OBA Nursing Academy

Course Syllabus

Clinical Leadership for Senior Nurses (OBA-CLN-2026)

DOCUMENT CONTROL

- Programme: Clinical Leadership for Senior Nurses (OBA-CLN-2026)
- Audience: Student and facilitator
- Version 1.0 | Issued 22/09/2026 | Review due 22/09/2027
- Provider: OBA Nursing Academy

The two errors this programme exists to correct

READ THIS FIRST

- OF THE THIRTY-THREE ACTIONS IN THE NSQHS CLINICAL GOVERNANCE STANDARD, THIRTY NAME THE HEALTH SERVICE ORGANISATION, TWO NAME THE GOVERNING BODY, AND EXACTLY ONE NAMES CLINICAL LEADERS.
- That single distribution is the first half of this course. A great many senior nurses are carrying obligations that no document assigns to them - the roster, the skill mix, the training system, credentialing, the defined scope of clinical practice, and every error made by every person on the shift. There is no document that says so.
- AND THE SECOND HALF, WHICH CANNOT BE LEFT OUT. The decision to delegate, the monitoring of performance, the evaluation of outcomes, the mandatory notification duty and a practitioner's own conduct do not move. 'I delegated it', 'I told management', 'it is in the risk register' and 'I notified Ahpra' all feel like transfers. None of them is one.
- The two meet in one paragraph of the NMBA decision-making framework, which says that accountability cannot be delegated - and then says that the delegatee is 'at all times responsible for their actions and accountable for providing delegated care'. Accountability does not transfer and it is not retained whole. It SPLITS.

Programme summary

Programme	Clinical Leadership for Senior Nurses (OBA-CLN-2026)
Provider	OBA Nursing Academy
Delivery	Self-directed online
Structure	11 modules, a case study assessment and a summative assessment
Nominal duration	9.0 CPD hours
Assessment	60 summative items, 80% to pass, 2 attempts
Version	1.0, issued 22/09/2026, review due 22/09/2027

Who this is for

- Nurse unit managers, clinical nurse consultants, clinical nurse specialists, team leaders and after-hours coordinators - anybody who is the most senior nurse in a building at three in the morning, whether or not their title says so
- Registered nurses who have just been made responsible for other people's practice, usually with a handover, a set of keys and no description of what changed
- Nurse educators and clinical facilitators, who supervise, assess and delegate every shift, and who are asked constantly to say where somebody's scope of practice ends
- Internationally qualified nurses stepping into Australian senior roles - where the regulator, the standards, the notification duties and the governance vocabulary are all new at once, and the consequences of guessing are regulatory
- Residential aged care and community nurses, who are frequently the only registered nurse on site, delegating to care workers, with supervision that is indirect by design
- Enrolled nurses working towards senior or team roles, and enrolled nurses who need to know exactly what a delegation obliges them to do and what it does not
- Nurses who have been told they are accountable for everything that happens on their shift and have never been shown the document that says so - because there isn't one
- Anybody who has had to decide, alone and quickly, whether what they just saw was a performance problem, a health problem or a notifiable one

How it is delivered

- Fully self-directed and entirely online, through the OBA learning management system. No scheduled classes, no live sessions, no clinical placement
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a formative knowledge check
- A case study assessment of five unfolding situations, and a single summative assessment
- Learners work at their own pace. Nothing is timed, and there is no completion deadline
- Every obligation stated in this programme is attributed to the document that imposes it, and to the person or body it names. Where an obligation belongs to your employer, the programme says so and tells you where to look

What this programme is not

THIS IS NOT A MANAGEMENT QUALIFICATION, AND IT IS NOT LEGAL ADVICE. It does not make you a nurse unit manager, it carries no credit towards a postgraduate award, and it does not authorise you to conduct a disciplinary process, an investigation or a performance review - those follow your employer's policy and your industrial instrument, neither of which this programme has seen. It is professional development in the regulatory and governance obligations that attach to a senior nursing role: what clinical governance requires and of whom, how delegation and supervision actually work under the NMBA framework, when a mandatory notification is triggered, and what open disclosure is.

