CHAPTER 4

MANAGEMENT OF HEALTHCARE COMPLIMENTS AND COMPLAINTS WITHIN DEFENCE

INTRODUCTION

4.1 A healthcare compliment and complaints management system is an integral part of dynamic health service delivery. It provides opportunities for health service managers to review and implement improvements to the quality and safety of healthcare provided to members.

4.2 The Australian Defence Force (ADF) Service Chiefs and Surgeon General of the ADF (SGADF) are regularly provided information regarding healthcare compliments and complaints from members as part of the overall commitment to the provision of high quality health services to members.

4.3 While the majority of healthcare compliments and complaints are submitted for a health service from members; commanding officers, managers and health personnel are also able to initiate the process on behalf of a member.

4.4 This chapter should be read in conjunction with Defence Health Manual (DHM) Level 3 Part 1 Chapter 5[25]–'Procedures for the management of healthcare compliments and complaints within Defence', which contains the procedures involved of how to provide guidance for the management of healthcare compliments and complaints.

Aim

4.5 The aim of this chapter is to provide guidance for the management of healthcare compliments and complaints relating to the health services delivered to ADF personnel.

4.6 This chapter is based on the principles outlined in the Complaints and Alternate Resolutions Manual[26] (CARM) which provides the overarching guidance on complaints and alternate resolution in Defence.

Scope

4.7 This policy applies to all health services provided by Defence in any health care environment including off base services, deployments and exercises. It is applicable to both the Service and Headquarters Joint Operations Command (HQJOC) health directorates, and garrison health facilities.

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4.8 This policy does not apply to the management of the following, as these are covered by separate policies:

a. Clinical incidents – it should be noted that clinical incidents may be managed concurrently with a complaint as per DHM Level 2 Part 1 Chapter 3[27]— 'Management of clinical incidents within Defence'

b. professional performance management issues

c. ADF disciplinary matters

d. workplace grievances

e. possible fraud or criminal conduct

f. unacceptable behaviour complaints

g. compiling a Defence incident record (DIR)

h. work health & safety (WH&S) incidents

i. radiation safety incidents.

POLICY

Roles and responsibilities

4.9 Members are able to submit healthcare compliments or complaints relating to healthcare they have experienced. A third party may also provide this feedback on behalf of the member. Investigation of a healthcare complaint submitted by a third party cannot occur without the consent of the member.

4.10 Defence health commanders and managers are to ensure they have a clearly articulated and documented procedure in place for managing healthcare compliments and complaints. This process should include the following steps:

a. receipt and identification

b. assessment and investigation

c. notification and escalation of management and

d. complete reporting and documentation requirements including quality improvement actions in accordance with Service or Joint Health Command (JHC) policy.

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Considerations

4.11 All healthcare compliments and complaints are to be managed in accordance with Defence values, behaviours and resolution principles. These include:

a. being managed in an effective, efficient and timely manner, at the lowest appropriate level, with consideration of all possible avenues

b. all personnel involved will be:

(1) provided appropriate support

(2) made aware of their rights and responsibilities, with open disclosure to occur where relevant

(3) informed about progress of the concerns and advised of any relevant outcomes

(4) accorded protection against unfair repercussions or victimisation

(5) given the right to be heard

(6) entitled to decisions made without bias.

4.12 **Obtaining member's consent/authority.** Investigation of a healthcare complaint will, in most instances, require consent/authority to release information in order to provide or access confidential information. A member's consent is required whenever:

a. the healthcare complaint relates to the treatment received by the patient but the complainant or incident notification is made by a third party eg family member or commanding officer

b. the healthcare complaint is to be referred to an external agency for investigation and resolution.

4.13 A member's chain of command should not be informed of the existence or content of a health care complaint (HCC) unless the member has provided consent to do so.

4.14 A HCC should be managed separately to the provision of clinical care. The fact that members have made a HCC should not be recorded in the e-Health system, unless the member discusses their HCC during a health care consultation.

4.15 Further information on the complaint management process can be found at Australian Health Practitioner Regulation Agency - Checklist for practitioners handling feedback and complaints[28].

[28] https://www.ahpra.gov.au/Resources/Checklist-for-practitioners-handling-feedback-and-complaints.aspx

4.16 **Open disclosure.** As a result of the investigation, open disclosure of the findings with the member (and if appropriate, their support person) may be necessary to ensure a transparent account is provided to the member. Each issue or incident must be assessed individually for the requirement to undertake open disclosure. If open disclosure occurs the member must be kept informed of the progress and outcome of the issue or incident by either verbal or written communication. A record of all communication is to be kept by the person undertaking the open disclosure.

4.17 Health practitioners, members and other individuals have a right of access, and in some cases are mandated to make notifications, to external agencies in relation to complaints. At times, the Defence response to the complaint will be subordinate to, or delayed by, such action. Defence must still provide support to affected members in this situation, including by providing advice on the internal progress of their complaint, and continuing without prejudice, the entitled health care of members.

Summary

4.18 The member's perspective of health service delivery is easily identified when an effective compliment and complaint management system is in operation. The compliment and complaint management system is an integral part of health service delivery as it provides opportunities for review and improvements to healthcare services within Defence.

SPONSOR: Deputy Surgeon General Australian Defence Force

CHAPTER 1

HEALTHCARE COMPLAINT AND CLINICAL INCIDENT MANAGEMENT PROCESS

INTRODUCTION

1.1 This policy is part of a series that details processes to ensure compliance with Defence Health Manual (DHM) Level 2 Part 1 Chapter 4[1]–'Management of healthcare compliments and complaints in Defence'.

Aim

1.2 This policy provides standardised national guidance for managing healthcare complaints and clinical incidents (HCCI) and aims to ensure that the responsibilities and procedures employed in managing HCCI within Garrison Health (GH) facilities are followed.

Scope

1.3 This policy applies to the management of HCCI received by Joint Health Command (JHC) relating to healthcare provided to members in GH facilities (on base) and by off-base service providers.

Note: Any HCCI involving contracted personnel or contracted service providers must follow the detailed guidance provided in DHM Level 3 Part 1 Chapter 2[2]–'Managing health care complaint and clinical incident involving contractors' in conjunction with this policy.

GUIDANCE

Responsibility for compliance

1.4 This policy shall be used by all personnel in GH facilities. Commanding officers of Joint Health Units (CO JHU), health governance managers (HGM), regional medical advisors (RMA), and health centre managers (HCM) are responsible to ensure that this policy is complied with.

PROCEDURE

1.5 This policy provides guidance on the:

a. identification, notification and acknowledgement of a HCCI

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b. risk assessment

c. recording details of the HCCI into the JHC endorsed management system (DHM Level 3 Part 1 Chapter 9[3]–'Performance outcomes management system')

d. investigation as required, indicated by the severity of the HCCI

e. analysis of the findings

f. recommendations for remedial action

g. implementation of remedial actions

h. evaluation and on-going monitoring

i. communication of outcomes.

Identification, notification and acknowledgement of healthcare complaints and clinical incidents

1.6 When a HCCI involving a member is identified or received, the HCM is to be advised. Identification and notification of a HCCI is detailed below.

1.7 An essential component of the complaint process is to acknowledge the occurrence of the issue/event to the member (and if appropriate, their support person), and to inform them of how the complaint will be managed.

1.8 Some clinical incidents will also require open disclosure and discussion of the issue/event with the member (and if appropriate, their support person). In this event the member will require follow up of the outcome of the incident.

1.9 The HCM must be advised within two hours following receipt of any HCCI during business hours. The HCM is responsible for recording details of a HCCI received into the JHC endorsed management system (DHM Level 3 Part 1 Chapter 21).

Healthcare complaints

1.10 Healthcare complaints may be received verbally or in writing. General guidance for responding to a complainant directly is provided in Annex 1A. All staff must be educated during their induction and orientation to the health facility on the correct procedure for responding to a complaint and initiating the complaint management process.

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1.11 If a verbal complaint is received, the staff member must:

a. listen to the perspective of the member

b. offer an acknowledgement of their experience and thank them for raising the issue

c. provide an explanation of details surrounding the event if information is available eg an appointment time was not kept due to the doctor being called to an urgent matter

d. determine the member's desired outcomes to their complaint

e. notify the HCM so that it can be documented in the JHC endorsed management system.

1.12 If the member is dissatisfied with the staff member's initial response (verified by asking if they are satisfied), or the resolution requires action that is beyond the responsibility of the staff concerned, refer them to the HCM.

1.13 If a complaint is unable to be resolved quickly, or at the point of health service delivery, the member should be encouraged to make a written complaint using Form AD092–'Healthcare compliment, feedback or complaint'.

1.14 If a written complaint is received, the staff member must forward it to the HCM.

1.15 The HCM or delegate must acknowledge receipt of the healthcare complaint in writing within seven calendar days. Annex 1B provides a template for acknowledging receipt of a complaint. The member must be contacted, either by phone or face to face, within fourteen calendar days of the complaint. This is to confirm the details and seek any further information needed to manage the complaint.

1.16 The member must be regularly informed (monthly) of the progress and the final outcome of their complaint. Annex 1C provides a template for reporting the progress or final outcome of a complaint. If a verbal complaint response is provided it must be followed up with a written summary to the member (eg email) noting the key points discussed and the response stored in Objective.

1.17 A member has the right to lodge complaints directly with external agencies, such as the Australian Human Rights Commission, the Office of the Australian Information Commissioner, the Commonwealth and Defence Force Ombudsman, Inspector General of the Australian Defence Force and relevant state and territory health practitioner regulation and health complaints agencies. If a member accesses an external agency, they must be advised that JHC will usually await the outcome of the external agency's inquiries and/or investigation before finally resolving the complaint.

