RNZCUC
ROYAL NEW ZEALAND COLLEGE OF URGENT CARE

DAA Group
Focus on Quality

Urgent Care Standard 2026 (Draft 1.0 Consultation)

Cover Note

This document presents the Urgent Care Standard (UCS) 2026 – Consultation Draft, developed to replace and modernise the Urgent Care Standard 2015.

The revised Standard reflects significant changes in the urgent and after-hours care environment in Aotearoa New Zealand over the past decade, including evolving models of care, workforce diversification, digital health, system integration, and increased emphasis on quality, safety, equity, and sustainability.

The purpose of this consultation draft is to seek sector feedback to ensure the Standard is clear, proportionate, clinically credible, and fit for purpose across a diverse range of urgent care services.

The development of UCS 2026 has followed a structured, evidence-informed process consistent with international best practice for standards development, including the ISQua External Evaluation Association (IEEA) Guidelines and Principles (6th edition).

Key elements of the development process included:

- review of the Urgent Care Standard 2015, including identification of strengths, limitations, and areas requiring modernisation.
- review of relevant international urgent care and emergency care standards, guidance, & frameworks.
- alignment with New Zealand health system requirements, including:
    - Health New Zealand urgent and after-hours care frameworks,
    - Ngā Paerewa Health and Disability Services Standard,
    - ACC requirements and interfaces,
    - ambulance and emergency department system interfaces.
- explicit consideration of ISQua IEEA principles, with mapping of standards content to relevant principles to support external evaluation and accreditation readiness.

The Standard has been developed to be risk-based, and proportionate, recognising the diversity of urgent care services by size, location, workforce model, and community need.

Compared with the 2015 edition, UCS 2026:

- places stronger emphasis on clinical governance, quality improvement, and risk management.
- clearly defines scope, capability, and escalation, supporting safe integration with ambulance and emergency department services.
- reflects contemporary multi-professional workforce models, including credentialling, supervision, re-credentialling, and wellbeing.
- explicitly addresses digital health, including digital triage, teleconsultation, and emerging technologies.
- strengthens focus on equity, cultural safety, accessibility, and priority populations.
- supports training environments aligned with current and emerging professional standards.
- incorporates explicit consideration of sustainability and system stewardship.

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Scope

The Urgent Care Standard (UCS) defines minimum, auditable requirements for the safe, effective, equitable, and system-integrated delivery of urgent care services in Aotearoa New Zealand.
The purpose of the UCS is to:

- protect service user safety and rights,
- support high-quality, consistent urgent care delivery,
- promote equity and culturally safe practice,
- support workforce capability, wellbeing, and sustainability, and
- provide a credible foundation for accreditation and continuous improvement.

The UCS recognises urgent care as a distinct and essential component of the New Zealand health system, operating at the interface between primary care, ambulance services, telemedicine/virtual care and hospital emergency departments. It is designed to support safe decision-making, timely escalation, and effective transitions of care across this system.

Requirements are expressed as minimum capabilities rather than prescriptive models, allowing services to demonstrate compliance in ways appropriate to their context while still meeting nationally consistent expectations.

Purpose:

The UCS is aligned with, and intended to complement:

- Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021),
- Health New Zealand system frameworks and clinical pathways,
- ACC requirements relevant to urgent care delivery,
- Collaborating for quality: A framework for clinical governance (Health Safety & Quality Commission),
- Medical Council of New Zealand training standards, and
- ISQua External Evaluation Association (IEEA) Principles (6th Edition).

The Urgent Care Standard is owned and maintained by the Royal New Zealand College of Urgent Care (RNZCUC). RNZCUC is responsible for ensuring that the UCS:

- is developed and reviewed using transparent, evidence-informed processes,
- reflects contemporary clinical practice, system expectations, and community needs,
- aligns with national and international standards for healthcare quality and safety,
- supports reliable, consistent interpretation and assessment.

The UCS is intended to be applied in a proportionate and risk-based manner. Not all urgent care services are the same, and assessment should consider:

- service size and complexity,
- hours of operation,
- service user acuity, complexity and volume,
- workforce configuration, and
- local system interfaces.

The following are the Essential Requirements for the operation of an accredited urgent care clinic in New Zealand:

Signage

- External and internal signage shall clearly identify the service as an "Urgent Care Clinic". Any existing signage using different terminology i.e. Accident and Medical shall be updated to this requirement within 2 years of the publication of this standard.
- Signage will clearly display the opening hours of the clinic.

Accessibility/opening hours

- Opening hours of at least 8am – 8pm every day, unless in exceptional circumstances where the service provider has written approval to do otherwise from RNZCUC with an accompanying rationale for the approval decision.
- Walk-in - no appointment necessary.
- Open on public holidays.
- Facilities, including toilets, shall be accessible for people with disabilities.

Minimal clinical capability

- A doctor and a registered nurse are on-site during all the clinic hours of operation each with current ACLS.
- A Medical/ Clinical Director that works on-site a minimum of 20 hours per week.
- A Nursing Services Coordinator (Clinical Nurse Manager/ Leader) that works on-site a minimum of 20 hours per week.

Urgent Care Services

- Triage Process
- Wound care and suturing
- Plaster application and fracture immobilisation
- Slit lamp biomicroscopy.

Imaging

- X-ray services shall be available on site or within a short, covered walkway suitable for wheelchair access, and:
  a) open weekdays for 6 hours as minimum and,
  b) open for a minimum of 3 hours per weekend day, or
  c) that the facility will operate a functioning on-call service for at least 6 hours per weekend day.

Ambulance transfer capability

- Ambulance transfer area with access via ambulance stretcher to resuscitation bay.

Dedicated Resuscitation and Procedural Treatment Areas

- Dedicated resuscitation area with essential equipment.
- Refer to Standard 14.5 - Procedural and Treatment Areas (14.5.1).

Patient result follow up

- Dedicated resources to ensure all results are followed up and communicated where necessary.

Definitions and Glossary

The following definitions apply for the purposes of this Standard. Where terms are defined in legislation, those legislative definitions take precedence.