A note on how this is written

A word about how this programme is written, because senior nurses arrive at this material carrying things. Many learners will have been part of an incident, a complaint, an investigation or a notification - as the subject, as the notifier, or as the person who had to decide. Nothing in this programme reproduces a real case, names a real practitioner or invites you to disclose an event you were involved in; every scenario is constructed. If working through the notification or open disclosure modules brings something back, the support lines are on every student-facing document and Nurse and Midwife Support exists precisely for this. Taking a break and returning is a reasonable professional judgement, not a failure of the kind of resilience nobody should be asking you for.

The source documents

Every requirement stated in this programme comes from one of these, and says which. In clinical governance a national requirement, a local policy and a strongly held ward custom are all described in the same confident tone of voice - frequently by the same person, in the same sentence.

Document	What it is, and what it carries
NSQHS Clinical Governance Standard (second edition)	THE AUTHORITY on who owes what. THIRTY-THREE ACTIONS in four criteria - and the subject of each action is the finding of this course. Thirty begin 'The health service organisation'; two begin 'The governing body'; ONE begins 'Clinical leaders'. Read the subject of the sentence before you read the obligation.
NMBA Decision-making framework for nursing and midwifery	Effective 3 FEBRUARY 2020, UPDATED AUGUST 2022. Two parts: nine principles of decision-making, and three guides - nursing practice decisions, midwifery practice decisions, and DELEGATION DECISIONS. Carries the definitions that this course turns on, including the one that splits accountability between delegator and delegatee. The 2013 flowcharts and the 2010 summary guides are RETIRED.
Ahpra and National Boards - Guidelines: Mandatory notifications about registered health practitioners (March 2020)	Made under section 39 of the National Law. FOUR concerns, and THREE different sets of thresholds depending on whether you are a treating practitioner, a non-treating practitioner or an employer. A senior nurse is almost always the second of those - 'most likely a manager, colleague or co worker' - and the non-treating thresholds are not the ones most people have been taught.
Australian Open Disclosure Framework (revised June 2026)	THE NEWEST DOCUMENT IN THIS PROGRAMME. Replaces the 2014 edition, and now applies across all healthcare settings. Four principles of person-centred open disclosure, two stages - initial and formal - and the sentence that most services still flinch at: using the words 'I am sorry' or 'we are sorry' is essential. Referenced by Action 1.12.
NMBA Code of conduct for nurses	Effective 1 March 2018, UPDATED MARCH 2026, next review June 2027. Seven principles in four domains. It applies to every nurse in every context including management, leadership and governance roles, an employer's code does not replace it, and where the code and the law conflict the law takes precedence.
NMBA Registered nurse and enrolled nurse standards for practice	RN Standard 3 (maintains the capability for practice) and Standard 4 (comprehensively conducts assessments) sit under most of this course; RN 1.4 and 3.5 bear directly on delegation

	and supervision. EN Standard 2 and Standard 3 define what an enrolled nurse may accept, and the EN standards are where the supervision requirement is set.
Work Health and Safety Act and Regulation (as in force in your jurisdiction)	Named, not taught. Psychosocial hazards are regulated work health and safety matters, and in Queensland the Regulation defines them and imposes a duty to manage the risk. The point for this course is narrow and important: the culture on your unit is not only a leadership aspiration, it is somebody's legal duty - and identifying which hazards exist is a consultation obligation, not a personality test.

Module structure and workload

#	Module	Video	Guide	Check	Workbook	Total
00	Orientation	4	17	4	8	33
01	Clinical governance	5	14	6	8	33
02	Accountability	4	15	6	8	33
03	Scope and the DMF	5	14	5	8	32
04	Delegation	5	13	7	8	33
05	Supervision	4	11	6	8	29
06	Speaking up	4	13	5	8	30
07	Open disclosure	5	14	5	8	32
08	Notifications	5	17	7	8	37
09	Four problems	5	11	4	8	28
10	The local map	5	13	4	8	30
	MODULE TOTAL					350

Programme-level reading and assessment

Component	Minutes
Course syllabus	30
Course descriptor	6
Assessment brief	7
Student scope of practice card	9
Further reading and organisation directory	14
Worked example: one shift, three decisions	10

Delegation decision record (reading the form)	8
Supervision agreement (reading the form)	7
Governance gap register (reading the form)	7
PROGRAMME READING TOTAL	98
Case study assessment - 19 minutes measured reading plus 30 seconds per decision across 25 steps	32
Summative assessment - 28 minutes measured reading plus 30 seconds per item across 60 items	58
ASSESSMENT TOTAL	90
PROGRAMME TOTAL (minutes)	538
PROGRAMME TOTAL (hours)	8.97
STATED CPD HOURS	9.0