1.18 When a complaint received by JHC has multiple issues that involve other commands or Service units, the complaint must continue to be managed by JHC. The HCM or JHC delegate responsible for managing the complaint must:

a. communicate in writing to the member advising them of how the complaint will be managed

b. advise the relevant command or unit and request an investigation and response to the issue/s identified

Healthcare Clinical Incidents

1.19 Clinical incidents may be identified by staff at the point of health service delivery; or as a result of an adverse outcome experienced by a recipient of healthcare. Once a healthcare clinical incident has been identified, the staff member must record the incident on Form AD441–'Health incident (CI) report' and forward it to the HCM.

Risk assessment

1.20 The severity or seriousness of the HCCI is assessed by the person receiving the complaint or recognising the clinical incident, in conjunction with the responsible HCM. The Defence health care severity assessment code (SAC) is the tool used to assess the risk of a HCCI and applies a numerical score based on the consequence or outcome and its likelihood of recurrence. The Defence Health care SAC matrix is in Annex C of DHM Level 2 Part 1 Chapter 3[4]–'Management of clinical incidents within Defence'.

1.21 In assessing the HCCI, the following must be considered:

a. Ensure that the HCCI is within the scope of this policy for management (eg not a complaint about a service outside the jurisdiction of JHC, not a workplace complaint/grievance, workplace health and safety issue, disciplinary or criminal matter)

b. Who are the relevant parties involved?

c. What are the key issues for management?

d. Is referral to higher authority required?

1.22 The SAC score is completed in the initial assessment phase, however, as more information is made available and any other relevant staff are consulted, the SAC score can be amended by the HCM to reflect the reassessment.

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1.23 A HCCI initially assessed as a SAC 1 or 2 event must be referred by the HCM to the RMA for a review of the score. If the RMA confirms the event as a SAC 1 or 2, the CO JHU must be advised. The CO JHU will escalate via their chain of command as per paragraph 26 of this policy.

1.24 SAC 1 or 2 clinical incidents are investigated in accordance with the JHC Clinical Review guidelines contained in DHM Level 3 Part 1 Chapter 3[5]–'Clinical review process'. A clinical review is required to analyse the incident and recommends key actions to minimise the risk of recurrence. Clinical reviews must be conducted in a timely manner by a multidisciplinary team nominated by the initiating authority.

1.25 Referral of a HCCI to the CO JHU for further assessment and management. It is acknowledged that certain HCCI may be unsuitable for management at the point of service delivery or if the HCCI is assessed as a SAC 1 or 2 event. These HCCI must be referred to the CO JHU or delegate for consideration and appropriate management. The RMA should be consulted in assessing the SAC of the HCCI in order to provide clinical technical advice and guidance. Cases likely to fall into this category include, but are not limited to:

a. allegation or indication of clinical incompetence

b. allegation or indication of professional negligence or misconduct

c. a HCCI that involves complex medical issues or a number of different staff from within the organisation that requires higher level management

d. allegations involving areas that may be under the direct control of the individual who receives the complaint

e. an identified cluster of clinical incidents

1.26 Reporting SAC 1 and 2 events. The following actions are required:

a. email notification by the CO JHU to Director of National Operations (DNO) and cc the Director of Clinical Services (DCS) by COB of the next working day after becoming aware of the incident

b. The CO JHU is to direct an initial fact finding be conducted in order to prepare and submit a brief for Director General Garrison Health (DGGH) within five calendar days of becoming aware of the event. The brief is to be cleared through DNO.

c. DNO in consultation with DCS will recommend further action in relation to the HCCI reported. This could include direction to the CO JHU to undertake a fact-finding or include on the brief to DGGH the recommendation that a

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clinical review be undertaken. In some instances, no further action may be required.

d. Interim actions can be implemented to reduce any immediate risk to staff or a member pending further direction from DGGH after the brief has been submitted.

1.27 **External Referrals.** Some complaints may require referral to an external agency for investigation and resolution. The relevant CO JHU in consultation with DNO and DCS will determine if a referral to an external agency is recommended. In some cases, the decision to refer to an external agency may need to be made by the Commander Joint Health (CJHLTH). In this event, a brief is to be sent through DGGH to CJHLTH seeking a decision to refer to an external agency. Examples of external agencies that may be referred issues include, but are not limited to:

a. another command

b. the Service

c. an external service provider

d. a contractor

e. the Human Rights Commission

f. the Commonwealth/Defence Force Ombudsman

g. the Inspector General of the Australian Defence Force

h. the civilian Police

i. Australian Health Practitioner Regulation Authority.

Investigation and information gathering

1.28 Once a HCCI has been determined appropriate for JHC management, an investigation should commence immediately.

1.29 Investigation and information gathering includes:

a. **Obtaining member's consent/authority.** In the following instances, consent to release information is required in order to provide confidential information to a third party. A member's consent is required whenever:

(1) the healthcare complaint or incident relates to the treatment received by the patient but the complainant or incident notification is made by a third party eg family member or Commanding Officer

(2) the healthcare complaint or incident investigation requires information from outside JHC Garrison Health

(3) the healthcare complaint or incident is to be referred to an external agency for investigation and resolution.

b. **Determine the issues.** Determine the issues by asking who, what, where, when, why, and how

c. **Information collection.** All HCCI require an initial review of the known facts in order to determine what has happened and what course of action is required. Information collection could involve some or all of the following actions:

(1) talking with the individual making the complaint or notification

(2) talking with the health facility staff and ensuring relevant stakeholders are consulted about the triggering event (whilst protecting the confidentiality of those involved)

(3) assessment of known facts to determine the chronology of events and whether faults or deficits exist in the current clinical systems

(4) talking with any witnesses, if relevant

(5) reviewing relevant documentation, such as clinical records, relating to the triggering event

(6) undertaking a formal fact finding if directed by the CO JHU or DNO

(7) undertaking a clinical review (if directed) as described in DHM Level 3 Part 1 Chapter 3.

1.30 In the event that a healthcare complaint or report of a clinical incident is provided anonymously, or consent/authority is not given, the member or informant must be advised of the limitations in managing and resolving the issue.

Analysis of findings

1.31 Analysis of a HCCI assists in determining how and why an event occurred, and identifying ways to prevent recurrence. The analysis takes into account all information gathered during the investigation. The analysis informs the development of recommendations.

1.32 Causative factors will generally fall into six key categories:

a. human factors – communications

b. human factors – training

c. human factors – fatigue/scheduling

d. environment/equipment

e. rules/policies/procedures

f. barriers.

Recommendations, implementation and reporting

1.33 Recommendations must be specific, appropriate and achievable. Each recommendation must have an individual nominated as responsible for implementation, and a realistic timeframe to achieve implementation. The impact of the action must be measurable. Recommendations that cannot be implemented should be reported to the CO JHU.

1.34 The HCM will advise the CO JHU to request acceptance, approval and appropriate resource allocation to implement recommendations.

1.35 Feedback of the findings and recommendations to relevant staff involved in a HCCI is an opportunity to provide education and improve clinical practice. Involving the relevant staff in implementing the recommended improvements ensures staff are engaged in clinical practice review and helps to identify the strengths and weaknesses of health service delivery.

Resolution and outcomes

1.36 Completion of the HCCI management process should occur within 30 calendar days of a SAC 3 or 4 event occurrence. Timeframe for completion of a SAC 1 or 2 event is variable depending on the follow up action required. Monitoring and follow up of higher level SAC 1 or 2 incidents needs to occur every 30 calendar days at JHU level.

1.37 Resolution may include one or more of the following, but is not limited to:

a. an apology – this is not an admission of liability but an acknowledgement of the member's concerns. Any written apology needs to be carefully worded to minimise the risk of it being construed as an admission of liability

b. an undertaking to review processes and to minimise the risk of recurrence

c. a recommendation for policy review

d. recognition of the requirement for staff education

e. review of workforce care delivery models

f. undertaking a formal clinical review of events relevant to the HCCI

g. a recommendation that no further action is required.

1.38 Resolving a HCCI is an opportunity to improve healthcare and service delivery. Once all relevant information is collected, options for resolution/closure should be discussed with staff, the member, or the person reporting the HCCI.

1.39 Ensure that the outcome is documented in the JHC endorsed HCCI management system; any corrective action recommendations to improve health service should then be integrated into a health facility/regional quality management system.

1.40 Ensure that the outcome is clearly communicated to the member and any staff involved in the HCCI. A healthcare complaint can be finalised by writing a formal letter to the member. The letter of response should clearly articulate the process applied to management of the complaint, including the outcomes. Annex 1C provides a template for reporting the progress or final outcome of a complaint.

1.41 A formal meeting may be required to provide information on the outcomes of the investigation to the member (and their support person if requested). Information provided is to be factual and use language that is easily understood.

1.42 On completion of a HCCI the following must occur:

a. the resolution or outcomes of the investigation is recorded in the JHC endorsed HCCI management system

b. any actions and recommendations formulated in achieving an agreed resolution should be implemented where possible

c. record the actions taken and effectiveness of the outcomes in the Continuous Improvement Activity (CIA) Register[6].

Evaluation and monitoring

1.43 **Healthcare complaints and clinical incidents management review meetings.** These meetings are the key forum for regular reviews and comprehensive management of HCCIs. Meetings are conducted at the regional level through two separate meetings:

a. HCCIs that relate to or are impacted by the ADF Health Services contract only

b. all other HCCIs not related to the contract.

1.44 The JHU Quality Managers must monitor and report the outcomes from all health facilities within their region on a monthly basis to the CO JHU. A report should be provided to the CO JHU. HGMs are available to provide advice and technical support to JHU staff in regards to HCCI Management.

1.45 The HCCI report is reviewed at JHU or facility level, HCCI review meetings on a monthly basis. An aggregated report from each JHU is to be provided to the Garrison Health Clinical Incident and Complaint Review Committee tri- annually that includes the data for the last reporting period and highlights any trends and issues of concern. This committee is a subordinate committee of the Garrison Health Clinical Governance Board.