Term	Definition
Adverse Event	An unplanned and unintended event that results in, or has the potential to result in, harm to a service user, staff member, or other person, or loss or damage to property or the environment.
Advocacy	The independent provision of information, advice, and support to assist service users to understand and exercise their rights.
All-hazards approach	A method of emergency and continuity planning that prepares for a wide range of potential events by focusing on common response capabilities rather than planning separately for each specific hazard.
Assessment	The collection and interpretation of information, with service user involvement, to determine clinical need, urgency, and appropriate care or escalation.
Audit	A systematic, independent, and documented process for obtaining evidence and evaluating it objectively to determine the extent to which criteria are fulfilled.
Behavioural disturbance	Behaviour that poses, or has the potential to pose, a risk to the safety or wellbeing of the individual or others, or significantly interferes with the provision of care, and may be associated with mental health conditions, substance use, distress, cognitive impairment, or situational factors.
CALM (Code for Active Learning and Management)	A national system used to report, review, investigate, and learn from adverse events, incidents, and near misses to improve patient safety and quality of care.
Clinical decision support system	A digital tool or application that provides clinicians with service user-specific or general information, alerts, or recommendations to support clinical decision-making, without replacing professional judgement.
Clinical Deterioration	A worsening of a service user's physiological, psychological, or mental state that increases the risk of harm and requires timely recognition and escalation.
Clinical Governance	Clinical governance is the system of leadership, accountability, partnership and continuous improvement through which urgent care services are responsible for delivering safe, effective, equitable and culturally responsive care.
Clinical Staff	The term Clinical Staff refers to all regulated and unregulated personnel, whether full-time, part-time, locum or sessional that are responsible for providing clinical judgement or clinical interventions in the care of service users.
Competence	The demonstrated ability to apply knowledge, skills, judgement, and professional behaviour to perform a role safely and effectively.
Complaint	An expression of dissatisfaction, verbal or written, about any aspect of an urgent care service that requires a response.
Continual Improvement	Ongoing activity to enhance the ability to fulfil requirements and improve outcomes.
Corrective Action	Action taken to eliminate the cause of a detected nonconformity or other undesirable situation.
Cultural Safety	The provision of care that is respectful of, and responsive to, a person's cultural identity, values, and needs, as determined by the recipient of care.
Diagnostic discrepancy	A difference between an initial or provisional diagnostic assessment or report and a subsequent final diagnosis or report that may affect clinical management, follow-up, or service user safety.
Digital Health	The use of digital technologies, systems, or platforms to support the delivery, coordination, documentation, or monitoring of healthcare.
Digital triage	The use of digital tools or platforms to support the initial assessment, prioritisation, and direction of care based on a person's reported symptoms or needs.
Document	Recorded information, including policies, procedures, guidelines, or instructions, in either electronic or hard-copy form.

Emerging technology	A new or evolving technology that is not yet widely established in routine clinical practice and that has the potential to influence clinical decision-making, service delivery, or service user outcomes.
Environment	The physical and operational setting within which urgent care services are delivered.
Facilities	The infrastructure, equipment, utilities, and systems necessary to deliver urgent care services safely and effectively.
Governing Body	The person or group with ultimate accountability for the governance, strategic direction, and oversight of the urgent care service.
High-risk intervention	A clinical procedure or intervention that carries an increased risk of significant harm if complications occur, requires specific competence, equipment, or monitoring, and may necessitate rapid escalation to emergency or specialist services.
Incident	An event or circumstance that could have, or did, result in harm.
Induction	A structured process to support new personnel to acquire the knowledge and skills required to perform their role safely.
Information System	An electronic or manual system used to collect, store, manage, or exchange information relevant to service user care or service operations.
Management	The coordination of day-to-day operations and implementation of policies and decisions determined by the governing body.
National Public Health Service (NPHS)	The Health New Zealand service responsible for public health functions, including health protection, disease prevention, surveillance, and public health emergency management.
Near Miss	An event that did not result in harm but had the potential to do so.
Nonconformity	The non-fulfilment of a requirement.
Outbreak	The occurrence of cases of an infectious disease in excess of what is normally expected for a defined population, place, or period of time, requiring a coordinated response to prevent further transmission.
Outcome	The result of care or services provided, reflecting their impact on service users, staff, or the system.
Orientation	The process of familiarising personnel with the organisation, its systems, and their responsibilities.
Personnel	All individuals who work within the urgent care service, including employees, contractors, locums, trainees, and volunteers.
Point of care testing	Advanced point-of-care testing (POCT) refers to more complex, analyser-based diagnostic testing performed near the patient that provides quantitative results used in high-acuity or time-critical clinical decision-making, requiring formal quality assurance, operator competency assessment, and clinical governance due to the higher risk associated with inaccurate results. E.g. Troponin testing. General point-of-care testing (POCT) refers to simple, low-complexity bedside or clinic-based tests that provide rapid results to support routine clinical assessment and low-risk decision-making, typically requiring minimal equipment and operator training. E.g. Urine dipstick, Urine pregnancy test.
Policy	A statement of intent that guides decision-making and consistent action.
Preventive Action	Action taken to eliminate the cause of a potential nonconformity or undesirable situation.
Priority population	A group of people identified within the clinic's service population who, because of clinical vulnerability, social disadvantage experience inequitable health outcomes or barriers to access, and for whom targeted actions are required to achieve equitable health care and outcomes.
Procedure	A specified way to carry out an activity or process.
Process	A set of interrelated or interacting activities that transform inputs into outputs.
Psychosocial crisis	An acute state of distress arising from psychological, social, or situational factors that significantly impairs a person's ability to cope, function, or remain safe, and may require urgent assessment, support, or escalation.