HOW THE CPD HOURS FIGURE IS ARRIVED AT

- The figure is MEASURED from the content, not asserted. Narration time is computed from word counts at 135 words per minute; reading time from the learner guides at 130 words per minute; knowledge checks from their own length plus thirty seconds per item; the workbook at eight minutes per module.
- The measured total is 538 minutes, or 8.97 hours. That is rounded to the NEAREST HALF HOUR, INCLUDING DOWNWARDS, which gives 9.0.
- Content is never adjusted in order to reach a rounder number. If a revision reduces the measure, the stated figure comes down.
- The five optional practice tools listed below add approximately 95 minutes and are NOT counted, because they are optional.

Modules

Module 00 - Orientation: The Job You Were Given, and the Job That Is Actually Yours

What the programme covers, and the two opposite errors it exists to correct. A senior nurse is usually carrying obligations that no document gives her - THIRTY of the thirty-three actions in the Clinical Governance Standard name the health service organisation, two name the governing body, and exactly ONE names clinical leaders. And a senior nurse is sometimes carrying less than she should, because 'I delegated it' and 'I told management' feel like transfers and are not. The module sets out the seven source documents, the paragraph in which the NMBA splits accountability between delegator and delegatee, what this course is deliberately NOT - a management qualification, and legal advice - and the currency layers, including an Open Disclosure Framework that is three months old.

Learning outcomes:

- State the two directions in which this programme's content rules point, and why neither can be taught without the other
- State how many actions in the Clinical Governance Standard name the health service organisation, the governing body, and clinical leaders
- Explain why management and leadership are nursing practice settings under the NMBA framework
- Name the seven documents this programme is built on, and the date of each
- State what this course is not, and where a learner must go instead
- Locate the twelve local questions this course cannot answer for you

Module 01 - Clinical Governance: Thirty-Three Actions, and the One That Names You

The NSQHS Clinical Governance Standard in the only way that is useful to a senior nurse: by the SUBJECT of each sentence. Four criteria - governance leadership and culture (6 actions), patient safety and quality systems (12), clinical performance and effectiveness (10), and safe environment (5). Thirty actions name the health service organisation; two name the governing body; ONE names clinical leaders. Action 1.06 read in full, including its verb. Then the eleven actions a senior nurse actually operates inside every shift - orientation, training, performance review, scope of clinical practice, credentialing, role assignment, supervision including after-hours advice, incident management, open disclosure and clinical variation - and which half of each one is yours.

Learning outcomes:

- Name the four criteria of the Clinical Governance Standard and the number of actions in each
- State how many actions name the organisation, the governing body and clinical leaders
- Quote Action 1.06 and identify its verb
- Distinguish the part of an action a senior nurse performs from the part the organisation owes
- Identify at least five organisational compliance gaps by action number
- Explain why naming the holder of an obligation is a precondition of fixing it

Module 02 - Accountability and Responsibility: Where the Line Actually Falls

The NMBA's definition of accountability, read in full rather than in the half everybody quotes. You answer to four parties - the persons in your care, the NMBA, your employer and the public - and the professional line does not run through your employer. Accountability cannot be delegated, so the decision to delegate, the monitoring of performance and the evaluation of outcomes stay with the delegator. AND the delegatee is 'at all times responsible for their actions and accountable for providing delegated care', which means the delegator is NOT accountable for the performance of the delegated activity. Six items sorted on either side of that line, then the inflations and the abdications side by side, each with the sentence that answers it.

Learning outcomes:

- Name the four parties a nurse is accountable to under the NMBA definition
- Distinguish responsibility from accountability and apply the practical test
- State the three things a delegator remains accountable for
- State what the delegator is NOT accountable for, and who is
- Identify six common accountability inflations and answer each from a source
- Identify six common accountability abdications and answer each from a source

Module 03 - Scope of Practice and the Decision-Making Framework

The NMBA decision-making framework - effective 3 February 2020 and updated August 2022, with the 2013 flowcharts and 2010 summary guides formally RETIRED. Its two parts: nine principles of decision-making, and three guides. Scope of practice as a judgement about an ACTIVITY for THIS person NOW, not a fixed property of a job title, decided on five stated considerations - including the fifth, which names organisational support, sufficient staffing levels and appropriate skill mix. The registration notations that limit scope and are invisible unless somebody looks. And the two sentences a senior nurse should be able to quote: the substitution rule, and the prohibition on an employer directing, pressuring or compelling a nurse to practise below a professional standard.