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Key Contact

Directorate Contact details

Clinical Governance Manager
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Records control – distribution and retention

1.46 All completed documentation including reports, briefs, clinical review findings, and recommended actions, as relevant to the healthcare complaint or clinical incident must be retained as electronic copies, marked with the appropriate dissemination-limiting marker, in an appropriate file on Objective.

SPONSOR: Director General Garrison Health

Annexes:
1A Ready reference for responding to a complaint
1B Template – Receipt of healthcare complaint
1C Template – Report on healthcare complaint

ANNEX 1A

READY REFERENCE FOR RESPONDING TO A COMPLAINT

The following guidelines are aimed to assist staff in how to deal with complaints made to them or about them and the health service provided[7].

RESOLVING COMPLAINTS

It is generally recommended to deal with complaints directly when they occur and try to resolve them locally with the person that complains. Inform the individual about how you will manage their complaint. Responding appropriately to a complaint can restore trust and prevent a minor grievance escalating.

Why do people complain? Many people have high expectations about treatments and about health service providers.

People complain because:

- they want an acknowledgement that something went wrong and an explanation of why
- they want an apology for the distress they experienced
- they do not want to see other people facing a similar problem
- they want to improve the service for themselves or others in the future
- they want someone to be blamed, punished or held accountable for what happened
- they want compensation.

It is important to keep in mind that people generally complain because they are dissatisfied. A complaint can be an opportunity to increase understanding of the patient's perspective. It can also help to improve the service that you offer.

Please remember that the person making the complaint may have found it quite distressing to do so and may have had difficulties in putting their experiences down on paper.

In the vast majority of situations people make a complaint because they genuinely believe that something went wrong. Only very few people complain just to cause trouble.

Who is telling the truth? 'Who is telling the truth' may not be relevant in cases where communication and perceptions are the main issues. Where there are differing

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7 https://www.hccc.nsw.gov.au/health-providers

accounts or points of view, it is important to acknowledge this without dismissing the complainant's or respondent's point of view.

Perceived cover-up. Many complainants believe that all incidents/conversations are on record, so if there is no record then they may believe there has been a tampering with the records or there is a cover-up.

Many complainants have a concern that their point of view will not be listened to and that the staff will 'defend each other' and stick together.

Reassure the complainant. People who make complaints are often worried that there will be some kind of negative consequences for their ongoing care.

It is important to offer reassurance throughout the complaints process that this is not the case. Make sure that the person will not be discriminated against or victimised as a result of making a complaint, and the fact of making a complaint will not affect the person's treatment.

Offer reassurance that the complaint will be kept confidential, and that there will not be a reference to the complaint in the complainant's Defence health record (DHR), unless they want that to happen.

If the complaint is about one of your staff

- Listen to the staff member's point of view and be aware of conflicts of interest.
- If you are the manager of the staff you are very likely to want to support the staff member by believing them/taking their side/accepting their point of view.
- Assist the staff member to acknowledge the complainant's point of view.
- If possible, separate the support of the staff member and the complaint handling mechanism.

Complainant's rights/entitlements. Complainants are to be advised of their entitlements, including options to pursue complaints through other avenues.

GENERAL COMPLAINT RESPONSE PRINCIPLES

The following guidelines provide some tips on how to best manage complaints at an early stage.

Tips for responding to a complaint

- Acknowledge the complaint.
- Try to resolve the complaint directly with the complainant.
- Be aware of differing views of what happened and what was said.
- Reassure the complainant.

- Have a complaint handling mechanism already in place.
- Avoid becoming defensive (including body language).

Timeliness

Respond as soon as possible to complaints, even if it is just to explain the process and give a commitment to a certain timeframe.

- Stick to the timeframe given.
- Keep the complainant informed.
- Give the reasons for any delay.

Every complaint is different, so the approach to resolving it will differ depending on:

- the nature of the complaint (the seriousness and the complexity).
- the complainant's wishes.
- the issues the complaint raises.
- how the complaint came to you.

Acknowledge the complaint

- When people get a response to their complaint, they often see this as a sign that their concerns are being taken seriously.
- Acknowledge their concerns and experiences, and take responsibility for what happened. Often the complaint may well be on the way to being resolved.
- It is important to give the person a clear time frame in which the complaint will be addressed and contact details of the person responsible.
- It can be helpful to outline the plan of action in investigating and responding to the complaint.

Try to resolve the complaint directly with the complainant

- Wherever possible, invite the person who made the complaint to talk directly. It is important to clarify the issues and the desired outcomes.
- The reason for a person's complaint may not always be clear in the written version. Most complainants greatly value the opportunity to talk about what happened and to tell their point of view and this can be also useful in guiding your response.
- If the matter can be resolved immediately, then a written response can follow to confirm the agreed action.

Be aware of differing views of what happened and was said. Many complaints involve issues with communication. Patient and provider can have different perceptions and understandings about what happened and what was said. Reasons for this may be that:

- a person with a health problem is in a vulnerable situation.
- health service providers assume that their information or explanation has been clear when in fact the patient or the patient's family may not have understood it.
- The person has been given conflicting information from other people. This may be from other treatment providers or media reports or general opinions from others.

Remember

- Try not to be defensive.
- Acknowledge the distress of the complainant.
- Apologise if appropriate, but in any event be sympathetic.
- Acknowledge any errors that did occur.
- Try to understand the situation from the complainant's perspective.
- Find out what will assist the complainant to resolve the matter and their preferred options for resolution, for example, a written response, a phone discussion, changes in policy or procedure, a meeting.
- Avoid official or technical language, jargon and clichés.
- Consider cultural background and the possible use of interpreters.

GUIDELINES FOR A WRITTEN RESPONSE TO A COMPLAINT

Address all aspects of the complaint. Provide a full response so that important issues are answered and the complainant can see that the complaint has been taken seriously. Explain the process of investigation. Acknowledge areas of disagreement or varying accounts without dismissing what the complainant has said.

- Acknowledge that voicing concerns is appreciated.
- Acknowledge the distress and the person's experience.
- Say what has been done to investigate the complaint.
- State what has been done/could be done to address the concerns.
- Mention any changes or action taken or that are being considered as a result of the complaint.

- Offer an opportunity to discuss further, with choice of options (meeting, telephone, written).

ANNEX 1B

TEMPLATE – RECEIPT OF HEALTHCARE COMPLAINT

Figure 1B–1: Receipt of healthcare complaint template

JOINT HEALTH COMMAND

Objective File Reference

insert Facility Address

Name
Address

Dear *insert name*

RECEIPT OF HEALTH CARE COMPLAINT - DATED dd mth yy

Thank you for taking the time to raise your concerns on (insert date) regarding xxxx.

Your complaint will be reviewed and assessed by xxxxx (name and position). You will be advised of the progress of your complaint or the outcome within one month from the date of receipt of your complaint by Joint Health Command, and every month thereafter until satisfactory resolution.

Should you require any further information, please contact xxxx.

Yours sincerely

Signature

NAME
Rank (if applicable)
Position
Organisation

Address
Tel
Email

Month Year (Leave 1 cm Tab space, so that date numerals can be hand written, month is written in full)

ANNEX 1C

TEMPLATE – REPORT ON HEALTHCARE COMPLAINT

Figure 1C–1: Report of healthcare complaint template

JOINT HEALTH COMMAND

Objective File Reference

insert Facility Address

Name
Address

Dear *insert name*

REPORT ON HEALTH CARE COMPLAINT

I write in response to your complaint dated dd mth yy concerning xxxx. You indicated that your desired outcome was xxxx.

Outline the investigation and findings.

State what is being done to address their concerns.

Thank you for taking the time to bring this event to our attention. Should you wish to discuss this any further please contact xxxx.

Yours sincerely

Signature

NAME
Rank (if applicable)
Position
Organisation

Address
Tel
Email

Month Year (Leave 1 cm Tab space, so that date numerals can be hand written, month is written in full)

CHAPTER 2

MANAGING HEALTHCARE COMPLAINT AND CLINICAL INCIDENT MANAGEMENT INVOLVING CONTRACTORS

INTRODUCTION

2.1 Where healthcare complaints and clinical incidents (HCCI) involve contracted personnel or contracted service providers, Joint Health Command (JHC) remains responsible for managing the HCCI; however, the Australian Defence Force Health Services (ADFHS) prime contractor and their contracted personnel and service providers will be involved in the investigation and management of the HCCI.

2.2 Defence Health Manual (DHM) Level 3 Part 1 Chapter 1[8]—'Healthcare complaint and clinical incident management process' provides the JHC processes for managing HCCI in garrison health facilities. This chapter provides the additional requirements for managing HCCI involving contracted health personnel and service providers.

GUIDANCE

PROCEDURE

2.3 Health centre managers (HCMs) are responsible for managing HCCI and notifying the relevant regional health governance manager (HGM) of any HCCI involving contracted personnel or service providers. The HGM is to notify the ADFHS prime contractor of the HCCI via the electronic file transfer management system by the end of the business day following the incident.

2.4 For HCCI that are severity assessment code (SAC) 1 or 2:

a. HCM are to complete Form AD441—'Health incident (CI) report' and verbally notify the relevant commanding officer (CO) of the joint health unit (JHU) within two hours

b. JHU CO are to inform relevant regional medical advisor (RMA) within two hours of being notified. Once the SAC 1 or 2 has been confirmed, JHU CO must complete commanders critical information requirement (CCIR) notification process to Director General Garrison Health (DGGH) and verbally inform ADFHS contract (ADFHCS) regional partner manager

c. Regional medical advisers (RMAs) are to inform the Director Strategic Clinical Governance and Clinical Services DCG&CS and ADFHSC senior clinical advisor within two hours of being notified.

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2.5 CO JHU is to submit a brief for DGGH (via Director National Operations (DNO)) within 72 hours of the HCCI using the standard HCCI brief template[9].

2.6 The JHC performance outcomes management system (POMS) provides the template for the written notification of HCCI. The completed complaints and clinical incident management (CCIM) template is to be sent to the ADFHS prime contractor via the electronic file transfer management system. The ADFHS prime contractor will provide written receipt of the notification.