Psychosocial Hazard	Workplace factors that may cause psychological harm, including stress, fatigue, bullying, violence, aggression, moral distress, or exposure to traumatic events.
Quality Management System	A system used to direct and control an organisation with regard to quality.
Quality Plan	A document that specifies which procedures and resources will be applied, by whom, and when, to achieve defined objectives.
Reasonable Accommodation	Adjustments or modifications made to enable equitable access to services for people with disabilities or other access needs.
Record	Documented evidence of activities performed or results achieved.
Reusable medical device	A medical device intended by the manufacturer to be reprocessed and reused for multiple service users.
Risk	The effect of uncertainty on objectives, expressed as a combination of the likelihood of an event and its consequences.
Scope of Practice	The range of activities, responsibilities, and decision-making authority that an individual is authorised and competent to perform.
Severity Assessment Code (SAC)	A nationally recognised classification system used to assess the severity of harm or potential harm resulting from an adverse event and determine the level of review required.
Service Provider	The organisation accountable for the delivery of urgent care services.
Service User	The service user, consumer, or person receiving services.
Standard	An agreed level of performance or quality used as a basis for comparison.
Structured clinical handover	A standardised approach to transferring clinical information and responsibility between clinicians or services, using an agreed framework to ensure critical information is communicated clearly, accurately, and consistently.
Supported decision-making	An approach that enables a person to make their own decisions to the greatest extent possible by providing appropriate support, information, communication assistance, and involvement of trusted people, while respecting the person’s will, preferences, and rights.
System Partner	An external organisation that interfaces with the urgent care service, including ambulance services, hospitals, laboratories, and primary care providers.
Teleconsultation	A clinical consultation delivered using telecommunications technology that enables real-time interaction between a clinician and a service user without requiring physical co-location.
Time-critical presentation	A clinical presentation in which delay in assessment, escalation, or definitive management is likely to result in significant harm, deterioration, or death, and where urgent care capability may be exceeded, requiring rapid escalation to ambulance services or an emergency department.
Transfer of care	The formal process by which responsibility for a service user’s care is handed over from one clinician or service to another, including the communication of relevant clinical information, risks, and ongoing care needs.
Triage	The process of prioritising service users based on the urgency of their condition.
Urgent Care	Urgent Care is episodic, unscheduled clinical care for patients that need timely assessment. Urgent Care provides the initial investigation and treatments and will refer back to primary care providers to support continuity of care.
Vulnerable person	An individual who may be at increased risk of harm, abuse, neglect, or exploitation due to factors such as age, disability, illness, mental health needs, cognitive impairment, social circumstances, or dependence on others for care or support.

Interpretation

"Shall" denotes a mandatory requirement. "Should" denotes recommended practice. This standard should be read together with operational documents, clinical guidance, service specifications and applicable legislation. “Normative Appendix” denotes mandatory requirements. “Informative Appendix” denotes guidance or supporting information.

Audit Sample Size

The minimum audit sample size should be calculated using the square-root sampling method.

Annual Patient Encounters	Annual Audit	Six-monthly Audit	Quarterly Audit
100,000	316	224	158
50,000	224	158	112
10,000	100	71	50
5,000	71	50	35
2,500	50	35	25

Part 1 – People-centred Access, Equity and Experience

Overarching Outcome:

Urgent care services are accessible, inclusive, culturally safe, and person-centred, supporting equitable access and positive experiences for service users and whānau.

Standard 1.1 – Consumer Rights, Communication and Information (UCS15 -Standard 1.1 & 1.2)

Consumers receive respectful, timely, and understandable information, and their rights are upheld. (aligned to Nga Paerewa 1.3, 1.6 & 1.7)

Communication needs (including health literacy) are assessed at first contact and revisited as needed to support informed participation and consent. (ISQua Principle 3)

Criteria:

1.1.1 The service shall clearly demonstrate how staff meet their obligations under the *Health and Disability Commissioner's Health and Disability Services Consumers' Rights*.

1.1.2 Consumer rights information shall be available, visible, and explained in a manner the service user understands and be provided in accessible formats and languages appropriate to consumer need.

1.1.3 Communication shall enable person-centred holistic care and informed participation in treatment planning, shared decision making, including the right to ask questions and receive honest, accurate answers demonstrated by consumer feedback.

1.1.4 The service provider shall inform service users of their right to have a support person, whānau or chaperone present during consultations, treatment or care decisions/planning, and when information or health education is being shared.

1.1.5 Interpreter services shall be available and used where language, hearing, or communication barriers may affect understanding, consent, or safety.

Standard 1.2 – Service Capability (UCS15 – 1.5)

Service capability is reviewed periodically with system partners and community needs to support integrated care transitions. (ISQua Principle 5) (aligned with Nga Paerewa 3.1)

Criteria:

1.2.1 The service shall document and publish its urgent care capability including:

a) Walk in – non appointment system
b) the hours of operation
c) services provided (e.g. x-ray)

NOTE: Urgent Care Clinic minimum requirements are specified on page 4.

1.2.2 The service should align its capability with relevant local, regional, and national urgent and emergency care pathways to support coordinated care and appropriate escalation.

1.2.3 The service shall support appropriate redirection, referral, or escalation when the service users' needs fall outside the defined urgent care capability, in a manner that is clinically safe and service user centred.

Standard 1.3 – Equity, Te Tiriti o Waitangi and Cultural Safety (UCS15 - 1.4)

The service delivers culturally safe, equitable care that gives effect to Te Tiriti o Waitangi, including Māori self-determination (tino rangatiratanga). (aligned to Nga Paerewa 1.1)

Criteria:

1.3.1 The service shall demonstrate commitment to Te Tiriti o Waitangi by giving effect to the principles of partnership, participation, protection, and Māori self-determination (tino rangatiratanga) within urgent care delivery, governance, and service improvement.

1.3.2 The service shall provide a culturally safe environment in which Māori service users' and whānau feel respected, listened to, and involved in care and decision-making, including recognition of cultural identity, values, and preferences.

1.3.3 Care delivery shall recognise the role of whānau, whakapapa, and lived experience in health and healing, and supports whānau participation where appropriate and desired by the service user.
1.3.4 Staff shall receive ongoing cultural safety training appropriate to their role, including understanding the impact of bias, racism, power imbalances, and institutional practices on Māori health equity.
1.3.5 The service shall use feedback, complaints, and experience data from Māori to inform service design, quality improvement, and equity-focused actions.
1.3.6 The service shall engage with Māori stakeholders, advisors, or iwi/hapū representatives to inform service improvement and strengthen culturally safe and equity-focused practice.
1.3.7 Equity for Māori shall be actively monitored using ethnicity, service utilisation, and service user satisfaction data, and identified inequities are addressed through documented, proportionate actions, where this is practicable.

Standard 1.4 - Pacific Health (aligned to Nga Paerewa 1.2)

The service identifies and responds to the health needs of Pacific peoples within its served population and community. The level of consultation and engagement is proportionate and reflects the local population of Pacific peoples in the community.