Learning outcomes:

- State the two parts of the decision-making framework and identify the retired versions
- State the nine principles of decision-making in outline
- List the five considerations on which a scope of practice decision is based
- Explain why staffing and skill mix are a scope consideration rather than a separate problem
- Identify the registration notations that limit scope, and where to check them
- Quote the substitution rule and the prohibition on employer pressure

Module 04 - Delegation: Four Phases, and What You Keep

The guide to delegation decisions, in full. Delegation is a RELATIONSHIP, not an instruction: it applies to aspects of care 'which they are competent to perform and which they would normally perform themselves'. It is DIFFERENT FROM ALLOCATION OR ASSIGNMENT of tasks, and collapsing the two is how the four phases get skipped. Phase 1 is a risk assessment with six factors, any one of which ends the question. Phase 2 is six responsibilities of the delegator - including assessment of knowledge, skill, AUTHORITY and ability. Phase 3 is six responsibilities of the delegatee, including the right to decline and the prohibition on sub-delegating. Phase 4 adds five questions for health workers and students. Then the definition of ROUTINE that decides most real cases, and the rule that the accountabilities for involving a volunteer or family member are the same as for delegation.

Learning outcomes:

- State the NMBA definition of delegation and both limbs of its central clause
- Distinguish delegation from allocation or assignment of tasks
- Apply the six Phase 1 factors to decide whether an activity may be delegated at all
- List the six delegator responsibilities and the six delegatee responsibilities
- Apply the five additional Phase 4 questions for a health worker or student
- Apply the NMBA definition of a routine activity, and say why it disqualifies many delegations

Module 05 - Supervision: Direct, Indirect, and What It Is Not

Supervision is three different things wearing one word - MANAGERIAL, PROFESSIONAL and CLINICALLY FOCUSED as part of delegation - and only the third is what the delegation framework means. Two levels: DIRECT, where the supervisor takes direct and principal responsibility for the care; and INDIRECT, where responsibility is shared and the supervisor is EASILY CONTACTABLE and AVAILABLE TO OBSERVE AND DISCUSS. Both tests, or it is not indirect supervision whatever the roster calls it. The delegatee's Phase 3 rights to agree the level and to seek direct supervision until deemed competent. The rule that enrolled nurse supervision cannot be replaced or substituted by another health professional. And Action 1.26, which makes the AVAILABILITY of supervision - including after-hours advice - the organisation's obligation rather than your endurance.

Learning outcomes:

- Distinguish managerial, professional and clinically focused supervision
- State both tests for indirect supervision and apply them to a real roster
- State what direct supervision requires of the supervisor
- Explain the delegatee's Phase 3 rights in relation to supervision
- State the rule about who may supervise an enrolled nurse's delegated care
- Identify supervision availability as an Action 1.26 organisational obligation

Module 06 - Speaking Up: the Culture, the Duty, and Both Halves of Just Culture

Whether your people report is a function of what happened to the last person who did. Action 1.11 has six limbs, and the one most often missing is the fourth - TIMELY FEEDBACK on the analysis of incidents to the governing body, the workforce and consumers. When feedback stops, reporting stops, and the unit then looks safe. Action 8.06 makes WORRY OR CONCERN an escalation criterion in its own right, which changes what a leader must accept from a junior nurse. Psychosocial hazards are regulated work health and safety risks with a duty to manage them, and the things a senior nurse most influences are named hazards - NAMED, NOT INTERPRETED. And just culture in both halves: eliminate UNNECESSARY punitive action 'while ensuring appropriate professional accountability', with competence and negligence issues managed through performance management processes.