2.7 Commonwealth representatives and clinical governance personnel from the ADFHS prime contractor are to review and monitor the progress of HCCI management via CCIM. Where practicable, written feedback on the HCCI outcomes and corrective actions should be provided to the member and relevant health personnel.

RECORDKEEPING

2.8 HCCI management is to be documented in POMS as per DHM Level 3 Part 1 Chapter 9[10]—'Performance outcomes management system'. Once any issues have been resolved, the relevant outcomes, corrective actions and recommendations are to be recorded in POMS and the HCCI is to be closed.

2.9 All quality improvements and actions are to be recorded in continuous improvement activity register Pages - CIA Home[11].

2.10 All documentation relevant to the HCCI must be marked with the appropriate dissemination limiting marker and filed within Objective.

CONSENT FOR ACCESS TO HEALTH INFORMATION

2.11 If the ADFHS prime contractor, their sub-contractors or service providers may require access to sensitive information relevant to an HCCI investigation, then the following is to occur:

a. If the member submitted Form AD092—'Healthcare compliment, feedback or complaint', then (unless otherwise specified by the member) consent for the release of health information has been provided

b. If the member has not submitted a Form AD092, then member consent is required before releasing health information to the prime contractor or their sub-contractors

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c. Clinical incidents are recorded via Form AD441 in accordance with DHM Level 2 Part 1 Chapter 3[12]—'Management of clinical incidents in Defence'.

2.12 A copy of the form or other written consent is to be sent to the ADFHS prime contractor via the electronic file transfer management system.

2.13 For anonymous HCCI or where consent is not given, the HCM is to advise the member or informant of the limitations in managing and resolving the HCCI. In some instances de-identified information can be supplied to the prime contractor or sub-contractor for the purpose of investigating HCCI.

Timeframes

2.14 1.14 HCCI involving contractors are to be managed in accordance with DHM Level 2 Part 1 Chapter 4[13]—'Management of healthcare compliments and complaints within Defence'.

SPONSOR: Director General Garrison Health

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CHAPTER 5

PROCEDURES FOR THE MANAGEMENT OF HEALTHCARE COMPLIMENTS AND COMPLAINTS WITHIN DEFENCE

INTRODUCTION

5.1 A healthcare compliment and complaints management system is an integral part of dynamic health service delivery. It provides opportunities for health service managers to review and implement improvements to the quality and safety of healthcare provided to members.

5.2 This Chapter should be read in conjunction with the principles of Defence Health Manual (DHM) Level 2 Part 1 Chapter 4[29]–'Management of healthcare compliments and complaints within Defence'. That contains the policies involved in providing guidance for the management of healthcare compliments and complaints.

Aim

5.3 The aim of this chapter is to provide guidance for the management of healthcare compliments and complaints relating to the health services delivered to the Australian Defence Force (ADF) personnel.

5.4 This chapter is based on the principles outlined in the Complaints and Alternate Resolutions Manual[30] that provides the overarching guidance on Complaints and Alternate Resolution in Defence.

GUIDANCE

Receipt of healthcare compliments and complaints

5.5 Healthcare compliments and complaints may be raised and received in many formats including:

a. verbally - face to face or via telephone

b. through surveys

c. written correspondence

(1) email

(2) letter or

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(3) Form AD092—‘Healthcare compliment, feedback or complaint’.

Healthcare compliments

5.6 When a healthcare compliment is received, it is good practice to acknowledge and provide feedback to relevant personnel in recognition of the good work they have done. This data can be used by the commanding officers (CO) or health centre managers (HCM) to identify and support applications for staff to be formally recognised for good conduct or service provision.

5.7 Defence health facilities are to keep a database of compliments received to be able to analyse and report positive trends and other relevant information on compliments received to relevant staff and managers.

Healthcare complaints

5.8 Members (members) who want to make a healthcare complaint should be encouraged to do this directly with the relevant healthcare provider and/or health facility involved. Every attempt should be made to address the concern at the point of service delivery.

5.9 Essential components of the healthcare complaint management process are: acknowledge the occurrence, clarify the issue(s) raised, inform the member the complaint is being managed and, as soon as possible, and advise the outcome to all relevant parties.

Assessment and investigation

5.10 When assessing a healthcare complaint, the following must be considered:

a. Where a healthcare complaint involves more than one jurisdiction, one health service is to be nominated with responsibility of coordinating management of the complaint. Discrete elements of the complaint are to be investigated, with a response provided to the managing health service provided prior to the member receiving a consolidated response.

b. All stakeholders must receive and clear a draft of the consolidated response prior to release to the member.

c. Ensure that the healthcare complaint is within the scope of this policy for management. For example, the complaint is not:

(1) related to a service outside the jurisdiction of Defence eg if the member seeks their own medical care outside of the Defence health system

(2) a performance management related issue

(3) a workplace complaint/grievance

(4) Workplace Health & Safety event

(5) a disciplinary or criminal matter.

d. identification of the relevant individuals and health service involved

e. identification of the key issues for management

f. follow up and recommended quality improvement actions and

g. establish if referral to a higher authority is required.

5.11 An initial risk assessment of the issue(s) should be completed. Reassessment may occur as more information becomes available and relevant personnel are consulted.

5.12 The person receiving the healthcare complaint should assess its severity and seriousness in the first instance. This is necessary to prioritise resolution and investigation. The Defence severity assessment code (SAC) is a standardised tool used by Defence health facilities and is designed to assess the level of risk or harm to the member, based on the consequence or outcome, including likelihood of recurrence. The tool uses a risk matrix and applies a numerical score consisting of four risk categories. A copy of the tool is included in Annex 5A. Managing complaints that constitute a clinical incident should be prioritised.

5.13 At all times, healthcare complaints that have a work health and safety component which potentially or actually injures a worker or visitor must be reported via Sentinel. This requires dual reporting and management as the healthcare complaint is managed separately to the work health and safety component of the event.

5.14 The investigation of a healthcare complaint should include:

a. collection of facts: who was involved, what occurred, where it occurred, when it occurred and why it occurred

b. determination of the key issue(s)

c. whether referral or mandatory reporting to regulatory agencies is required

d. determine the desired outcome(s) of the member

e. a recommended course of action and quality initiatives to address identified issues.

Notification and escalation

5.15 Where matters are straightforward and/or can be resolved immediately, they should be managed at the point of service. Health personnel responsible for the clinical governance of the unit should be notified of the incident and outcome as soon as practicable for reporting purposes. This will be the Joint Health Command (JHC) Garrison Health facility manager or senior health officer of a Service or Headquarters Joint Operations Command (HQJOC) health directorate.

5.16 If a healthcare complaint is assessed as having severe or serious outcome (SAC 1 or 2), the event requires reporting to the applicable Service or HQJOC health directorate or JHC within 24 hours or as soon as is practicably possible.

5.17 Once a healthcare complaint is assessed as serious and/or complex requiring management at a higher level, escalation of the issue is required. The health facility manager, senior health officer of a Service or HQJOC health directorate must refer the issue to:

a. the CO of the Joint Health Unit (JHU) and the senior medical advisor (SMA) in garrison facilities

b. the Director of the Service health directorates and/or

c. the relevant HQJOC health directorate.

5.18 In the event that a healthcare complaint is assessed to be serious in nature the senior health commander or manager of a health unit must ensure a Defence Incident Report (DIR) is completed in accordance with Incident Reporting[31]. This action will enable the salient points of the complaint to be established in the shortest possible time frame and provide an indication for the way ahead. On completion and review of the DIR the senior health commander or manager is responsible for determining the next course of action.

Timeframes

5.19 When managing and resolving healthcare complaints received, the following timings are recommended from receipt of the complaint:

a. seven calendar days: acknowledge receipt of the complaint submission.

b. 14 calendar days: contact the complainant to confirm the details and seek any further information needed to manage the complaint.

c. 30 calendar days: investigate, resolve and advise the member of the final outcome of the complaint of the complaint.

d. if resolution cannot occur within 30 calendar days due to the complexity of the healthcare complaint, progress monitoring and follow update reports must occur every 30 calendar days until completion. The member must be informed regularly of the progress of the complaint investigation

e. once resolution is reached and the corrective actions completed and outcomes recorded, the healthcare complaint must be recorded as closed in the relevant database.

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Recording, reporting and implementation of quality improvement activities

5.20 All complaints must be recorded, even if informal or minor. Recording and reporting of healthcare date enables aggregation and analysis which can support in identifying trends and developing recommendations to prevent recurrence. Trends may indicate requirement for further action, and process and/or system improvements.

5.21 Defence health facilities must document and report the outcomes and recommendations following the investigation of a complaint. Relevant clinical details regarding to healthcare complaints should also be recorded in the member's Defence health record (DHR).

5.22 Recommended corrective actions should be specific and achievable, and nominate an individual to manage the implementation and follow-up reporting. All personnel involved should receive feedback and findings following complaint resolution. Ensure Technical Authorities responsible for policy and procedures are consulted prior to recommendations being made.

5.23 Services and HQJOC health directorates should maintain an active database, managed by their units, which records all health care complaints. Annex 5B provides an example of information required for reporting purposes. Examples of categories of healthcare compliments and complaints can be found in of DHM Level 2 Part 1 Chapter 3[32]–'Management of clinical incidents within Defence', Annex 3D.

5.24 The Surgeon General Australian Defence Force (SGADF) as the Chair of the ADF Health Quality and Safety Committee should receive a quarterly report from the Services and HQJOC health directorates detailing the number and severity of healthcare complaints, identified trends, and corrective actions taken.

5.25 Garrison health facilities are required to record the management and outcomes of all complaints in the JHC endorsed management system, and include a consolidated report and analysis of healthcare complaints in the JHC performance indicator report (PIR).

Escalation and referral

5.26 Where a complainant is dissatisfied with the outcome of a healthcare complaint, they may seek resolution through:

a. escalation up through the relevant ADF health technical chain of command

b. a Redress of Grievance

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c. seeking legal assistance.