Criteria:

1.4.1 The service provides care that is culturally safe, respectful, and responsive to Pacific peoples and their families.
1.4.2 The service takes active steps to reduce barriers to access, assessment, treatment, referral, and follow-up for Pacific peoples.
1.4.3 The service supports staff to develop and maintain capability in Pacific health, cultural responsiveness, and equitable care.
1.4.4 The service engages with Pacific peoples, families, communities, and relevant Pacific providers or networks to improve service responsiveness.
1.4.5 The service incorporates Pacific perspectives into service planning, delivery, quality improvement, and evaluation.
1.4.6 The service monitors, reviews, and responds to inequities in access, experience, and outcomes for Pacific peoples where this is practicable.

Standard 1.5 – Respect for Individual Beliefs, Values, Identity and Preferences (UCS15 - 1.5)

Care is delivered in a manner that respects and responds to each person's rights, beliefs, values, identity, lived experience, and preferences. (aligned to Nga Paerewa 1.4)

Criteria:

1.5.1 The service shall provide care that respect's individual identity, beliefs, ethnicity, sexual orientation, lived experience, disability and gender identity using current accepted terminology.
1.5.2 Beliefs, values, identity, and preferences (including ethnicity data) relevant to care shall be identified and documented where appropriate.
1.5.3 Care planning and decision-making shall take these factors into account, particularly for sensitive, high-risk, or value-based decisions.
1.5.4 Where there is tension between clinical recommendations and a person's beliefs, values, or identity-related needs, supported decision-making shall be used.

Standard 1.6 – Consent, Capacity and Supported Decision-making (UCS15 – 1.2)

Care is provided with documented consent wherever possible, and people are supported to make decisions about their care in a manner that respects their rights, dignity, and preferences. (aligns with Nga Paerewa 1.7)

Criteria:

1.6.1 The service shall have a process to obtain and document informed consent appropriate to the urgency, complexity, and risk of care provided.
1.6.2 The service shall support decision-making to the greatest extent possible, including through communication support, education, health information, use of interpreters, and involvement of whānau or support people where appropriate.

1.6.3 The service shall have clear processes for situations where care is declined, delayed, or refused, including assessment of capacity, documentation of decisions, and escalation where service user safety is at risk.
1.6.4 The service manages ethical dilemmas that arise during care delivery.

Standard 1.7 – Open Disclosure and Complaints (UCS15 – 2.2)

Adverse events, near misses, and complaints are responded to in a transparent, timely, compassionate, and learning-focused manner that supports service users, whānau, and staff. (aligned to Nga Paerewa 1.8)

Information on how to make a complaint is easily accessible and includes options for external escalation and advocacy support. (ISQua Principle 3)

Criteria:

1.7.1 The service shall have a complaints management process that is accessible, fair, and responsive in accordance with the *Code of Health and Disability Services Consumers' Rights* and is supported by a complaints register.
1.7.2 The service shall have documented processes for adverse events and open disclosure that align with relevant guidelines and legislation, e.g. *National Adverse Events Policy – Health Quality and Safety Commission (HQSC)* (please refer to Standard 2.4).
1.7.3 Service users and whānau shall be supported to raise concerns without fear of negative impact on their care.
1.7.4 Staff involved in complaints shall be offered appropriate support.
1.7.5 Information from complaints shall be analysed to identify themes and inform quality and risk improvement activities.

Part 2 – Governance, Quality and Risk Management

Overarching Outcome:

The urgent care service operates within a robust governance framework that ensures accountability for clinical safety, quality, equity, and continuous improvement.

Standard 2.1 – Governance Framework (aligned to Nga Paerewa 2.1)

The organisation maintains documented mission/values and strategic and operational objectives that are reviewed by the governance body. (ISQua Principle 2)

Criteria:

2.1.1 The organisation shall have governance oversight that ensures compliance with relevant legislative, regulatory and contractual compliance.
2.1.2 The governance oversight shall ensure the mission/values and strategic and operational objectives are clearly identified, planned, monitored and evaluated at regular intervals.
2.1.3 The organisation shall have a clinical governance framework that is appropriate to the size and complexity of the service being provided which aligns with guidelines and legislation, e.g. *Collaborating for Quality: A framework for clinical governance – Health Safety and Quality Commission.*
2.1.4 The governance oversight shall receive and review regular reports on safety, quality, risk, equity, service user experience and performance.

Standard 2.2 – Quality Improvement (UCS15 – 2.1) (aligned to Nga Paerewa 2.2)

Summary quality/performance and improvement information should be made available to consumers and stakeholders in a manner appropriate to the service context. (ISQua Principle 9)

The service maintains document control for policies/procedures to ensure current, approved guidance is used in practice. (ISQua Principle 2) **(UCS15 – 2.1)**

Criteria:

2.2.1 The service shall maintain a documented quality management and improvement framework approved by the governance body. Supported by a management system of controlled policies, procedures and forms.

2.2.2 A defined set of quality and safety indicators relevant to urgent care is monitored, including clinical outcomes, access, and safety measures.

2.2.3 Opportunities for improvement result in documented improvement actions, with responsibilities and timeframes assigned.

2.2.4 The effectiveness of improvement actions is evaluated and informs subsequent quality planning.

2.2.5 The service provider shall maintain a programme of internal audits. (UCS15 – 2.1.4) The programme of internal audits shall Include, but not be limited to:

- a) Compliance with the Code of Rights
- b) Human resource management processes
- c) Triage system compliance in alignment with the Australasian College for Emergency Medicine (ACEM) triage scale, or an equivalent that is approved by the Royal New Zealand College of Urgent Care.
- d) Test tracking system and transfer of information
- e) Medical records (apply square root principle for sample size, refer to example at the beginning of the standard and 2.3.1)
- f) Urgent care facilities and equipment
- g) Fire safety precautions
- h) Infection prevention and control.
- i) Address and take account of:
  - i. A history of conformity with quality requirements;
  - ii. The introduction of new and amended processes;
  - iii. Systems with known problems and / or significant associated risks.

2.2.6 The service provider shall maintain a programme of continual improvement through:

- a) Corrective action that addresses identified systemic deficiency
- b) Preventive action that responds to analysis of quality and risk related data
- c) Implementation of quality plans with measurable objectives for systemic improvement and achieving clinical and non-clinical goals
- d) Follow-up to internal audit findings.

Standard 2.3 – Consumer and Whānau Experience (UCS15 – 2.1.3)

Community & priority population engagement informs service planning and improvement. (ISQua Principle 3)

Criteria:

2.3.1 The service shall have documented processes to systematically collect consumer and whānau service user experience information at least annually that aligns with the RNZCUC Patient Clinic Satisfaction Survey (Appendix 4). The square root of the total number of service users for the period being reviewed shall be used to determine the sample size. Services with multiple sites shall ensure the sample size for each site is adequate to enable meaninful quality improvement analysis.

