Australian Government
Department of Health and Aged Care

Operational Guidance for Urgent Care Clinics

Purpose and scope

- This operational guidance is intended to apply across Commonwealth funded urgent care clinics (UCCs). It is intended to set a minimum standard for the activity, infrastructure and staffing of these UCCs while allowing sufficient flexibility for services to adapt to local conditions and needs.
- This operational guidance does not extend to clinical guidance or protocols (e.g., management of specific conditions such as chest pain); these areas should be covered by other recognised guidelines adopted to local circumstance where necessary.
- As clinics are intended to adapt to local needs and context, in some circumstances clinics may have different operational parameters (e.g., different mix of staff, or level of procedures available). Where such parameters conflict with this document written permission must be given by the Commonwealth or their delegate.
- This is an interim document, and it is anticipated that it will be revised on an ongoing basis as a result of program learnings.

Structure of document

The guidance is divided into ten parts as follows:

1. Scope of conditions
2. Triage and patient direction within the UCC
3. Accessibility
4. Patient follow up and communication with usual General Practitioner (GP)[1]
5. Follow up of diagnostic tests and referrals
6. Referral pathways and integration with health services
7. Staffing
8. Monitoring activity and clinical safety
9. Facilities, infrastructure, and equipment
10. Infection prevention and control

Appendix 1: Indicative list of core equipment and drugs required by a UCC

[1] Note that in this document 'usual GP' and 'usual General Practice' are also intended to refer to a patient's usual primary care provider which may include Aboriginal Controlled Community Health Organisations and other primary care providers

Acknowledgements and relation to other documents

Clinics using this guidance will also be accredited to another recognised and relevant Standard (such as the Royal Australian College of General Practitioner *Standards for general practice*). This guidance therefore focuses primarily on the particular aspects of urgent care rather than broader aspects of clinical governance and quality and safety in patient care.

This document has been developed by the UCC Operational Guidance Working Group. It draws heavily on the Urgent Care Standard developed by the Royal New Zealand College of Urgent Care and is further informed by the Western Sydney Care Collective Urgent Care Service Standards and ACCRM Recommended Minimum Standards for small rural hospital emergency departments.

1. Scope of conditions

1.1. UCCs are intended to provide short term, episodic care for urgent conditions that are not immediately life-threatening.[2]

1.2. A UCC will be equipped to treat problems including:

1.2.1. Minor illnesses (including respiratory illness, gastrointestinal illness, urinary tract infections and sexually transmitted infections)

1.2.2. Minor injuries including closed fractures, simple lacerations, simple eye injuries and minor burns

1.3. UCCs will be equipped to provide the following procedures:

1.3.1. Wound management including gluing, suturing and dressings (including for minor burns)

1.3.2. Incision and drainage of abscesses

1.3.3. Basic fracture management including application of backslabs and plasters

1.3.4. Intravenous cannula insertion to allow for IV antibiotics and IV rehydration fluids

1.3.5. Urinary catheter management and changes for males and females

1.3.6. Removal of foreign bodies from the ear and nose

1.4. UCCs will provide care for acute exacerbations of chronic disease (such as infective exacerbation of chronic obstructive pulmonary disease) but should not provide ongoing chronic disease care including chronic disease care plans or health assessments. UCCs will also not provide pre-employment or training medicals, GP mental health care plans, routine antenatal care or routine vaccinations of childhood and adulthood or travel related vaccines.[3]

1.4.1. A UCC will provide bridging prescriptions for chronic conditions (such as hypertension) where not doing so would place the patient at clinical risk, however these prescriptions will be for the shortest time possible, with the aim that longer prescriptions will be provided by the patient's usual primary care provider.

1.4.2. A UCC will not provide referrals for radiology, pathology or specialist care unless these constitute part of the acute treating episode.

1.5. UCCs are not intended to treat potentially life-threatening problems (such as cardiac chest pain, severe shortness of breath or altered conscious state) or manage labour and birth. However, UCCs should have capacity to identify and manage these problems should people present with them including capacity to stabilise conditions whilst awaiting transfer to hospital, including providing resuscitation where required.