5.27 If the complaint has been referred to an external agency, the Defence health element managing the healthcare complaint must continue the process until resolution or closure is achieved.

Related documents and readings

Complaints and Alternate Resolutions Manual

Incident Reporting

DHM Level 3 Part 1 Chapter 1[33]–'Healthcare complaint and clinical incident management process'

DHM Level 3 Part 1 Chapter 2[34]–'Managing health care complaint and clinical incident involving contractors'

Form AD092

Form AD441—'Health incident report'

NSW Health Incident Management Policy[35]

Australian Commission on Safety and Quality in Healthcare Australian Open Disclosure Framework[36]

SPONSOR: Director General Garrison Health

Annexes:
5A Defence healthcare severity assessment code
5B Information guide for reporting

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[35] https://www.health.nsw.gov.au/legislation/Pages/incident-management-complaints.aspx

[36] https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework

ANNEX 5A

DEFENCE HEALTHCARE SEVERITY ASSESSMENT CODE

Figure 6A5A–1: Consequences table

Defence Healthcare Severity Assessment Code (SAC)

STEP 1 - Consequences Table (For notification purposes, consider the **actual consequence or outcome** using this table as a guide. The examples listed here are not exhaustive.) The dot point lists provide added guidance, however all JHC facilities will assess the consequence of the incident using the **descriptors** provided.

Analyse all incidents against ACTUAL and POTENTIAL outcomes				
Serious	**Major**	**Moderate**	**Minor**	**Minimal**
Patient/member **death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or any of the following: • Suicide of a patient/member known to an ADF mental health service within 7 days of contact with the service or during an inpatient episode • Procedures involving the wrong patient or body part • Medication error involving the death of a patient/member • Patient/member returning from operations because of an inappropriate MEC status	Patient/member suffering a **major permanent disability or loss of function (sensory, motor, physiologic or psychological)** unrelated to the natural course of the illness and differing from the expected outcome of the patient management or any of the following: • Attempted suicide of a patient/member known to an ADF mental health service within 7 days of contact with service • Threatened/actual physical/verbal assault of patient/member or staff requiring security intervention • Unregistered practitioner or clinician practicing outside their scope of practice • Patient/member at significant risk due to being absent against medical advice • Emergency life saving measures required for a patient/member as a result of the incident	Patient/member with **permanent reduction in bodily functioning (sensory, motor, physiologic, or psychological)** unrelated to the natural course of the illness and differing from the expected outcome of the patient management or any of the following: • Unplanned transfer of a non emergency patient/member from a JHC facility to civilian facility as a result of the incident • Surgical or other intervention required as a result of the incident • Increased length of stay as a result of the incident • Use of equipment for which sterility is required but has not been assured	Patient/member requiring **Increased level of care** including: • Review and evaluation • Additional investigations • Referral to another clinician/practitioner/facility Or any of the following: • Incorrect controlled drug (schedule 8) drug count • Lost documents relating to patient/member medical record • Unsafe equipment used • Essential equipment not available	Patient/member with **no injury or increased level of care or length of stay** Includes near misses/close calls
Staff: Death of a staff member related to work incident or suicide, or hospitalisation of 3 or more staff	**Staff:** Permanent injury to staff member, hospitalisation of staff for >24 hours or significant injury requiring >7 days off work	**Staff:** Medical expenses incurred, lost time or restricted duties for < 7 days	**Staff:** First aid treatment only with no lost time or restricted duties	**Staff:** No injury or review required
Visitor: Death of a visitor or hospitalisation of 3 or more visitors	**Visitor:** Hospitalisation of up to 2 visitors	**Visitor:** Medical expenses incurred or treatment of up to 2 visitors but not requiring hospitalisation	**Visitor:** Evaluation and treatment with no expenses	**Visitor:** No treatment required or refused treatment
Services: Complete loss of service or output	**Services:** Major loss of agency/service to users, GAS recommendations requiring action within 6 weeks	**Services:** Disruption to a key service; GAS recommendations requiring action within 3 months	**Services;** Reduced efficiency or disruption to service; GAS recommendations requiring action within 6 months	**Services:** No loss of service
Finances: Critical financial loss > $5,000,000	**Finances:** Major financial loss $500,000 - $5,000,000	**Finances:** Moderate financial loss $100,000 - $500,000	**Finances:** Minor financial loss < $100,000	**Finances:** Cost overrun – minimal financial impact
Environment: Chemical or radiation exposure with detrimental effect. Fire requiring evacuation	**Environment:** chemical or radiation exposure with no detrimental effects or fire that grows larger than an incipient stage	**Environment:** Chemical or radiation exposure contained with outside assistance or fire at incipient stage or less	**Environment:** chemical or radiation exposure contained without outside assistance	**Environment:** Nuisance exposure requiring no intervention

5A–2

Figure 6A–2: Steps 2, 3 and 4 risk matrix

STEP 2 – Likelihood Table

PROBABILITY CATEGORIES	DEFINITION
Certain	Is expected to occur again either immediately or within a short period of time (likely to occur at least once in the next 3 months)
Almost certain	Will probably occur at least once in the next 4-12 months
Likely	Is expected to occur within the next 1 to 2 years
Unlikely	Event may occur at some time in the next 2 to 5 years
Highly unlikely	Unlikely to recur – may occur only in exceptional circumstances (i.e. 6+ years)

STEP 4 – Action Required Table

ACTION REQUIRED FOR 'ACTUAL' INCIDENT RATING	
1	Extreme risk – immediate action required – A Root Cause Analysis (RCA) investigation must be completed within 28 calendar days. Notify RHD immediately or as soon as practicable. Reportable Event Brief (REB) must be forwarded by RHD to CJHLTH via DGGHO within 24-48 hours of the event occurring. Implement relevant GIAR recommendations within 28 days. Complete REB and RCA if unable to complete recommendations within this timeframe.
2	High risk – immediate action required – an investigation must be completed within 28 calendar days. Notification of the incident must occur to the RHD within 24-48 hours. Reportable Event Brief (REB) must be forwarded by RHD to CJHLTH via DGGHO within 24-48 hours. Implement relevant GIAR recommendations within 28 days. Complete REB and RCA if unable to complete recommendations within this timeframe.
3	Medium risk – All incident forms/complaints to be reviewed; review 'in common' incident types; may be most appropriate to develop a common action plan. Responsibility for management of these incidents must be assigned. Usually managed at local and regional levels.
4	Low risk – manage through team or unit level review and improvement procedures. Managed locally.
Incidents rating a SAC of 3 or 4 may also be reported to the DGGHO if the incident is considered by the Health Centre Manager and/or Regional Health Director to represent potential risk of serious harm that should be widely known. Incidents that are likely to attract external attention are also to be reported to DGGHO using a REB.	

STEP 3 – SAC Matrix

LIKELIHOOD	CONSEQUENCE: Serious	Major	Moderate	Minor	Minimal
Certain	1	1	2	3	3
Almost certain	1	1	2	3	4
Likely	1	2	2	3	4
Unlikely	2	2	3	4	4
Highly unlikely	2	3	3	4	4

ANNEX 5B

INFORMATION GUIDE FOR REPORTING

Figure 6B–1: Information guide for reporting

Health Unit/Location:			Reporting Period:	
	No.	Category of Clinical Incident	Key Issues / Trends Identified	Feedback / Corrective Action
Clinical Incident				
Total for period				
No. closed				
No. open				
No. remaining open over 30 days				
No. remaining closed over 30 days				

Australian Government
Department of Defence

CONTRACT FOR THE PROVISION OF ADF HEALTH SERVICES

CONTRACT NO: JHC/ADFHS/2019

DETAILS SCHEDULE

THIS CONTRACT INCLUDES AMENDMENTS THAT INCORPORATE THE CHANGES PROPOSED UNDER CCP BU130. SOME OF THESE AMENDMENTS TAKE EFFECT ON AND FROM THE DESCOPING EFFECTIVE DATE.

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3.2 Credentialing 24

3.3 Notification of Complaints, Suspension or Disciplinary Action 24

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3.11 Key Persons and Personnel 32

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5.16 Health Information 47

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11.11 Freedom of Information 94

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s22 [redacted]

3.2 Credentialing

3.2.1 The Contractor shall, and ensure that its Subcontractors and Health Practitioners shall at all times throughout the Term, hold all Credentials:

a. required by Law to be held by the Contractor, Subcontractor or Health Practitioner, as relevant; and

b. in the case of a Health Practitioner performing Services on-base or for MATRS, required in the applicable Position Description.

3.2.2 The Contractor shall certify to the Commonwealth that all Health Practitioners are appropriately Credentialed:

a. prior to the Operative Date; and

b. on or before each anniversary of the Operative Date.

3.2.3 The Contractor shall provide evidence of the Credentials of the Contractor, a Subcontractor or Health Practitioner (including copies of all relevant documentation) within five Working Days of request by the Commonwealth.

3.2.4 The Commonwealth will not approve the Credentials of Contractor Personnel. The Contractor remains fully responsible for ensuring that Contractor Personnel are appropriately Credentialed as required by this Contract.

3.3 Notification of Complaints, Suspension or Disciplinary Action

3.3.1 The Contractor shall promptly notify the Commonwealth of any suspension or termination of the licences, approvals and registrations required to be held by the Contractor or Credentials required to be held by a Health Practitioner for the provision of the Services on becoming aware of such suspension or termination of Credentials. The Contractor shall use reasonable efforts to ensure it is notified of the suspension or termination of Credentials required to be held by a Health Practitioner.

3.3.2 The Contractor shall promptly notify the Commonwealth if it becomes aware:

a. of any complaint made, or likely to be made, against it or any Health Practitioner to a Complaints Body or regulatory authority; or

b. that the Contractor's or a Health Practitioner's appointment to provide services to a hospital or health service is suspended, terminated or has conditions imposed due to complaints or concerns about the conduct of the Contractor or the Health Practitioner.

