection Crisis Line: 13 12 78 (24/7)
- Police: 000 (if immediate danger)

Documentation:

- Factual, objective observations
- Direct quotes where possible
- Date, time, context
- Actions taken. For NDIS participants: assess whether the matter constitutes an NDIS reportable incident requiring notification to the NDIS Commission within 24 hours
- Store securely

3.14 Documentation Requirements

Emergency documentation must include:

- Date, time, duration of incident
- Presenting situation
- Risk assessment process and findings
- Risk level determination
- All interventions attempted
- Consultation sought
- Client capacity and cooperation
- Family/support involvement
- Emergency services involvement
- Outcome
- Follow-up plan
- Clinical reasoning for all decisions

Timing:

- Document contemporaneously or immediately after
- Do not delay documentation
- Note exact times of key decisions and actions

Storage:

- Secure storage
- Flag file for high-risk client
- Ensure documentation accessible for continuity of care

3.15 Post-Emergency Follow-Up

Immediate Follow-Up (24-48 hours):

- Contact client to check safety
- Confirm follow-up appointments
- Review Safety Plan
- Assess need for any adjustments

Ongoing Monitoring:

- Frequent appointments while risk elevated
- Regular risk reassessment
- Review effectiveness of interventions
- Maintain contact with support system (with consent)
- Coordinate with other providers

Treatment Planning:

- Address underlying issues
- Trauma-informed approach
- Build coping skills
- Strengthen protective factors
- Consider adjunct services (medication, groups, case management)

3.16 Self-Care After Emergencies

Immediate Self-Care:

- Debrief with supervisor or peer
- Take break if needed
- Engage in grounding/calming activities
- Contact professional indemnity insurer if needed

Ongoing Self-Care:

- Process in supervision
- Seek own therapy if vicarious trauma
- Monitor for signs of burnout
- Maintain work-life boundaries
- Access peer support

4. BUSINESS CONTINUITY AND EMERGENCY PREPAREDNESS PROCEDURE

4.1 Purpose

To ensure continuity of client care (including NDIS participant supports) and protection of client information during disruptions, emergencies, or disasters, and to establish protocols for maintaining essential practice functions or safely suspending services. For NDIS participants, service disruption may have significant impacts on wellbeing and support continuity; this procedure addresses the specific obligations to notify support coordinators, plan managers, and the NDIA, and to prioritise participants at highest risk from service discontinuation. This procedure should be read in conjunction with the OHS Policy (Version 3.0, Section 10) which sets out the business continuity framework.

4.2 Scope

This procedure addresses:

- Natural disasters (bushfire, flood, earthquake, severe weather)
- Pandemic or infectious disease outbreaks
- Technology failures and cyber incidents
- Practitioner illness, injury, or incapacity
- Practice location unavailability
- Utility disruptions
- Other unforeseen disruptions

4.3 Core Principles

Client Welfare Priority:

- Client care and safety is primary concern
- Continuity of care maintained where possible
- Clear communication about service disruptions
- Alternative arrangements provided
- Client information protected

Preparedness:

- Proactive planning for potential disruptions
- Regular testing and updating of plans
- Redundancies built into systems

Proportionate Response:

- Response scaled to nature and severity of disruption
- Flexibility to adapt to changing circumstances
- Regular reassessment of situation
- Return to normal operations when safe

Communication:

- Timely communication with clients
- Clear information about service status
- Multiple communication channels
- Regular updates during extended disruptions

4.4 Risk Assessment and Planning

Potential Disruption Scenarios:

High Probability, High Impact:

- Practitioner short-term illness (flu, injury)
- Technology/internet failure
- Extreme weather events
- Pandemic/infectious disease

Low Probability, High Impact:

- Serious practitioner illness or incapacity
- Natural disaster destroying practice location
- Death of practitioner
- Major cyber-attack or data breach

Moderate Probability, Moderate Impact:

- Extended power outage
- Building access issues
- Equipment failure
- Transport disruptions

Planning for Each Scenario:

- Identify triggers for activating plan
- Define essential vs. non-essential functions
- Establish alternative service delivery methods
- Identify resources needed

4.5 Essential Practice Functions

Critical Functions (Must Continue):

- Care for high-risk clients
- Emergency response capability
- Access to client records
- Communication with clients about changes (including notification to NDIS participants' support coordinators and plan managers)
- Protection of client information

- Mandatory reporting obligations

Important Functions (Continue if Possible):

- Scheduled appointments for moderate-risk clients
- New client assessments
- Routine follow-up appointments
- Administrative support
- Billing and payments