Learning outcomes:

- State the six limbs of Action 1.11 and identify the one most often missing
- Explain the relationship between feedback, reporting rates and apparent safety
- State what Action 8.06 requires a leader to accept from a junior nurse
- Describe psychosocial hazards as a regulated duty without interpreting a jurisdiction's law
- State both halves of just culture from the Open Disclosure Framework

- Explain why system and human factors are considered before individual accountability

Module 07 - When It Goes Wrong: Open Disclosure and the Word Sorry

The Australian Open Disclosure Framework, REVISED AND RELEASED JUNE 2026, replacing the 2014 edition and now applying across ALL healthcare settings - which makes any service policy written against the 2014 edition out of date, and that is checkable this week. Four principles of person-centred open disclosure, with a wording discrepancy between the Framework and the Commission's web page noted rather than resolved. When open disclosure is EXPECTED - whenever harm has occurred, physical, psychological or social - and when it may be CONSIDERED. Two stages: INITIAL disclosure as soon as possible after recognising harm, EVEN IF NOT ALL THE FACTS ARE KNOWN; and FORMAL open disclosure, an organised process led by a nominated lead. The apology, which must contain the word sorry. And the Framework's own statement that where clinicians do not speculate or apportion blame, there are no medico-legal grounds for avoiding it - alongside its equally clear instruction to seek legal advice about individual cases.

Learning outcomes:

- State the currency of the Australian Open Disclosure Framework and what it replaced
- Name the four principles of person-centred open disclosure
- State when open disclosure is expected and when it may be considered
- Distinguish initial disclosure from formal open disclosure and say who leads each
- State what an apology must contain, and what must not accompany it
- State the limit of what this programme says about apology legislation

Module 08 - Mandatory Notifications: You Are the Non-Treating Practitioner

Mandatory notifications under the National Law, from guidelines made under section 39 in March 2020. FOUR concerns: impairment, intoxication while practising, significant departure from accepted professional standards, and sexual misconduct. THREE sets of thresholds, and the threshold depends on WHICH GROUP YOU ARE IN when you form the belief. A senior nurse is a NON-TREATING PRACTITIONER - Ahpra's own gloss is 'most likely a manager, colleague or co worker' - and the non-treating thresholds are LOWER than a treating practitioner's. Reasonable belief generally requires DIRECT KNOWLEDGE; speculation, rumours, gossip or innuendo are not enough, and where somebody else holds the direct knowledge you encourage THEM to notify. The exemptions, the section 237 protections, what does NOT trigger a notification - and the sentence that stops a notification being an exit: after notifying, managing performance and protecting the public is still yours.

Learning outcomes:

- Name the four concerns that must be notified
- Identify which of the three notifier groups a senior nurse is in, and why
- State the non-treating practitioner threshold for each of the four concerns
- Apply the test for reasonable belief, and state what is not enough
- Identify the exemptions and the protections under the National Law
- State what remains the leader's responsibility after a notification is made

Module 09 - Capability, Conduct, Health and System: Four Different Problems

One nurse, one worrying event, and four completely different problems it could be - each with a different process, a different document and a different person responsible. A CAPABILITY problem goes to supervision, teaching and the organisation's training and performance review systems under Actions 1.20 and 1.22. A CONDUCT problem goes to the employer's process, measured against the Code of conduct, and becomes notifiable only if it meets one of the four concerns at the applicable threshold. A HEALTH problem goes to support and the controls Ahpra names - and a health condition is not an impairment unless it detrimentally affects capacity to practise. And a SYSTEM problem wears whichever of the first three is nearest: the Open Disclosure Framework asks that involvement in adverse events be considered in the context of staffing, skill mix, workload and workflow. Ask the system question first, out loud, before a name is attached to anything.

Learning outcomes:

- Distinguish capability, conduct, health and system problems and name the process for each
- Identify which NSQHS actions support a capability response
- State when a conduct problem becomes a notifiable concern, and when it does not
- Apply the distinction between a health condition and an impairment
- Identify the four system and human factors the Open Disclosure Framework names
- Explain why the system question is asked before a name is attached

Module 10 - Your Local Map, What to Report, and Your Own Practice

What the programme deliberately hands back. TWELVE LOCAL QUESTIONS - the clinical governance framework that names your clinical leaders, the defined scope of clinical practice for your role, the after-hours advice pathway, the delegation and supervision policies, the incident feedback loop, the open disclosure lead, and THE DATE YOUR OPEN DISCLOSURE POLICY WAS LAST REVIEWED. TEN REPORTABLE GAPS, each with the action number or source that makes it a finding rather than a grievance - because the difference between an absorbed burden and a reportable gap is a citation. Then the thing senior nurses are worst at: their own practice. Management and leadership are nursing practice settings, so your registration, your CPD, your scope, your conduct and your own professional supervision are all still yours - and the most common gap in a senior nurse's portfolio is evidence about the senior nurse.