1.6. UCCs are not expected to manage patients with difficult and disruptive behaviours, where such behaviours could compromise the safety of staff and other patients. UCCs should develop protocols to safely refer patients with these behaviours to other more appropriate services as required.

1.6.1. Note that this does not preclude the treatment of those with mental health conditions. UCCs should treat (including referral) those with mental health conditions (including acute exacerbations of mental health conditions and for physical conditions) where these can be safely treated within the UCC.

1.7. UCCs are intended to treat patients of all ages.

---

[2] This includes providing care for conditions which are being palliated, where treatment is aligned with a person's goals of care.

[3] Where appropriate UCCs may provide opportunistic vaccination (e.g., for seasonal influenza or COVID-19) as part of the treating episode. Any administration of vaccines must be communicated to the patient's usual General Practice and entered into the Australian Immunisation Register.

2. Triage[4] and patient direction within the UCC[5]

2.1. The UCC will conduct initial assessment and triage patients according to the severity of their condition to determine priority of treatment

2.2. The UCC will develop and implement a triage system to ensure:

2.2.1. Identification and rapid referral of life-threatening conditions, or other conditions requiring immediate attention, when they arrive at the UCC (including mechanisms for reception staff to alert clinical staff when individuals present with life threatening symptoms), with re-evaluation as necessary if their condition changes

2.2.2. That patients who are waiting are re-triaged as necessary if their condition changes

2.2.3. That individuals are directed to call for an ambulance when they telephone about life threatening symptoms

2.2.4. Appropriate triage decision making, categorisation and waiting times

2.2.5. Patients are seen according to clinical urgency

2.3. The UCC should maintain a system that:

2.3.1. Directs service users to the reception area on arrival

2.3.2. Lists life-threatening symptoms and informs service users that they should advise clinic personnel immediately when they present with life-threatening symptoms

2.3.3. Lists symptoms of infectious respiratory diseases and informs service users that when they present with these, they should immediately don a mask and inform clinic personnel

2.3.4. Informs users of the triage system and waiting times

2.3.5. Informs users when their condition is not within scope of the UCC (see section 1 above) and/or can be safely and is more appropriately managed via a usual primary care provider (taking into account timely access), with alternative care options given (see also section 4).

2.4. A clinic staff member is present in the reception area at all times during opening hours and is monitoring the waiting area regularly.

[4] In this document the term triage is used to refer to preliminary assessment of patients to determine whether they are suitable to be treated within a UCC, and the urgency of their treatment. While it does not imply use of a specific triage scoring system for clinical management of patients, data on the urgency of presentations may be required to be recorded for monitoring and evaluation purposes and will be specified in contracts.

[5] This section refers to triage activities that occur at the level of the UCC. Note that triage activities will also occur outside of the UCC via referral phone lines etc, as covered in section 6.

3. Accessibility

3.1. A UCC will be open extended hours 7 days a week. Exact hours will depend on local conditions and needs.

3.2. UCC facilities should have:

3.2.1. Car parking sufficient for the expected volume of patients, within a reasonable distance of the UCC, that allows wheelchair access to the UCC and has with adequate night-time lighting.

3.2.2. Clinic external approaches and interior areas that are accessible by wheelchair.

3.2.3. Waiting area with specialized seating (elevated and with arms).

3.2.4. A toilet with mobility access.

3.2.5. A designated area for ambulances to stop and obtain ready access to the resuscitation area.

3.2.6. Ready accessibility via public transport, preferably on or within easy walking distance of a main transport route. Any routes or linkages (e.g., pavements) with public transport should be wheelchair accessible.

3.3. UCCs should ensure that they are welcoming, accessible, and safe spaces for groups who may be marginalised within the population, in accordance with RACGP Standards for general practices – Criterion C2.1 – Respectful and culturally appropriate care. This includes:

3.3.1. Providing services within a culturally safe environment for the First Nations community

3.3.2. Consulting with culturally appropriate and First Nations groups when planning initiatives that may have a significant impact on the needs of UCC patients.