Non-Essential Functions (Can Be Suspended):

- Marketing and business development
- Professional development activities
- Non-urgent administrative tasks
- Practice improvement projects

4.6 Communication Systems

Client Communication:

- Ensure current contact details for all clients
- Multiple contact methods for each client
- Nominated emergency contact for each client
- Clear voicemail message directing clients during disruptions

4.7 Alternative Service Delivery

Telehealth Capability:

- Maintain current telehealth technology
- Ensure platform meets Australian privacy legislation requirements (Privacy Act 1988, Health Records Act 2001 (Vic))
- Test regularly
- Keep backup platform available
- Client consent for telehealth in place
- Clear protocols for telehealth delivery

Telephone Support:

- Phone counselling capability
- Structured phone check-ins for high-risk clients
- Crisis support via phone
- Documentation of phone sessions

Extended Disruption Options:

- Reduced schedule maintaining high-risk clients only

- Referral to other providers
- Temporary transfer of care
- Group support arrangements
- Asynchronous support (email, secure messaging within boundaries)

4.8 Information and Records Management

Data Backup:

- **Frequency:** Daily automated backup
- **Location:** Cloud-based secure storage (encrypted)
- **Testing:** Monthly test of backup restoration
- **Redundancy:** Multiple backup locations
- **Access:** Ensure access from any location with internet

Physical Records:

- Fire-proof and water-proof storage
- Secure location
- Duplicate essential documents stored separately
- Digital backup of critical paper records

Remote Access:

- Secure remote access to practice management system
- VPN or secure connection
- Multi-factor authentication
- Access from multiple devices (laptop, tablet)

Technology Redundancies:

- Backup internet connection (mobile hotspot)
- Backup computer/device
- Backup power (battery backup for essential equipment)
- Paper-based backup systems for critical functions

Cloud-Based Systems:

- Practice management software: [Name]
- Video conferencing: [Platform]
- File storage: [System]
- Email: [Provider]
- Ensure all systems accessible remotely

4.9 Financial Continuity

Banking and Payments:

- Online banking access
- Multiple payment options for clients (direct debit, credit card, online transfer)
- Digital invoicing system
- Accounts receivable process can continue remotely

Financial Reserves:

- Maintain 3-6 months operating expenses in reserve
- Access to emergency funds

Revenue Protection:

- Professional indemnity insurance current
- Public liability insurance current
- Business insurance (if applicable)
- Understand insurance coverage for disruptions

4.10 Practitioner Incapacity Planning

Short-Term Incapacity (Days to Weeks):

Planned Absence (Surgery, etc.)

- Give clients advance notice (minimum 2 weeks)
- Reschedule appointments
- Provide crisis contact information
- Arrange colleague coverage for emergencies
- Out-of-office messages activated
- Delegate urgent administrative tasks (if staff)

Unexpected Absence (Sudden Illness, Accident)

- Designated emergency contact person to notify clients
- Template messages prepared
- List of current clients and contacts accessible
- Crisis resources provided to all clients. For NDIS participants, support coordinators and plan managers are notified of the disruption and assisted to arrange alternative supports where needed
- Colleague on standby for true emergencies

Medium-Term Incapacity (Weeks to Months)

- Transfer of care arrangements
- Colleague agreement for temporary case transfer
- Process for providing records to new provider (with consent)
- Ongoing communication with clients
- Plan for return to practice

Long-Term or Permanent Incapacity

- Professional will or succession plan
- Executor or practice closer identified
- Instructions for:
    - Client notification
    - Records transfer
    - Records storage and eventual destruction
    - Financial wind-down
    - Professional obligations completion
- Stored with will or with trusted colleague
- Updated annually

4.11 Pandemic and Infectious Disease Protocols

Triggers for Activation:

- Public health directives
- Government restrictions on face-to-face services
- Significant community transmission
- Practitioner exposure or symptoms
- Client or household member exposure/symptoms

Pandemic Response Plan:

Phase 1: Preparedness

- Monitor public health information
- Review infection control procedures
- Stockpile supplies (masks, sanitiser, cleaning products)
- Ensure telehealth systems functional
- Communicate preparedness to clients

Phase 2: Modified Operations

- Implement infection control measures:
    - Hand hygiene stations
    - Surface cleaning between clients
    - Physical distancing in waiting area
    - Masks if required
    - Health screening questions
    - Ventilation optimisation
- Offer telehealth as alternative
- Reduce waiting room time
- Stagger appointments
- Modify high-risk procedures