2.3.2 Consumer and whānau feedback shall be analysed for themes, trends, and equity impacts, including identification of variances or reduced outcomes for priority populations.

2.3.3 Consumer and whānau feedback shall be reviewed to identify underlying system issues and learning opportunities.

Standard 2.4 – Risk Management and Adverse Incident Reporting (UCS15 – 2.1)

Clinical, organisational, and system risks are proactively identified, managed, and reviewed in a manner proportionate to the size, scope, and complexity of the urgent care service. (aligned to Nga Paerewa 2.2)

Criteria:

2.4.1 The service shall have a documented risk management system appropriate to its size, scope, and complexity.

2.4.2 The service provides and maintains a safe and healthy workplace for workers, patients, whānau, and visitors through the systematic identification, assessment, and management of health and safety risks.

2.4.3 Identified risks shall be recorded in a risk register or equivalent risk record, with controls, including risk rating, mitigations, owners, and review timeframes defined.

2.4.4 Incident reporting processes shall enable staff to report adverse events, near misses, and hazards without fear of reprisal. The reported events are analysed and corrective actions taken in a timely manner.

2.4.5 Incidents and high or emerging risks shall be analysed to identify underlying system issues and learning opportunities.

2.4.6 The service provider shall ensure the adverse event reporting system meets any statutory requirements for essential notification i.e.:

Area	Trigger/ Event	Recipient or Authority
Infectious disease	Suspected or confirmed notifiable disease	Medical Officer of Health / NPHS
Hazardous substance injury	Exposure or poisoning	NPHS / Public Health Unit
Privacy breach	Serious data breach	Office of the Privacy Commissioner
Serious adverse event (SAC 1–2)	Serious harm, potential harm	Health New Zealand - Te Whatu Ora / HQSC
Radiology incident	Radiation over-exposure	Office of Radiation Safety
Medicines/vaccines adverse reaction	Unexpected or serious effect	CARM / Medsafe
Child protection	Suspected abuse or neglect	Oranga Tamariki / Police/ hospital child protection team
Practitioner competence risk	Safety or conduct concern	Relevant Regulatory Council
Serious Harm Event	Refer to Worksafe list of events that are required to be reported	Worksafe – Notify Worksafe

Standard 2.5 Environmental and Resource Sustainability

The service shall demonstrate responsible environmental sustainability and stewardship of resources through governance, planning, and implementation of practical initiatives, proportionate to the size and complexity of the service. *(ISQua Principle 6)*

Criteria:

2.5.1 Environmental sustainability goals and responsible resource stewardship shall be incorporated into governance goals, quality planning, and improvement activities, proportionate to the size and complexity of the service.

2.5.2 The service shall implement practical actions to reduce environmental impact, including waste minimisation, energy efficiency, sustainable procurement practices and avoiding unnecessary consumption e.g.:

a) avoiding unnecessary tests or treatments
b) stock control to reduce expired items
c) using electronic records, e-prescribing, and digital referrals where possible
d) reducing paper use without impacting care.

2.5.3 The service shall consider their carbon footprint to monitor and help reduce greenhouse gases produced through the care processes provided.

Part 3 – Workforce, Capability and Wellbeing

Overarching Outcome:
The urgent care service has a competent, supported, and appropriately governed workforce that delivers safe, high-quality care.

Standard 3.1 – Workforce Planning and Safe Staffing (UCS15 – 2.4)

The urgent care service has a competent, supported, and appropriately resourced workforce that delivers safe, high-quality care. (aligned with Nga Paerewa 2.3)

Criteria:

3.1.1 The service shall undertake workforce planning appropriate to its scope, service model, hours of operation, and community need to ensure safe and sustainable delivery of urgent care.

3.1.2 Workforce arrangements shall ensure the availability of appropriately skilled clinicians and staff to meet anticipated demand, acuity, and risk.

3.1.3 The service provider shall employ a Medical/Clinical Director.
The Medical/Clinical Director shall be:

a) Either a Fellow of the Royal New Zealand College of Urgent Care; or
b) An urgent care vocational programme trainee whom the Royal New Zealand College of Urgent Care has approved in writing as medical director; or
c) Another doctor approved as Medical/ Clinical Director by RNZCUC.
d) The Medical/ Clinical Director must in good standing with RNZCUC and the MCNZ

The Medical/Clinical Director position holder shall:

a) Be responsible for clinical oversight including:
   i. medical records review
   ii. performance appraisal and clinical performance review of medical personnel
   iii. adverse event review
   iv. ongoing training of clinic medical personnel.
b) Document any required collegial relationships of medical personnel;
c) Have a current New Zealand Annual Practising Certificate;
d) Work on-site a minimum of 20 hours per week.

3.1.4 The service provider shall employ a Nursing Services Coordinator (Nurse).
The Nursing Services Coordinator (Clinical Nurse Manager/ Leader) shall:

a) Be a registered nurse with experience and training in urgent care and/or other associated specialities (such as emergency medicine, primary health care, orthopaedic surgery, plastic surgery).
b) Be responsible for providing clinical leadership of urgent care services, including coordination of ongoing education of nurses, in accordance with New Zealand Nursing Council guidelines and directives, and in collaboration with the Medical/ Clinical Director and/or other management personnel.
c) Have a current New Zealand Annual Practising Certificate.
d) Work on-site a minimum of 20 hours per week.

3.1.5 The service shall have a documented Human Resource Management System that includes employment processes, agreements and up to date workforce records.

3.1.6 Roles, responsibilities, and lines of accountability for all key workforce groups shall be clearly defined and understood.

3.1.7 The service shall ensure that staff have access to ongoing education appropriate to their role and responsibilities.

3.1.8 Workforce planning and deployment shall consider staff wellbeing, fatigue, and psychosocial risk, consistent with safe work practices.

3.1.9 The service shall monitor workforce performance including sick leave, staff turnover, recruitment success and capacity, and uses this information to inform improvement.

3.1.10 All clinicians shall hold appropriate professional indemnity or insurance arrangements relevant to their scope of practice.

3.1.11 Prior to commencement of independent practice staff shall undertake a recorded programme of recruitment, and if returning after an absence greater than 12 months, undertake an orientation to the role and organisation and induction based on the skills and responsibilities of the position.