3.3.3. Providing culturally sensitive and safe care for those from Culturally and Linguistically Diverse and non-English Speaking Backgrounds.

3.3.4. Ensuring services are accessible and inclusive for people with disabilities (both physical and intellectual) of all ages.

3.3.5. Ensuring services are welcoming and inclusive for people identifying as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI)

3.4. UCCs should maintain connections with relevant services to support quality and continuity of care to marginalised groups. Connections need to be tailored to the UCCs local setting and patient population served, and may include initiative such as:

3.4.1. Developing and maintaining linkages with Aboriginal Controlled Community Organisations, refugee support organisations and other relevant local services.

3.4.2. Having appropriate individuals, such as an Aboriginal Health Worker or interpreter, on-site for some or all hours of UCC operation.

3.5. UCCs should have documented processes for staff to easily access interpreters (including the Translating and Interpreting Service) and a policy that users are offered an interpreter whenever appropriate.

4. Patients follow up and communication with usual GP

4.1. UCCs should maintain systems that informs users when their condition is not within scope of the UCC (see section 1) and/or can be safely and is more appropriately managed via a usual primary care provider. This includes:

4.1.1. Conditions identified at point of triage.

4.1.2. Conditions treated during the consultation – where future episodes would be better managed by a usual primary care provider.

4.1.3. Appropriately pitched educational and follow-up information, that enables for self-translation, should be provided, where possible.

4.1.4. Decisions on when a condition can be safely and more appropriately managed via usual primary care provider should take into account the patients situation and ability to access a usual primary care provider.

4.2. To facilitate patient care for conditions that are better managed by a patient's usual primary care provider, as well as follow up care, UCCs should maintain systems and networks that facilitate:

4.2.1. Patients to book in with their usual GP

4.2.2. Patients to identify and book in with another primary care provider (where a patient does not identify a usual GP) with the aim of developing a long-term relationship with this GP.

4.3. In general, UCCs should not conduct follow up care instead this should be referred to the patient's usual GP or GP practice (or other appropriate service, see section 6.1).

4.4. Where timely follow up with a patient's usual GP is required, UCCs should facilitate this wherever possible including through facilitating booking an appointment.

4.5. Follow up care can be arranged at the UCC where:

4.5.1. Patients are not able to see their usual GP for follow up within an appropriate time frame (including follow up of urgent diagnostic results). Follow up should only occur until management of the condition can be transferred back to the patient's usual GP.

4.5.2. A patient has a condition that requires care outside of their usual GPs capacity or capability or there is preference for the UCC to do this. e.g., removal of sutures, fracture management

4.6. Every patient attending a UCC should have a discharge summary. Information included in the discharge summary should include case notes, referrals and tests requested.

4.7. UCCs should ensure the discharge summary is communicated to the patient's usual GP or GP practice. This includes:

4.7.1. Uploading information to the My Health Record (MyHR) – unless requested not to do so by the patient

4.7.2. Electronic provision of a discharge summary to the patient's usual GP or GP practice within 24 hours – unless requested not to do so by the patient.

4.7.3. If electronic medical note transfer is not possible, a hard copy of the discharge summary should be given to the patient, including if the patient does not name a usual GP or GP practice.

4.7.4. Copying a patient's usual GP provider into all diagnostic test requests and other referrals

4.8. Where a patient requests not to disclose all or part of their consultation to their usual GP or GP practice the UCC should record this.

5. Follow up of diagnostic tests and referrals

5.1. UCCs should maintain a system for timely follow up and actioning of all patient tests and referrals. This includes:

5.1.1. A clinician has reviewed and actioned patient results within 24 hours of these being received

5.1.2. That patients are notified of abnormal test results within appropriate time frame, including being advised of appropriate follow up. Follow up will preferentially be with the patient's usual GP where ever possible.

5.1.3. Where follow up with the patient's usual GP cannot occur within a clinically appropriate time frame, or the patient has not nominated a usual GP, follow up may be organised at the UCC.