Phase 3: Restricted Operations

- Telehealth only for most clients
- Face-to-face only for clients unable to engage via telehealth
- Enhanced infection control for face-to-face
- Reduced schedule if needed

Phase 4: Suspension of Face-to-Face

- All services via telehealth
- Phone support for clients unable to use video
- Regular check-ins with high-risk clients
- Crisis support maintained
- Clear communication about service model

Phase 5: Recovery

- Graduated return to face-to-face
- Maintain telehealth options
- Ongoing infection control
- Client choice of modality
- Review lessons learned

Infection Control Protocols:

- Hand hygiene (practitioner and clients)
- Surface disinfection between clients
- Appropriate PPE when required
- Ventilation and air quality
- Physical distancing where possible
- Health screening
- Stay home if unwell policy

If Practitioner Contracts Illness:

- Cancel appointments immediately
- Notify clients
- Offer telehealth if well enough
- Referral to colleague for urgent needs
- Follow public health isolation requirements
- Regular communication with clients about return

4.12 Natural Disaster Preparedness

Bushfire:

- Monitor fire danger ratings
- Early cancellation of appointments on catastrophic days

- Client notification system
- Evacuation plan
- Emergency kit (go-bag with essential items)
- Backup of all records off-site

Flood:

- Elevate essential equipment and records
- Waterproof storage for critical documents
- Alternative location identified
- Evacuation plan
- Insurance coverage review

Earthquake:

- Secure heavy items and equipment
- Emergency supplies on-hand
- Evacuation procedures
- Post-earthquake safety assessment
- Communications plan

Severe Weather:

- Monitor weather warnings
- Flexible cancellation policy
- Client safety prioritised over appointments
- Indoor safety procedures
- Damage assessment protocols

Post-Disaster Recovery:

- Safety assessment before returning to practice
- Damage documentation for insurance
- Client welfare checks
- Referrals for disaster trauma support
- Graduated return to operations
- Support for clients affected by disaster

4.13 Cyber Security and Technology Disruptions

Prevention:

- Regular software updates
- Strong passwords and multi-factor authentication
- Antivirus and firewall protection
- Encrypted data storage and transmission
- Regular security audits
- Backup and recovery systems tested

Cyber Incident Response:

Detection Indicators:

- Unusual system behaviour
- Unauthorised access alerts
- Missing or encrypted files (ransomware)
- Suspicious emails or messages
- Client reports of suspicious communications

Immediate Actions:

1. Disconnect affected systems from internet
2. Do not pay ransomware demands
3. Document incident
4. Contact IT security professional
5. Notify professional indemnity insurer
6. Assess data breach implications

If Data Breach Suspected:

1. Contain breach
2. Assess extent of breach
3. Notify Office of the Australian Information Commissioner (OAIC) if required
4. Notify affected individuals if required
5. Notify AHPRA. If the breach involves NDIS participant information and may constitute a reportable incident, also notify the NDIS Quality and Safeguards Commission within 24 hours
6. Document all actions
7. Implement remedial measures
8. Review security protocols

Technology Failure Response:

- Switch to backup systems
- Alternative service delivery (phone, different platform)
- Client notification of temporary changes
- IT support engaged promptly
- Document for insurance claim if applicable

4.14 Building or Location Unavailability

Scenarios:

- Building damage
- Utility failure (power, water, HVAC)
- Access restrictions
- Lease termination

- Safety concerns

Immediate Response:

- Assess safety and accessibility
- Cancel appointments if unsafe
- Notify clients promptly
- Activate alternative location
- Switch to telehealth temporarily
- Arrange essential items retrieval if safe

Alternative Arrangements:

- Telehealth for all clients temporarily
- Use of colleague's office space
- Temporary office rental
- Community facility

Extended Unavailability:

- Secure new permanent location
- Professional office space requirements
- Client notification of new location
- Update all practice materials
- Address change notifications (AHPRA, insurance, etc.)

4.15 Practice Activation Protocols

Decision to Activate Plan:

- Assess nature and severity of disruption
- Determine impact on essential functions
- Evaluate safety considerations
- Consider duration of disruption
- Activate appropriate level of response

Activation Levels:

Level 1: Minor Disruption

- Impact: Short-term, minimal service interruption
- Example: Brief internet outage, minor illness
- Response: Use backup systems, reschedule few appointments
- Communication: Individual client contact as needed
- Documentation: Brief note in practice log

Level 2: Moderate Disruption

- Impact: Service modifications required, several days duration
- Example: Extended power outage, moderate illness, severe weather
- Response: Alternative location or modality, affect multiple clients
- Communication: Notify all affected clients, update voicemail/website
- Documentation: Incident log, client notifications, modified procedures