3.3.3 On receipt by the Commonwealth of a notification by the Contractor under clauses 3.3.1 or 3.3.2, or if the Commonwealth becomes aware of any such suspension, termination or complaint that the Contractor has not notified to the Commonwealth, the Commonwealth may take such reasonable action as is necessary to protect the Commonwealth, including suspension of the Contractor's engagement to provide the Services and/or termination of this Contract under clause 12.2.

s22 [redacted]

3.11 Key Persons and Personnel

3.11.1 The Contractor shall ensure that each person named in the Approved SMP is appointed to the Key Staff Position nominated for that person by the dates (if any) specified in that document.

3.11.2 If the Contractor becomes aware that a Key Person will or may become unavailable for the performance of work under the Contract for a period of four consecutive weeks or more, the Contractor shall:

a. promptly notify the Commonwealth of the impending unavailability; and

b. as soon as possible, nominate a suitable replacement.

3.11.3 The Commonwealth may give a notice in writing, including reasons, directing the Contractor to remove Personnel of the Contractor or Subcontractor from work in respect of the Services, if in the Commonwealth's opinion that the person specified in the notice:

a. is unable to undertake the work required of them under the Contract for reasons of incapacity or incompetence;

b. is a Health Practitioner, who has failed to observe and conform to all of the Laws and customs of the medical profession relevant to his or her profession;

c. has failed to observe and conform to Defence Policies and Procedures and, if applicable, the Defence environment;

d. has failed to comply with any Law;

e. is performing in a manner that falls below the standards, competence or performance required of the Contractor Personnel under this Contract;

f. should be removed to protect people or property; or

g. is inappropriate to undertake the work required of them under the Contract for reasons relating to WHS, security, equity and diversity, probity or the relationship between the Commonwealth and the Contractor.

3.11.4 If the Commonwealth gives the Contractor a notice under clause 3.11.3 the Contractor shall (or shall ensure that the Subcontractor shall) within the time specified in the notice:

a. remove the person from work in respect of the Services;

b. immediately implement a temporary workaround so as to prevent or minimise any interruption to the provision of the Services arising from the removal of each affected person; and

c. as soon as reasonably practicable, provide an appropriately qualified, Credentialed, competent and experienced replacement.

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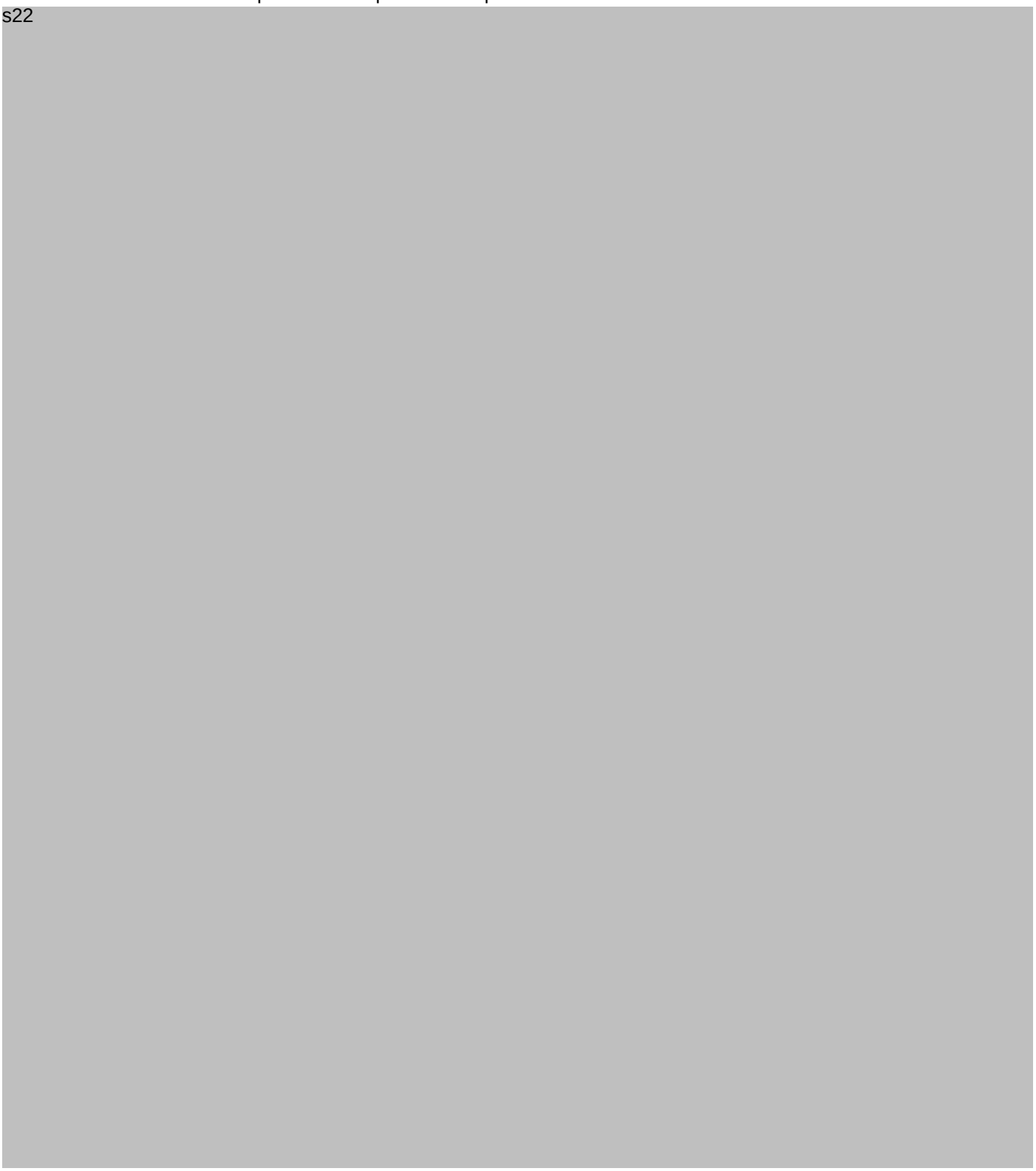

5.16 Health Information

5.16.1 All Health Information relating to the Services is the property of the Commonwealth. The Contractor shall store and maintain, or arrange for the storage and maintenance of, Health Information in accordance with Commonwealth directions.

5.16.2 The Contractor shall ensure that Health Information created pursuant to this Contract is kept confidential in accordance with relevant privacy legislation and standards, including the *Privacy Act 1988* (Cth).

5.16.3 The Contractor:

a. acknowledges the importance of continued access to Health Information prepared by the Contractor and by other health professionals involved in the care of the Eligible Personnel;

b. shall ensure that the Health Information provided by the Contractor or its Service Providers is accurate, complete and is available to be used by Associated Parties involved in the care of the Eligible Personnel;

c. shall ensure that Health Information (including Health Information prepared by Service Providers) is sufficiently detailed for the purposes of quality assurance, professional development, clinical and other health services research, defence of medicolegal litigation and the Commonwealth's assessment of a compensation claim by Eligible Personnel; and

d. agrees to provide all reasonable assistance required by the Commonwealth following reduction of the Services or the termination or expiry of the Contract to ensure the accuracy, completeness and utility of the Health Information or copies of such Health Information held by the Commonwealth relating to the Services.

5.16.4 The Contractor may retain, or may permit any of its Approved Subcontractors to retain, one copy of Health Information provided by the Contractor to the Commonwealth, for so long as the Health Information is required by Law to be kept, and for the purposes of quality assurance and defence of medicolegal litigation. The Contractor shall, in retaining the Health Information, comply with its obligations under this Contract including clauses 10.4, 10.10 and 11.8.

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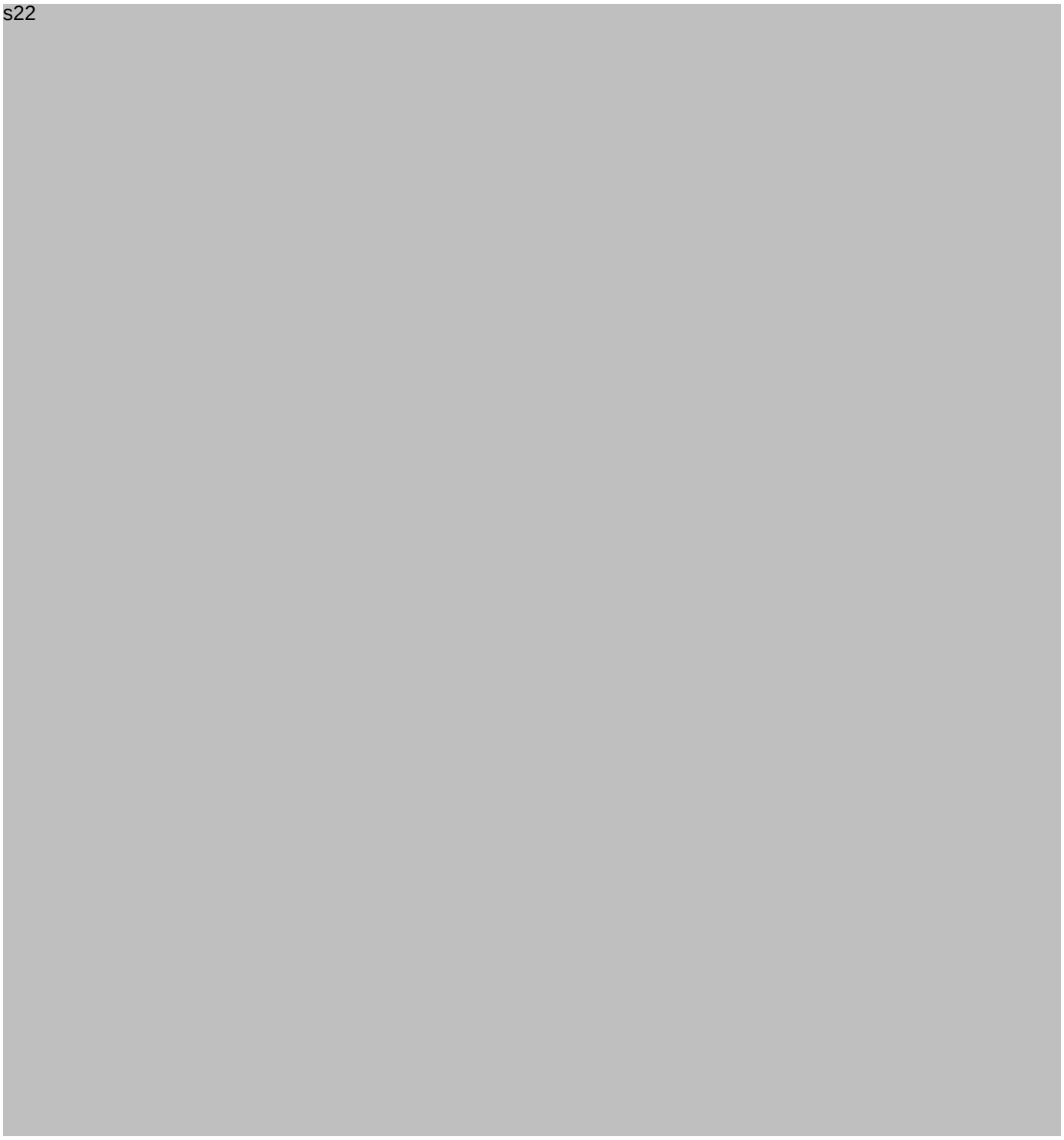
s22 