5.1.4. All actions are documented in the patient record

5.2. Preferred patient mode of notification for test results (e.g., SMS, telephone, email or mail) should be documented in the patient's record.

6. Referral pathways and integration with other health services[6]

6.1. The UCC should be part of a referral network aimed to ensure patients are directed to the most accessible and efficient service for their need.

6.2. All referral pathways into and out of the UCC should be driven by local need and co-designed with relevant stakeholders including local general practices.

6.3. While UCCs should have capacity to accept patients who self-refer, referral pathways into the UCC should also include:

- Ambulance
- Local emergency departments
- Local general practices
- Local after-hours services
- Other non-GP primary health care services such as Allied Health and community-based nursing services
- Health direct and other telehealth triage services such as 13 HEALTH (in Queensland)

6.4. The UCC should have clear escalation and referral pathways to local hospitals for acute care including:

- The emergency department
- Inpatient services including expedited access to specialist advice (including systems to organise direct admission where appropriate)
- Direct referral to outpatient clinics (e.g., fracture clinic)

6.5. The UCC should have pathways and direct referral for follow up care to hospital and community-based systems including:

- Mental health services
- Community health
- Hospital in the home
- Outpatient services (e.g., fracture clinic)
- Other community support services
- Virtual care options

6.6. Where appropriate and based on local context pathways may also be developed with:

- Local Residential Aged Care Homes
- Disability Accommodation
- Private hospitals and other private providers including medical specialists and optometrists (for investigation and treatment of acute eye complaints) – noting that any private follow up must be based on patient preference and awareness of any potential costs.

6.7. Referral pathways into and out of UCCs should be outlined in regional HealthPathways[7]

---

[6] Referral pathways back to usual General Practitioner are outlined in section 4

[7] HealthPathways is an online resource containing evidence-based guidance on treatment of chronic conditions, including referral pathways and adapted to the local area

6.8. Referral back to usual GP or GP practice should be as per section 4

6.9. Clinical directors of UCCs (and other interested staff) should participate in local and national communities of practice/networks relevant to UCCs.

7. Staffing

7.1. UCCs will be GP led, with staffing mix based on availability, local need and context

7.2. UCCS will require sufficient staff on-site during UCC hours of operation in order to meet the core functions and operational parameters of a UCC (as outlined in section 1) and the competencies outlined 7.4, in a clinically safe environment

7.2.1. In general, minimum staffing will include a doctor, registered nurse (RN) and a receptionist, where the doctor is a vocationally registered GP and both the doctor and RN have further skills in urgent care and emergency medicine.

7.2.2. The staffing mix may include, but is not limited to, administrative staff, other suitably qualified medical practitioners, nurse practitioners, extended care paramedics, allied health and Aboriginal Health Practitioners.

7.3. Approval for a staffing mix that differs from 7.2.1 will require the UCC to demonstrate how they will still meet core functional requirements and operational parameters (as outlined in section 1) and clinical safety requirements.

7.4. A UCC shift should be staffed during all hours of operation to ensure they are able to meet functional requirements and operational parameters (as outlined in Section 1). This includes ensuring the following competencies are covered:

- Receptionist first aid (receptionists shall have a documented guideline for identifying life-threatening conditions)
- Clinical use of radiology
- Clinical use of ECGs
- IV cannulation
- Plastering
- Wound care (including suturing and gluing)
- Minor burns management
- Treatment of musculoskeletal injuries including fractures where reduction is not required
- Urinary catheter management
- Identification and management of potentially life-threatening problems whilst patients await transfer to hospital (as per 1.5)
- Infection control practices for sterilization and disinfection, for personnel responsible for managing infection control

7.5. All clinical staff members should hold current (yearly) Basic Life Support (BLS) or advanced life support (ALS). If a UCC is situated in an area where there is likely to be a delay to emergency hospital care ALS may instead be used as the minimum requirement

7.6. UCCs will be required to have a clinical director who is responsible for clinical oversight including medical records review, clinical performance review of other staff and adverse event review.