3.1.12 The service shall have a process to evaluate staff engagement and satisfaction.

3.2 – Credentialling and Scope of Practice (UCS15 – 2.4.8)

All clinical staff (regulated and unregulated) are credentialled and authorised to practise within a defined scope of practice that supports safe, high-quality urgent care. (aligned to Nga Paerewa 2.4)

Criteria:

3.2.1 The service shall have a documented credentialling process for all clinical staff that includes:
Pre employment:
   a) Currency of practice certification/registration (Regulated health professionals)
   b) Police vetting
   c) Verification of qualifications and experience

3.2.2 Each clinician shall have a defined scope of practice approved by the service that aligns with their credentials and the service's scope and capability.

3.2.3 All regulated staff shall maintain professional registration, certification, and continuing professional development relevant to urgent care practice, in accordance with relevant regulatory and professional body requirements.

3.2.4 The service shall have processes to restrict, modify, or suspend scope of practice where concerns about conduct or safety arise.

Standard 3.3 – Clinical Competence (UCS15 – 2.4.7)

The service ensures all clinical staff (regulated and unregulated), including temporary, locum, and support staff, maintain and demonstrate competence appropriate to their role, scope of practice, and the urgent care setting through ongoing training, assessment, and support.

Criteria:

3.3.1 Clinical staff maintain and demonstrate ongoing clinical competence appropriate to their role, scope of practice, and the urgent care context.

3.3.2 The service shall monitor the practice of urgent care skills for clinical staff, appropriate to their role, scope of practice, and level of autonomy including:

   a) Triage competence
   b) X-ray interpretation
   c) ECG interpretation
   d) Slit lamp use
   e) IV cannulation
   f) Plastering
   g) Basic wound care
   h) Wound closure
   i) Foreign body removal
   j) Burns management
   k) Conscious sedation (where applicable)
   l) Closed reduction
   m) ACLS

3.3.3 The service shall have a process to monitor and record ongoing clinical competence of all staff.

3.3.4 Temporary/ locum clinical staff shall receive orientation appropriate to the duration and nature of their engagement, including critical safety processes, escalation pathways, supervision arrangements, and local procedures.

3.3.5 Where healthcare assistants (or equivalent roles) are utilised, they shall be trained to implement treatment plans, follow the clinics documented guidelines, and their initial and ongoing competence is monitored and recorded.

3.3.6 Where concerns about competence are identified, the service shall have processes to provide support, supervision, remediation, or modification of scope of practice.

Standard 3.4 – Clinical Supervision and Delegation (UCS15 – 2.4)

Clinical supervision and delegation arrangements support service user safety, effective decision-making, and workforce development.

Criteria:

3.4.1 Supervision requirements shall be defined for each clinical role and level of experience within the urgent care clinic. This includes specifying:
  a) The mode of supervision required (direct, indirect, or remote)
  b) The amount of supervision (hours per week or per shift)

3.4.2 Delegation of clinical tasks, responsibilities, and authority shall occur only when the delegate is working within their defined scope of practice and demonstrated competence. The delegating clinician retains clear accountability for delegated tasks.

3.4.3 Access to senior clinical advice shall be available in a manner responsive to clinical acuity, case complexity, or clinical uncertainty.

3.4.4 Clinical supervisors shall be supported to fulfil their supervisory responsibilities effectively, including protected time and availability during clinic operating hours.

3.4.5 Supervision and delegation arrangements shall be reviewed and adjusted following:
  a) Clinical incidents or near-misses
  b) Patient complaints
  c) Staff performance concerns
  d) Changes in workforce composition, skill mix, or service capability

Standard 3.5 – Re-credentialling

Clinical competence and performance are maintained, reviewed, and supported over time to ensure safe, high-quality urgent care.

Criteria:

3.5.1 The service shall support continuing professional development that is relevant to urgent care practice, role, scope of practice, and identified learning needs.

3.5.2 Re-credentialling of clinical staff shall occur at defined intervals and is informed by evidence of current competence, performance, scope of practice, and clinical risk.

3.5.3 Processes shall exist to identify, manage, and resolve performance or competence concerns in a fair, timely, and supportive manner that prioritises service user safety.

3.5.4 Outcomes of competence review and re-credentialling shall be documented and reviewed to ensure ongoing effectiveness of workforce assurance processes.

Standard 3.6 – Workplace Culture, Psychosocial Safety and Staff Wellbeing

Safety culture and psychological safety are periodically assessed and used to inform improvement actions, proportionate to service size and risk. (ISQua Principle 8)

Criteria:

3.6.1 The service shall have a documented approach to promoting positive workplace culture and psychological safety.

3.6.2 Workforce management practices shall support fairness, respect, and natural justice.

3.6.3 Psychosocial hazards (including violence, aggression, bullying, fatigue, and moral distress) shall be identified, assessed, and managed in a manner proportionate to service size and risk.

3.6.4 Staff shall have access to appropriate psychosocial support following incidents, complaints, or traumatic events.

3.6.5 Processes shall exist to raise and address concerns about workplace behaviour, culture, or safety without fear of reprisal.

3.6.6 Workforce wellbeing indicators (such as turnover, absenteeism, and incident trends) shall be monitored and reviewed at governance level.

Part 4 – Clinical Care Delivery and Escalation

Overarching Outcome:
Clinical care is delivered safely and effectively within defined scope and capability, with timely recognition of deterioration and appropriate escalation for adults, children, and young people.

Standard 4.1 – Triage and Initial Assessment (UCS15 3.2)

Service users undergo an initial assessment of the severity of their condition in order to determine priority of treatment.

Criteria:

4.1.1 The service shall have a documented triage system based on the Australasian College for Emergency Medicine (ACEM) triage scale, or an equivalent that is approved by the Royal New Zealand College of Urgent Care. Staff performing triage shall be trained, credentialled, and authorised to do so, and competency is reviewed at defined intervals.

4.1.2 The service shall ensure it has signage that:
- a) Directs service users to the reception area on arrival
- b) Informs service users about the triage process and that the service shall see service users according to their triage priority rating
- c) Lists life-threatening symptoms
- d) Informs service users that they should advise clinic personnel immediately when they present with or develop life-threatening symptoms
- e) Informs services users that urgent cases will be prioritised.
- f) Informs service users on request about the waiting time or general waiting times or a change in waiting time.