Learning outcomes:

- Identify the twelve local questions and where the answers live
- Report an organisational gap with the action number or source attached
- Explain why a citation converts an absorbed burden into a reportable finding
- State which of your own professional obligations continue in a leadership role
- Complete the governance gap register for your own service
- Plan the reflection and professional supervision entries for your own portfolio

Assessment

Two assessments. A CASE STUDY ASSESSMENT of five unfolding situations, each with several decision points and feedback on every option including the plausible wrong ones. And a SUMMATIVE ASSESSMENT of 60 items delivered through the learning management system, 80% to pass, 2 attempts.

Summative blueprint

Module	Items
00	4
01	6
02	6
03	5
04	7
05	6
06	5
07	6
08	7
09	4
10	4
TOTAL	60

Case studies

	Case	Modules
CS1	Thirty of thirty-three	00, 01, 02, 10
CS2	The evening with no one else	03, 04, 05
CS3	Not all the facts are known	06, 07
CS4	Your row is the middle one	08, 09
CS5	Everybody has already decided	09, 10

WHAT THE ITEM BANK IS NOT ALLOWED TO CONTAIN

- Twelve content rules bind every keyed answer and every keyed rationale, and they are enforced mechanically by bank.py rather than trusted to the author.
- NO KEYED ANSWER INFLATES ACCOUNTABILITY - it may not make the senior nurse the holder of the roster, the skill mix, the training system, credentialing, the defined scope of clinical practice, the incident system or the open disclosure program.
- NO KEYED ANSWER ABDICATES IT EITHER - 'out of your hands' and 'no longer your responsibility' appear only in a distractor or in an answer correcting them.
- NO KEYED ANSWER GIVES LEGAL ADVICE OR PREDICTS A REGULATORY OUTCOME. No keyed answer treats a notification as a performance tool or a performance problem as notifiable. None treats rumour, gossip or a second-hand account as a basis for notifying. None names an individual. None states a local arrangement as a national requirement. None asserts a number that is not in the sourced list, checked as a (number, unit) pair. None presents just culture as the absence of accountability. None accepts substitution of a health worker for a nurse, or an enrolled

nurse supervised by a non-nurse. None treats an employer instruction as overriding a professional standard. And none defers open disclosure until the facts are known or avoids the word sorry.

- Each of the twelve is fired at known-bad text by check_bank_negative_control.py before release.

A guard that has never been seen to fire is not a guard - and on the first run of that control for this course, EIGHT of the twelve were found to be silently suppressed by a denial marker that was too generic.

Standards mapping

Document	What is used	Where
NSQHS Clinical Governance Standard (second edition)	All 33 actions across four criteria, and the subject of each - 30 the health service organisation, 2 the governing body, 1 clinical leaders. Actions 1.06, 1.11, 1.12, 1.19, 1.20, 1.22, 1.23, 1.24, 1.25, 1.26 and 1.28 in detail	Every module, and Modules 01, 09 and 10 in particular
NMBA Decision-making framework for nursing and midwifery (3 February 2020, updated August 2022)	Nine principles of decision-making; scope of practice considerations; the guide to delegation decisions and its four phases; and the definitions of accountability, delegation, health worker and supervision	Modules 02, 03, 04 and 05
Ahpra and National Boards - Guidelines: Mandatory notifications about registered health practitioners (March 2020)	Section 39 of the National Law; the four concerns; thresholds for treating practitioners, non-treating practitioners and employers; reasonable belief; exemptions; and section 237 protections	Module 08, and Module 09 for the boundary with performance management
Australian Open Disclosure Framework (revised June 2026)	The four principles of person-centred open disclosure; when open disclosure is expected and when it may be considered; initial and formal disclosure; the apology; just culture; and the Framework's statement of leadership responsibility	Modules 06 and 07
NMBA Code of conduct for nurses (1 March 2018, updated March 2026)	Seven principles in four domains; application to every nurse in every context including management and leadership roles; the relationship between the code, employer codes and the law	Modules 00, 02 and 09
NMBA Registered nurse standards for practice	Standard 1 thinking critically and analysing nursing practice; Standard 3 maintaining capability	Modules 03, 04 and 05