Level 3: Major Disruption

- Impact: Significant service changes, extended duration
- Example: Pandemic restrictions, building unavailability, serious illness
- Response: Comprehensive alternative arrangements, possible temporary suspension
- Communication: All clients notified, multiple channels, regular updates
- Documentation: Full incident response documentation, decision rationale, ongoing tracking

Level 4: Critical Incident

- Impact: Practice closure, indefinite duration
- Example: Death or permanent incapacity, complete practice destruction
- Response: Practice closure procedures, full client transfers
- Communication: Formal notifications, support for transitions
- Documentation: Complete records transfer, legal notifications, final reporting

4.16 Return to Normal Operations

Readiness Assessment:

- Safety verified
- Systems functional and tested
- Resources available
- Practitioner fitness to practice
- Client safety assured

Graduated Return:

- Phased increase in service capacity
- High-risk clients prioritised
- Continued flexibility in modality
- Monitoring for issues
- Regular review of situation

Client Communication:

- Notify clients of return to normal services
- Outline any ongoing changes
- Reschedule appointments
- Offer choice in service modality if applicable

- Check in on client wellbeing during disruption

Debriefing and Review:

- Review response effectiveness
- Identify what worked well
- Identify improvements needed
- Update continuity plan
- Document lessons learned
- Discuss in supervision

4.17 Documentation Requirements

Continuity Plan Documentation:

- Current version of continuity plan
- Contact lists (current)
- Communication templates
- Activation protocols
- Recovery procedures
- Review and update log

During Disruption:

- Incident log (date/time, nature, actions taken)
- Client communications
- Service modifications
- Decisions and rationale
- Consultation sought
- Outcomes and resolution

Post-Disruption:

- Summary report
- Impact assessment
- Response evaluation
- Lessons learned
- Plan updates made
- Review in supervision

4.18 Annual Review Checklist

☐ Review entire continuity plan for currency and relevance
☐ Test all backup systems
☐ Update all contact lists
☐ Review insurance coverage and policy numbers
☐ Test data backup restoration

☐ Review and update communication templates
☐ Assess technology redundancies
☐ Review financial reserves and arrangements
☐ Update professional will/succession plan
☐ Brief emergency contact person on any changes
☐ Review lessons from any disruptions during year
☐ Update plan based on changes to practice
☐ Document review completion and changes made

5. ADVERSE EVENTS MANAGEMENT PROCEDURE

5.1 Purpose

To establish a systematic approach to identifying, reporting, managing, and learning from adverse events (including NDIS reportable incidents) to enhance client safety and continuously improve quality of care. This procedure should be read in conjunction with the Feedback and Complaints Policy (Version 2.0), which contains the complaint-to-incident triage pathway and NDIS reportable incident notification procedures.

5.2 Scope

This procedure applies to all adverse events, near misses, and safety concerns occurring in the provision of psychological services, including events related to:

- Clinical care and treatment
- Communication failures
- Administrative processes
- Physical environment
- Technology and equipment
- Confidentiality breaches

5.3 Definitions

Adverse Event: An incident in which harm resulted to a person receiving health care, including psychological services.

Sentinel Event: An adverse event resulting in death or serious harm (physical or psychological) requiring immediate investigation and response.

Near Miss: An incident that had the potential to cause harm but did not, either by chance or through timely intervention.

Hazard: A situation, condition, or practice that has the potential to cause harm.

Root Cause: The fundamental reason an adverse event occurred - the underlying system failure rather than individual error.

Clinical Deterioration: Worsening of a client's mental health status or functioning.

5.4 Types of Adverse Events in Psychological Practice

Clinical: Suicide attempt, deterioration, harm during treatment, inadequate assessment
Communication: Consent failures, miscommunication, information gaps
Confidentiality: Unauthorised disclosure, privacy breach, lost records
Administrative: Wrong records used, billing errors, missed appointments for high-risk clients
Environmental: Client injury on premises, safety hazards
Professional Conduct: Boundary violations, practicing outside competence, discrimination

5.5 Severity Classification

Level 1 - Near Miss: No harm, potential existed
Level 2 - Minor: Minor temporary harm, minimal intervention
Level 3 - Moderate: Moderate temporary harm, intervention required
Level 4 - Major: Significant harm, substantial intervention, long-term impact
Level 5 - Sentinel: Death or permanent serious harm

5.6 Immediate Response

Sentinel Events (Level 5):

1. Ensure safety of all persons
2. Emergency care if needed
3. Notify emergency services if required
4. Notify professional indemnity insurer immediately
5. Notify AHPRA if mandatory reporting required
6. Do not alter records
7. Seek immediate consultation