8. Monitoring activity and clinical safety

8.1. In addition to data requirements for clinical care, UCCs should have systems in place for the collection and transmission of appropriate and timely structured data for health systems monitoring, planning and evaluation.

8.1.1. Specific variables and format of data required will be outlined in relevant contracts.

8.2. UCCs should have systems in place to improve clinical quality and safety including:

- An incident management system
- Practising open disclosure
- Feedback and complaints management
- Patient reported outcome measures and patient reported evaluation measures
- Providing evidence-based care, including clinical audits
- Systems for escalation of concerns for staff performance, including following guidance for notification as per the Australian Health Practitioner Regulation Agency
- Systems for safe storage, management, administration and monitoring of S8 medications on site in line with local legislation

9. Facilities, infrastructure and equipment

9.1. The UCC should maintain facilities that include:

- A treatment area with sufficient privacy
- A designated resuscitation area with defibrillator, airway management equipment[8], ECG machine, mobile bed, IV fluid resuscitation equipment, and emergency medications (resuscitation equipment should be stored in a trolley or other receptacle able to be moved should resuscitation be required outside of the resuscitation area)
- A designated area for plaster application and removal
- A designated area for treatment of eye complaints[9]
- A designated area for nappy-changing
- A private area that can be used for breast-feeding
- Adequate lighting in all areas
- Medicine, medical equipment and medical supplies, stored according to the supplier's directions and relevant legislation, inaccessible to unauthorized persons, and sufficient to provide safe treatment of service users
- An alert system for identifying and managing service users who are seeking drugs of addiction
- Secure storage for medicines and accessible only to designated personnel
- Facilities for recording computerised clinical notes
- Adequate infrastructure for clinical communication within the UCC and between the UCC and external providers, and the UCC and patients.

9.2. UCCS should have an x-ray facility on-site or easily accessible across all hours of operation

- An x-ray image must be made available to the attending clinician immediately after the x-ray is taken
- UCC clinicians must be able to access on-call assistance for interpretation of x-rays, with a formal report by a radiologist available within 24 hours.

9.3. UCCs should have timely access to ultrasound and CT across the majority of hours of operation

9.4. UCCs should have timely access to laboratory-based pathology (at a minimum basic results available same day)

9.5. The UCC must be equipped with appropriate equipment and drugs for diagnosis and treatment in order to meet core function and operational parameters (see section 1).

9.5.1. While noting that treatment of life-threatening conditions is not considered within scope of UCC operations, UCCs are expected to have capacity to provide treatment for these including resuscitation where required whilst patients await transfer to hospital.

9.5.2. An indicative list of equipment and medications is provided in Appendix 1. UCCs may substitute drugs or equipment on this list so long as they are still able to meet core functions, including the ability to provide resuscitation as required.

[8] In some facilities this may include a cricothyroidotomy set

[9] This may include a slit lamp

10. Infection prevention and control

10.1. UCC facilities should be able to safely assess people who potentially have a communicable disease in a manner that presents minimal risk of transmission to staff and attendees including through:

10.1.1. Standard precautions for all patients

10.1.2. Maximising physical distancing and ventilation in all patient assessment and waiting areas at all times regardless of levels of circulating disease in the community.

10.1.3. Routine triage of all patients for respiratory symptoms (including through signage) and immediate direction to these patients to don a mask and wait in the designated area

10.1.4. Designated rooms (or other appropriate areas) that are easy to clean and have sufficient ventilation whilst affording adequate privacy for consultation for assessment of patients with respiratory symptoms.

10.1.5. Staff trained in use of personal protective equipment (PPE) and adequate stocks of PPE present in the clinic

10.1.6. Protocols for cleaning down areas after reviewing potentially infectious patients

10.1.7. Capacity and protocols to safely conduct remote triage and assessment to minimise time spent in contact with patients who may have a communicable disease

10.2. UCCs should maintain linkages with their local public health unit and other systems to keep staff informed of levels of COVID-19 and other infectious diseases, and protocols for increasing stringency of infection control protocols in response to increasing risk.