11.11 Freedom of Information

11.11.1 In this clause 11.11, 'document' and 'Commonwealth contract' have the same meaning as in the *Freedom of Information Act 1982* (Cth).

11.11.2 The Contractor acknowledges that this Contract is a Commonwealth contract.

11.11.3 Where the Commonwealth has received a freedom of information request for access to a document created by, or in the possession of, the Contractor or any Subcontractor that relates to the performance of this Contract (and not to the entry into the Contract), the Commonwealth may at any time by written notice require the Contractor to provide the document to the

Commonwealth and the Contractor shall, at no additional cost to the Commonwealth, promptly comply with the notice.

11.11.4 The Contractor shall include in any Subcontract relating to the performance of this Contract provisions that will enable the Contractor to comply with its obligations under this clause 11.11.

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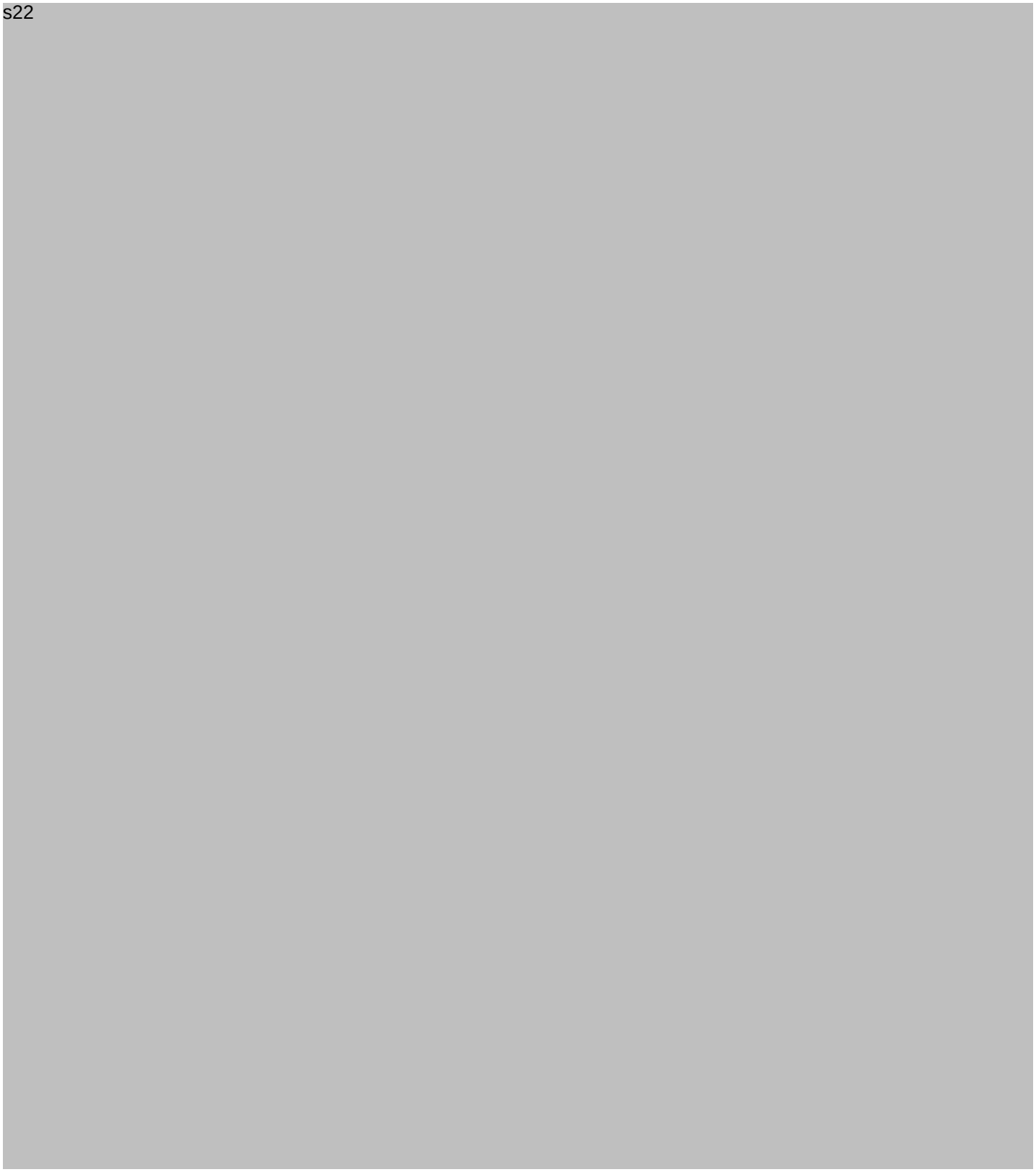

STATEMENT OF WORK
APPENDIX A TO ANNEX A: POSITION DESCRIPTIONS

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38.3. Tasks..... 113

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16. Nurse Coordinator – Health Practitioner

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16.3. Tasks

16.3.1 The Nurse Coordinator will perform the following tasks as outlined below, on an ongoing basis as directed by the Commonwealth.

16.3.2 Clinical tasks may include:

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e. Accepting responsibility for complex situations which may encompass clinical, managerial and educational contexts eg assistance with emergency medical responses, clinical review and complex complaint resolution;

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n. Provide support to the JHU Health Governance Manager and Regional Medical Advisor and/or quality manager in staffing all clinical incident reports, health care complaints, reviews and appeals or quality management activities.

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See distribution list

DGMLS DIRECTIVE: 02/23

MILITARY LEGAL SERVICE - PROFESSIONAL CONDUCT STANDARDS, EXPECTATIONS AND PROCESS

References:

A. s22

B.

C. Chief Counsel Directive 12/2019 – Defence Legal Code of Practice

D. s22

E.

F.

Introduction

1. This Directive sets out professional standards, expectations and process for Legal Officers within the Military Legal Service (MLS), regardless of SERCAT. This Directive complements relevant Chief Counsel Directives and existing MLS policies.

2. Where an inconsistency is identified between this Directive and a Directive issued by Chief Counsel, the Chief Counsel Directive is to prevail to the extent required to address the inconsistency.

3. This Directive does not extend to MLS officers who are posted to a Military Justice Entity[1] (MJE), or for the period in which they provide legal services to, on behalf of, or under the instructions of the MJE, except with the approval of the MJE.

4. DGMLS is responsible for the maintenance and enforcement of professional standards and for Technical Control (TECHCON) of the MLS in accordance with references A and B.

Purpose

5. MLS officers are expected to be professional leaders in the provision of legal advice, support and training in the ADF. This directive sets out standards, expectations and processes additional to those specified by the Chief Counsel that are specific to the MLS.

[1] MJEs are Inspector General of the Australian Defence Force, Judge Advocate General, Chief Judge Advocate, Judge Advocates, Registrar of Military Justice, Director of Military Prosecutions and Director Defence Counsel Services.

Professional Standards

6. The professional standards generally expected of all Defence Legal Practitioners, including MLS officers, are set out in reference C. The following paragraphs further explain the application of reference C to MLS officers.

a. MLS officers are expected to provide high quality legal services at a standard consistent with their rank, experience and legal level.

b. The ADF Legal Officers' Specialist Officer Career Structure (LOSOCS) Policy at reference D and the MLS Competencies at reference E are relevant to the standards expected at each legal level.

c. Since the publication of reference C, Defence has implemented the Defence Values of service, courage, respect, integrity and excellence and the related Behaviours. The professional conduct of MLS Officers will be considered with reference to the Defence Values and Behaviours.

Expectations

7. MLS officers must demonstrate, at all times, the highest standards of personal and professional conduct. MLS officers are expected to:

a. exemplify the Defence Values and Behaviours

b. conform to the professional standards set out in reference C and this Directive

c. take appropriate steps to inform, correct and educate MLS officers under their supervision whose professional performance may not have met the required standard

d. be collegiate, respectful and professional in engaging with fellow Defence Legal Practitioners regarding professional conduct matters

e. refer matters to the MLS TECHCON chain for investigation/inquiry and action where that is appropriate.

Complaint Management

8. Complaints and concerns regarding the professional conduct of MLS officers can be raised in a variety of ways, depending on the seriousness of the matter.