Major Events (Level 4):

1. Address safety concerns
2. Provide care and support
3. Notify insurer within 24 hours
4. Document thoroughly
5. Implement corrective actions
6. Seek consultation

Moderate/Minor Events (Levels 1-3):

1. Address immediate concerns
2. Document event

3. Implement improvements
4. Discuss in supervision

5.6 Open Disclosure

When Required: All events causing harm (Levels 2-5)

Process:

1. **Preparation:** Review facts, consult insurer/supervisor, plan discussion
2. **Initial Disclosure (ASAP):** Express regret, provide factual account, acknowledge impact, outline actions
3. **Ongoing Communication:** Updates, answer questions, maintain relationship
4. **Formal Disclosure After Investigation:** Share findings, explain why, outline changes, apologise if below standard

Apology Laws: Victoria - expressions of regret protected from legal use (Wrongs Act 1958, s14I)

5.7 Investigation

Triggers:

- All Level 4-5 events (mandatory)
- Level 3 events (usually)
- Recurrent Level 1-2 events
- Client complaints

Timing:

- Sentinel: Commence immediately, complete in 45 days
- Major: Commence in 48 hours, complete in 30 days
- Moderate: Commence in 1 week, complete in 21 days

Process:

1. **Establish Facts:** Gather information, review records, interview parties, timeline
2. **Identify Contributing Factors:** Client, practitioner, task, environment, system, external factors
3. **Root Cause Analysis:** Ask "Why?" repeatedly to reach system-level issues
4. **Identify Improvements:** For each cause, what can change?
5. **Develop Recommendations:** Specific, measurable, achievable, relevant, time-bound

Hierarchy of Controls:

1. Elimination (most effective)
2. Substitution

3. Engineering
4. Administrative
5. Personal (least effective)

5.8 Action Planning

For Each Recommendation:

- Specific action required
- Person responsible
- Resources needed
- Timeline
- Success measures
- Monitoring method

Prioritisation:

- Immediate (safety-critical): Days
- Short-term (significant impact): 1-3 months
- Long-term (system improvements): 6-12 months

5.9 Monitoring and Review

- **1 Month:** Verify immediate actions, assess effectiveness
- **3 Months:** Evaluate progress, measure outcomes
- **6-12 Months:** Comprehensive evaluation, sustainability check

5.10 External Reporting

- **AHPRA (within 24 hours):** Sexual misconduct, impairment, placing public at risk
- **Professional Indemnity Insurer:** All Level 4-5 events, potential claims
- **OAIC:** Eligible data breaches (serious harm threshold)
- **Coroner:** Client death by suicide, death during/after treatment

5.11 Documentation

- **Adverse Event Report:** Objective facts, contributing factors, immediate actions
- **Investigation Report:** Process, findings, root causes, recommendations, action plan
- **Clinical Records:** Brief factual note if impacts care ("See separate incident file")
- **Adverse Events Register:** De-identified log for trend analysis, quarterly review

5.12 Learning and Prevention

Individual:

- Reflect on each event

- Identify learning needs
- Attend training
- Update practice
- Discuss in supervision

System:

- Identify themes
- Share learnings (de-identified)
- Update policies
- Trend analysis quarterly
- Annual comprehensive review

Prevention Strategies:

- Regular risk screening
- Validated tools
- Clear documentation
- Appropriate consultation
- Stay within competence
- Regular CPD
- Self-care

5.13 Supporting the Practitioner

Adverse events can cause:

- Guilt, shame, self-doubt
- Anxiety, decreased confidence
- Professional isolation

Support:

- Immediate supervision
- Trusted colleagues
- Personal therapy if needed
- Self-compassion
- Practitioner Health programs
- Professional association support

Related Policies and Documents

These procedures should be read in conjunction with the following Behavioural Edge Psychology policies:

- Feedback and Complaints Policy (Version 2.0, February 2026) — including complaint-to-incident triage pathway, NDIS reportable incident procedures, and independent complaints pathway
- Privacy Policy (Version 2.0, February 2026) — including NDIS participant information sharing framework
- OHS Policy (Version 3.0, February 2026) — including infection prevention and control, participant safety, NDIS reportable incidents, and business continuity
- Clinical Governance Policy (Version 2.0, February 2026) — overarching governance framework including NDIS Verification Module mapping
- AI Usage Policy
- NDIS Service Agreements

Document Control

Version: 1.0

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Approved by: Dr Sarah Fischer, MAPS, Principal Psychologist