Appendix 1: Indicative list of core equipment and drugs required by a UCC

1.1. Diagnostic equipment within the UCC should include:

- Specimen collection equipment, including blood and swab taking equipment
- Disposable syringes and needles
- Tongue depressor
- Blue light
- Fluorescein
- Topical anaesthetic
- Ophthalmoscope
- Otoscope earpieces, child and adult sizes
- Equipment for neurological examination, including to test reflexes and sensation
- Weighing scales
- Visual acuity chart
- Sphygmomanometer with a full range of cuffs and connections
- Stethoscope
- Tape measure
- Tuning forks, 256 Hz and 512 Hz
- Thermometer
- Pulse oximetry

1.2. UCCs should have point of care testing (POCT) capability including:

- INR
- Blood glucose testing equipment
- Pregnancy testing kits

1.2.1. Depending on local context POCT capability may include:

- Troponin
- COVID-19 and influenza

1.3. Resuscitation equipment within the UCC should include:

- Airway suction
- Bag-mask ventilators
- Laryngoscope / laryngeal masks – all sizes
- Oro-pharyngeal airways – all sizes
- Oxygen supply with regulator, tubing, nebulisers and masks

1.4. Cardiac equipment within the UCC should include:

- 12-lead ECG machine
- 3-lead ECG monitor/recorder
- Automatic electronic defibrillator (AED) with manual option

- IV administration sets – includes pump sets and metrisets
- IV fluids – 0.9% saline
- IV luer plugs
- IV set-up and infusion, 14-26 gauge

1.5. Wound care equipment within the UCC should include:

- Adhesive dressings
- Appropriate dressings for burns
- Angle poised lamp
- Fine needles
- Local anaesthetic
- Monofilament nylon sutures, 3/0 – 6/0
- Skin closures such as steri strips
- Suturing equipment
- Wound glue

1.6. Fracture management equipment within the UCC should include:

- Crutches or access to hire services within close proximity, open throughout all hours of UCC operation
- Electric plaster saw
- Mallet finger splints (all sizes)
- Plaster scissors
- Plaster splitter
- POP splints
- Slings/collar and cuff equipment
- Wrist, hand and thumb splints – all sizes
- Moonboots – all sizes
- soft neck collars (all sizes)
- Ring cutter
- Wheelchair
- Knee splints

1.7. Emergency drugs and antidotes within the UCC should include:

- Adrenaline
- Amiodarone
- Aspirin
- Atropine
- Glucagon
- Glucose 50% and 10% (injectable)
- Glyceryl trinitrate spray/tablets

- Insulin (fast acting)
- Corticosteroids (oral and injectable)
- Naloxone hydrochloride
- Benztropine
- Narcotic (oral and injectable)
- Salbutamol

1.8. Essential drugs within the UCC should include:

- Antibiotics (injectable and oral) – including:
    - Benzylpenicillin
    - Cephalosporin antibiotic
    - Sufficient stocks for dispensing a short course
- Antiemetic (oral and injectable)– including sufficient stocks for dispensing
- Ventolin inhalers and spacers– including sufficient stocks for dispensing
- Antihistamine
- Benzodiazepine (oral and injectable)
- Dihydroergotamine
- Frusemide
- Chlorpromazine
- Methoxyflurane inhaler
- Local anaesthetic
- Paracetamol
- Sterile water and 0.9% sodium chloride for injection
- Vitamin K for injection
- Depending on local epidemiology – antivirals for COVID-19 and/or influenza

1.9. Miscellaneous equipment within the UCC should include:

- Nasal packing equipment including lighting, speculae, forceps and suitable packing
- Packs for unavoidable/emergency delivery of babies
- Urinary catheterization sets, catheters and catheter bags
- Rampley forceps
- Combined dTPa vaccine
- Doppler for foetal heart beat detection
- Urinalysis testing equipment
- Vaginal speculae
- Ear syringing apparatus
- Mobile bed or trolley
- Gloves, gowns and masks (surgical and P2/N95)