4.1.3 Receptionists shall be trained and follow the clinics documented guidelines for identifying and escalating life-threatening conditions when service users present at reception or deteriorate in the waiting area.

4.1.4 The service shall ensure a member of staff is in the reception area at all times during opening hours to monitor service users in the waiting area for deteriorating conditions.

4.1.5 The service provider shall audit their triage system including:
- a) Verification that triage has taken place, or if no triage occurred, that absence of triage is appropriate
- b) Assessments and measurements of time from presentation to triage and from presentation to the first assessment by the responsible clinician.
- c) Assessment of the appropriateness of triage decisions, categorization and waiting times.

4.1.6 The triage audit shall include a minimum sample size of service users selected across the opening hours based on square root of the total number of annual users. The frequency of audit shall be not less than six-monthly.

4.1.7 When an assessment finds nonconformity with triage system requirements:
- a) The frequency of audit shall be increased
- b) A review and corrective action process shall be implemented.

Standard 4.2 – Recognising and Responding to Clinical Deterioration

Clinical deterioration is identified early, communicated clearly, and responded to promptly to reduce the risk of harm.

Criteria:

4.2.1 The service shall use validated clinical deterioration identification tools appropriate to urgent care to support early recognition of deteriorating service users.

4.2.2 Clinical deterioration identification tools shall align with, the *Health Quality and Safety Commission - New Zealand Early Warning Score Vital Sign Chart* and the *Recognising and Responding to Patient Deterioration Guide* to support consistency of assessment and escalation across settings, including:
- a) Adult and Paediatric-specific deterioration identification tools
- b) Observation frequency
- c) Escalation thresholds
- d) Expected clinical responses
- e) Deterioration scores or triggers.

4.2.3 Clear escalation pathways shall exist, including access to senior clinical decision-makers, ambulance services, or emergency departments where required.

4.2.4 Clinical handover shall use a structured approach to ensure accurate and timely communication of risk, assessment, and actions taken.

4.2.5 Staff responsible for recognising and responding to deterioration shall be trained and competent in the use of deterioration tools, escalation pathways, and communication processes.
4.2.6 Deterioration events, delayed escalations, or failures to respond shall be reviewed to identify learning and improvement opportunities.

Standard 4.3 – Mental Health, Behavioural and Psychosocial Crisis Care

People experiencing mental health, behavioural, or psychosocial crises receive timely, safe, respectful, and appropriate care, with escalation to specialist or emergency services where required.

Criteria:
4.3.1 The service shall have processes to identify and respond to acute mental health, behavioural, or psychosocial crises, including risk of harm to self or others.
4.3.2 The service shall use strategies to support de-escalation, safety, and dignity, and minimises the use of restrictive or coercive interventions.

Standard 4.4 – Safeguarding of Vulnerable People

People at risk of abuse, neglect, exploitation, or harm are identified early, supported appropriately, and safeguarded through timely action and escalation.

Criteria:
4.4.1 The service shall have clear procedures for responding to suspected or confirmed safeguarding concerns, including immediate safety actions and referral to appropriate agencies.
4.4.2 Safeguarding responses shall align with relevant legislation, national guidance, and interagency expectations, including mandatory or expected reporting requirements.
4.4.3 Staff shall receive training appropriate to their role to recognise and respond to safeguarding concerns.

Standard 4.5 – Referrals and Advice for Non-Urgent Presentations (UCS15 – 3.6)

The service user has referrals made through effective links with other health and disability service providers.

Criteria:
4.5.1 Where urgent care is not required, service users shall be provided with clear, timely, and appropriate advice or referral to alternative services that better meet their needs.
4.5.2 Referral decisions shall reflect patient wishes (where applicable), education and up-to-date information about local, regional, or national services, including primary care, after-hours services, community services, or digital health services.
4.5.3 The service shall ensure that referral or advice does not delay care for people whose condition may deteriorate and that clear instructions are provided on when and how to seek further care.

Part 5 – Medicines Management and High-risk Interventions

Overarching Outcome:

Medicines and high-risk interventions are managed safely and appropriately to minimise harm and support effective urgent care treatment.

Standard 5.1 – Medication Safety and Prescribing (UCS15 – 4.1)

Medicines are prescribed, supplied, administered, and managed safely to minimise the risk of medication-related harm. (aligns with Nga Paerewa 3.4)

Criteria:
5.1.1 The service shall have a documented and implemented medication safety framework that applies across prescribing, supply, administration and monitoring within urgent care.

5.1.2 Medication histories, allergies, and adverse drug reactions shall be obtained, documented, and reviewed prior to prescribing or administration.
5.1.3 Medicines supplied or administered shall be clearly documented in the clinical record, including dose, route, timing, the prescriber and administrator, and any advice provided to the service user or whānau.
5.1.4 A certified Cold-Chain system shall be in place and regularly monitored that complies with the National Standards for Vaccine Storage and Transportation for Immunisation Providers.
5.1.5 Processes shall exist to manage anti-microbial stewardship, in line with national guidelines.
5.1.6 Service users shall be provided with appropriate information about medicines prescribed or supplied, including purpose, key risks, and follow-up or safety-netting advice.
5.1.7 Medication-related errors, near misses, and adverse drug events shall be reported, reviewed, and used to inform quality improvement and risk mitigation activities.

Standard 5.2 – Standing Orders

Where the service uses standing orders, they are managed in accordance with New Zealand legislation and best practice guidelines.

Criteria:

5.2.1 The service shall ensure each standing order is issued by an authorised issuer, is current, documented, signed and dated by the issuer, and contains all matters required by regulation and best practice guidance, including monitoring.
5.2.2 The service shall ensure standing orders are used only for lawful administration or supply of medicines and are not used for proxy prescribing, unsigned prescriptions, pre-signed prescriptions, or dispensing outside lawful authority.
5.2.3 Where countersigning is required, the issuer shall countersign in the clinical record within the timeframe specified in the standing order.
5.2.4 The issuer shall review and re-sign and reissue each standing order at least annually, or sooner where indicated.
5.2.5 Where a standing order is embedded in a clinical pathway, protocol or guideline, the standing order component shall remain clearly identifiable and meet all legislative and organisational requirements.
5.2.6 The service shall not authorise unregulated health care workers to supply or administer medicines under standing orders.