	for practice; Standard 4 assessment; and the delegation and supervision expectations that run through them	
NMBA Enrolled nurse standards for practice	What an enrolled nurse may accept, the requirement for supervision by a registered nurse or midwife, and the EN's own accountability for the care they provide	Modules 04 and 05
NSQHS Recognising and Responding to Acute Deterioration Standard	Action 8.06 - worry or concern in the workforce, the patient or the family is an escalation criterion in its own right	Module 06
Work Health and Safety Act and Regulation, as in force in your jurisdiction	Psychosocial hazards as regulated risks with a duty to manage them, and consultation obligations. NAMED, NOT INTERPRETED - your jurisdiction's provisions and codes of practice are the authority	Module 06

The twelve local questions

This programme states which obligations are national and which are local. These twelve are local, and Module 10 hands them back to you deliberately.

1. Who is named as a clinical leader in my organisation's clinical governance framework, and have I read the document that names them?
2. What is my service's defined scope of clinical practice for my role, and where is it written down? (Action 1.23 requires the organisation to have a process for this.)
3. What is the after-hours clinical advice pathway, by name and number, and have I ever used it? (Action 1.26.)
4. Which activities does my service's policy permit me to delegate to an assistant in nursing or care worker, and which does it prohibit?
5. What supervision arrangement does my service require for enrolled nurses, and does it correctly require a registered nurse or midwife?
6. How does a member of my team report an incident, how long does it take, and what feedback do they get afterwards? (Action 1.11's fourth limb.)
7. Who is my service's nominated open disclosure lead, and how would I reach them at 2am?
8. WHEN WAS MY SERVICE'S OPEN DISCLOSURE POLICY LAST REVIEWED - was it written against the Australian Open Disclosure Framework revised in JUNE 2026, or the 2014 edition it replaced?
9. Does my service have a documented process for assessing when and how IT would make a mandatory notification as an employer, and have I seen it?
10. Where do I find my employer's performance management procedure, and what does my industrial instrument say about my role in it?

11. What psychosocial hazard identification and consultation has happened on my unit in the last twelve months, and where is it recorded?
12. Who provides MY professional supervision, and when did I last have any?

SUPPORT - FOR YOU

- Nurse & Midwife Support - 1800 667 877. 24 hours, seven days. Free and confidential, for nurses, midwives and students - including if you are the person who had to make a notification, the person one was made about, or the person who was involved in an adverse event.
- Lifeline - 13 11 14. 24 hours, seven days. National crisis support.
- You may stop this programme at any point and come back. Nothing is timed and there is no penalty.

SCOPE, CURRENCY AND THE LIMIT OF THIS PROGRAMME

- This programme is professional development. It explains the NSQHS Clinical Governance Standard, the NMBA decision-making framework and professional standards, the Ahpra and National Boards guidelines on mandatory notifications, and the Australian Open Disclosure Framework; it does not replace them, and IT IS NOT LEGAL ADVICE. It cannot tell you whether a particular set of facts meets a notification threshold, what a regulator, tribunal or coroner would decide in your case, or what your jurisdiction's apology legislation protects. Those are questions for Ahpra, your professional indemnity insurer, your union or a lawyer. Your employer's policies, your position description and your industrial instrument govern your role and override anything in this programme wherever they differ.
- Content verified 22/09/2026 against the NSQHS Clinical Governance Standard (second edition) and the Commission's current action-by-action guidance; the NMBA Decision-making framework for nursing and midwifery (effective 3 February 2020, updated August 2022); the NMBA Code of conduct for nurses (effective 1 March 2018, updated March 2026); the NMBA registered nurse and enrolled nurse standards for practice; the Ahpra and National Boards Guidelines: Mandatory notifications about registered health practitioners (March 2020); and the AUSTRALIAN OPEN DISCLOSURE FRAMEWORK, REVISED AND RELEASED JUNE 2026. NOTE THE CURRENCY LAYERS. The Open Disclosure Framework is three months old at the date of issue and replaces the 2014 edition, so a service policy written against the 2014 edition is now out of date - that is Local Question 8. The NMBA formally lists the 2013 decision-making flowcharts and the 2010 summary guides as RETIRED, and they still circulate in induction packs. Where this programme relies on a document it names the document and its date.