9. The primary means for dealing with professional conduct is action by the MLS officer's supervisor or command chain in accordance with extant Defence personnel management and reporting processes. Supervisors or commanders who are not legal officers may require assistance from a legal officer in the MLS TECHCON chain to determine whether professional conduct was not at the required standard.

10. Officers in the MLS TECHCON chain who are required to assess professional conduct can request assistance where necessary through Director of Legal Capability – Military (DLC-M).

11. Allegations of failure to comply with legal profession conduct rules, and other serious instances of professional conduct not at the required standard, should be referred to DGMLS through DLC-M.

12. A complaint regarding the professional conduct of DGMLS should be referred directly to the Chief Counsel.

Professional Conduct Assessment

13. DGMLS may determine that a professional conduct assessment is required when considering a complaint of failure to comply with legal profession conduct rules or other serious instances of professional conduct not at the required standard. DGMLS may seek subject matter advice in determining whether a professional conduct assessment is required. DGMLS may direct a suitable person with appropriate experience to conduct or contribute to a professional conduct assessment.

14. The purpose of a professional conduct assessment is to assess the conduct and performance of an MLS officer against the professional standards and expectations. A professional conduct assessment may utilise extant Defence processes for determining facts. A professional conduct assessment must be conducted in accordance with principles of procedural fairness.

15. In accordance with reference C, DGMLS may determine that an allegation should be referred to a relevant State or Territory Law Society or Bar Association. Such a referral may be made regardless of whether a professional conduct assessment has been completed. DGMLS may also determine that a matter needs to be referred to a Defence Investigative Authority.

16. The Inspector-General of the Australian Defence Force (IGADF) may also review the professional conduct of an MLS officer/s in circumstances where there is nexus to the military justice system, where it is directed by the CDF or Minister as a matter concerning the ADF, or where it arises incidentally during the performance of an IGADF function

Consequences of an Adverse Finding

17. The normal range of Defence personnel actions may be applied to MLS officers who fail to meet professional standards and expectations.

18. Less serious instances of failing to meet professional standards and expectations should, where appropriate, be dealt with through debriefing, counselling, corrective training and reflection of appropriate results in annual performance reporting.

19. More serious instances of failing to meet professional standards and expectations may result in disciplinary action or administrative sanctions (including but not limited to

reversion of Legal Level or action under MILPERSMAN Part 9 Chapter 2 – *Formal Warnings and Censures in the Australian Defence Force* and the *Defence Regulation 2016).*

20. A failure to comply with professional standards and expectations may be referred to the Chief Counsel, to assess whether the approval of a member to be a Defence Legal Practitioner should be revoked, in accordance with reference F.

21. Queries regarding this Directive should be directed to s47E(d) s47E(d)

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PJ Keane
Air Commodore
Director General Military Legal Service

Oct 23

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Head Defence Legal Directive 12

DEFENCE LEGAL CODE OF PRACTICE

References:

A. s22

B.

C.

Introduction

1. As the Accountable Officer for legal services in Defence, I require Defence Legal Personnel to meet certain work and behavioural standards when performing their duties.

2. Attachment A contains the Defence Legal Code of Practice. The Code of Practice is designed to confirm the existing professional and personal obligations of Defence Legal Personnel and articulate the work and behavioural standards required. It also acts as a measure against which individual's conduct and performance can be assessed and enhances awareness of the issues that may arise in the performance of legal and associated duties.

3. The Code is applicable to all Defence Legal Personnel. This includes all personnel within Defence Legal Division, including paralegals, enablers and Defence Legal Practitioners. Where a rule is specific to a certain group of Defence Legal Personnel, this is stated.

Interaction with other obligations

4. The Code of Practice operates concurrently with all relevant laws, policies, duties and requirements that apply to Defence Legal Personnel.

5. As ADF members and APS employees, Defence Legal Personnel must conform with whole of Government and Defence-wide duties and obligations. As personnel working within Defence Legal Division, Defence Legal Personnel must comply with directives issued by me, including this Directive. Those Defence Legal Personnel who are Defence Legal Practitioners must also comply with professional obligations set down by the relevant external State and Territory law societies and bar associations,

and are subject to the jurisdiction of those external regulatory bodies. We also have obligations under the *Legal Services Directions 2017* and Model Litigant Rules.

6. The purpose of the Code of Practice is not to replace any of these existing obligations. State and Territory law societies and bar associations will continue to be responsible for professional misconduct, which includes allegations of breaches of the relevant solicitor or barrister rules. I will still be responsible for performance management, which includes work and behavioural expectations. The Code of Practice is also not intended to overregulate behaviour. Rather, it consolidates some of the fundamental obligations of Defence Legal Personnel.

7. There may be some overlap in situations where conduct constitutes both professional misconduct and a performance management issue. For example, fraudulent activity may be a breach of the relevant solicitors practice rules, a breach of the Defence Legal Code of Practice, and a breach of the APS Code of Conduct or *Defence Force Discipline Act 1982*. It may therefore be reportable to the relevant law society for consideration in parallel to internal action. Actions in such a scenario would be independent of each other and not necessarily result in similar outcomes given the different perspectives and standards that may be applied.

8. To assist Defence Legal Personnel to understand the regulatory environment in which they operate, Attachment B contains a snapshot of the key sources of duties and obligations.

Interaction with section 122B of the *Defence Act 1903*

9. As well as setting the standards for work and behaviour, conversely the Code of Practice is intended to provide protection for ADF members and APS employees in the event that they are requested to act in a manner that would be contrary to the Code.

10. In the Defence environment there is a risk that Defence Legal Practitioners, APS or ADF, may be subject to attempts by their clients or members of their chain of command or management to improperly influence the outcome of their advice. Section 122B of the *Defence Act 1903* provides that ADF legal officers are entitled to exercise their professional rights, and discharge their professional duties and obligations, in accordance with the generally accepted rights, duties and obligations applying to legal practitioners. The Code of Practice extends this protection through firstly applying the same level of protection to Defence Legal Practitioners who are APS employees, and secondly providing a broader range of obligations with which Defence Legal Practitioners are required to comply.

Consequences of breach of this Directive

11. Reference B sets out a notification and workflow process, which may be followed in the event that an allegation is made against Defence Legal Personnel for failure to comply with the Code of Practice. Any allegations involving a breach of the Code of Practice are to be dealt with in a timely manner in accordance with the principles of procedural fairness, where appropriate and reasonably practicable.

12. Failure to comply with the Code of Practice may result in performance management, administrative or disciplinary action, and/or revocation or imposition of conditions upon my approval to perform legal duties and provide legal advice in Defence as a Defence Legal Practitioner under Reference C. Where a Defence Legal Practitioner is performing duties within a military unit or command, or is working directly within a supervisory chain outside of the Defence Legal head office, any action taken (or lack of action) by the relevant military unit, command or supervisory chain does not preclude Defence Legal from taking action in accordance with Reference C and the related technical control arrangements.

13. Where fact finding into a potential breach of the Code of Practice involves reviewing legal advice, the use of the advice for that and related purposes does not constitute a waiver of legal professional privilege.

Reporting to professional bodies

14. As identified above, internal action may be undertaken concurrently with any actions taken by a State and Territory law society or bar association. Defence Legal Practitioners are advised to self-report any initiation of internal action to the relevant body in accordance with the relevant practising certificate and membership rules. In the event that a Defence Legal Practitioner does not self-report, myself, the Director General ADF Legal Services, the relevant Head of Corps or other supervising legal officer may report the individual in accordance with our own duties to the legal profession, along with any supporting information.

Revocation of previous Directive

15. This Directive revokes HDL Directive 9 – Defence Legal Behavioural Expectations.

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Adrian D'Amico
Head Defence Legal

13 August 2019

Attachments

A: Defence Legal Code of Practice
B: Snapshot of sources

Defence Legal Code of Practice

All Defence Legal Personnel

- Be positive, be respectful of others, be a team player.
- Communicate openly and honestly, and show respect and courtesy, towards all colleagues and clients.
- Behave at all times in a manner that upholds the values and integrity of Defence Legal.
- Be responsive to colleagues and clients.
- Avoid and disclose any potential or apparent conflict of interest.
- Ensure the confidentiality of information obtained within the course of duties.
- Ensure accuracy of records through compliance with Defence Legal policies and directives on records management.

Supervisors

- Be informed about the requirements of being a supervisor, diligently perform all necessary functions and actively manage your team.
- Ensure that Defence Legal Personnel are provided with information through the regular conduct of meetings or other appropriate communication tools.

Defence Legal Practitioners

- Provide professional, diligent and prompt service delivery to all Defence Legal clients.
- Provide high quality, independent and contextually sound advice.
- Communicate effectively with legal supervisors to ensure that relevant personnel, including Head Defence Legal where appropriate, are informed of significant legal matters.
- Be aware of the Department's approach to risk management and incorporate risk as a factor in legal decision making and advice.
- Exercise professional rights, and discharge professional duties and obligations, in accordance with the generally accepted rights, duties and obligations applying to legal practitioners.
- Act in accordance with the issued standards of professional bodies.

Attachment B

Snapshot of Sources

Defence Legal Personnel are required to comply with duties and obligations contained in a number of source documents. Which source documents, and therefore which duties and obligations apply, depend on whether the individual is an APS employee or ADF member, and whether they are a Defence Legal Practitioner or not.

The following table provides a snapshot of some of the key source documents that apply in the Defence Legal operating environment. The duties and obligations contained in these source documents operate concurrently, so the same behaviour can give rise to a breach of multiple source documents.

Source	APS Defence Legal Personnel	ADF Defence Legal Personnel	APS Defence Legal Practitioners	ADF Defence Legal Practitioners
Defence Administrative Policy Framework	X	X	X	X
Defence Legal Code of Practice	X	X	X	X
APS Code of Conduct	X		X	
Defence Force Discipline Act 1982		X		X
Single Service Values		X		X
State and Territory Solicitor or Barrister Conduct Rules			X	X
Legal Services Directions 2017 and the Model Litigant Rules	X	X	X	X