Standard 5.3 – Controlled Drugs Management (UCS15 - 4.1)

Controlled drugs are prescribed, stored, administered, recorded, and disposed of safely and lawfully to minimise the risk of harm, diversion, or misuse.

Criteria:

5.3.1 The service shall have documented policies and procedures for the management of controlled drugs that align with applicable legislation and regulatory requirements.
5.3.2 Prescribing, supply, and administration of controlled drugs shall be undertaken only by appropriately authorised clinicians within their scope of practice.
5.3.3 Access to controlled drugs shall be:
  a) Restricted to authorised personnel,
  b) Stored securely (controlled drug safe)
  c) Recorded in a controlled drug register.
5.3.4 Accurate, contemporaneous records shall be maintained for the receipt, prescribing, administration, and disposal of controlled drugs, and records are subject to at least six-monthly review.
5.3.5 Processes shall exist to ensure independent checks where required, particularly for high-risk controlled drugs and doses.
5.3.6 An alert system shall be in place for identifying and managing service users who are seeking drugs of addiction.
5.3.7 Discrepancies, losses, suspected diversion, or misuse of controlled drugs shall be promptly investigated, managed, and escalated in accordance with policy and legislation.

5.3.8 Controlled drug management practices shall be included in routine audit, risk review, and quality improvement activities.

Standard 5.4 – Conscious Sedation

Where the service uses conscious sedation, it is provided safely, appropriately, and within defined capability to minimise the risk of harm. Where a service has chosen not to provide conscious sedation this is documented.

Criteria:

5.4.1 Conscious sedation shall comply with ANZCA Procedural Sedation Guideline and be performed only by clinicians who are credentialled, trained, and authorised to do so within their scope of practice.

5.4.2 Informed consent for conscious sedation shall be obtained and documented wherever feasible, including discussion of risks, benefits, and alternatives.

5.4.3 Appropriate equipment, medicines, monitoring, and resuscitation capability shall be available and checked prior to conscious sedation.

5.4.4 Service users undergoing conscious sedation shall be monitored appropriately during and after the procedure, with clearly defined criteria for recovery and discharge or escalation.

5.4.5 Clear escalation pathways shall exist for adverse events, failed sedation, or clinical deterioration, including timely access to ambulance services or emergency departments.

Part 6 – Diagnostics and Clinical Decision Support

Overarching Outcome:

Diagnostic services are used safely, effectively, and within service capability to support timely clinical decision-making and continuity of care.

Standard 6.1 – Results Management (UCS15 – 3.3)

Results are managed safely to ensure timely review, appropriate action, and continuity of care.

Criteria:

6.1.1 The service shall maintain a results tracking system that monitors:
a) Tests that have been ordered and not performed
b) Reports including laboratory results, imaging reports, investigations, and relevant clinical referral letters
c) Timely follow-up of reports, and immediate and appropriate action.

6.1.2 The service shall ensure a clinician takes responsibility for:
a) Review and action of all reports within 48 hours of receipt
b) Annotating as suitable for filing all reports prior to filing.

6.1.3 The service shall ensure that all tests or investigations requiring follow-up are communicated to the service user at the earliest opportunity and are documented in the clinical record.

6.1.4 Service users shall have the opportunity to request notification of all test results if the services' policy is to only notify abnormal, critical, or unexpected results.

6.1.5 Abnormal, critical, or unexpected results shall trigger defined escalation and communication processes, including contact with the service user, whānau, or receiving service where required.

6.1.6 Service users shall be provided with clear information about what to do if symptoms worsen or results are not received.

6.1.7 Result management processes shall be reviewed through audit, incident review, or quality improvement activities to identify delays, failures, or system improvements.

Standard 6.2 – Radiology Governance and Discrepancy Management

Radiology investigations are governed and managed to support accurate diagnosis, timely action, and continuity of care, including management of discrepancies.

Criteria:

6.2.1 The service shall ensure that the responsible clinician documents the initial interpretation of the image, provisional diagnosis and follow up. Where x-rays are ordered by staff other than the

responsible clinician the service will define the scope of this practice and ensure staff are appropriately trained.

6.2.2 Where an X-ray is deferred, the service shall have a process to make alternative arrangements for imaging to occur, be reported on and enable follow-up.

6.2.3 The service shall ensure that a radiologist report is received on all radiology investigations within 72 hours.

6.2.4 Clear responsibility shall be assigned for reviewing radiology reports, including provisional, preliminary, or final reports that become available after the service user has left the service.

6.2.5 Processes shall exist to identify, manage, and escalate discrepancies between provisional or preliminary interpretations and final radiology reports.

Standard 6.3 –Point-of-Care Testing (POCT)

Where the service has implemented the use of point-of-care testing devices, they are clinically governed and used safely to support timely, accurate clinical decision-making.

Criteria:

6.3.1 Point-of-care testing devices and methods shall be selected, maintained, and used in accordance with manufacturer guidance and relevant quality standards.

6.3.2 Staff performing point-of-care testing shall be trained, credentialled, and authorised to do so, and competency is reviewed at defined intervals.

6.3.3 Clinical governance, calibration, and maintenance processes shall be in place to ensure the accuracy and reliability of point-of-care test results.

6.3.4 Point-of-care test results shall be documented in the clinical record and communicated as part of handover, referral, or escalation where relevant.

6.3.5 Point-of-care testing practices, errors, or discrepancies shall be monitored, reviewed, and used to inform quality improvement activities.

Standard 6.4 – Point-of-Care Ultrasound (POCUS)

Where the service has implemented point-of-care ultrasound, it is clinically governed and used safely to support timely, accurate clinical decision-making.

Criteria:

6.4.1 POCUS devices and methods shall be selected, maintained, and used in accordance with manufacturer guidance and relevant quality standards.

6.4.2 Staff performing POCUS shall be trained, credentialled, and authorised to do so, and competency is reviewed at defined intervals.

6.4.3 Clinical governance, calibration, and maintenance processes shall be in place to ensure the accuracy and reliability of POCUS results.

6.4.4 POCUS use, images, findings, and limitations shall be documented in the clinical record, including where scans are incomplete, educational or non-diagnostic.

6.4.5 POCUS practice shall be included in quality assurance, peer review, or audit activities appropriate to service size and scope.

Standard 6.5 – Ophthalmic Assessment and Slit Lamp Biomicroscopy

Slit lamp biomicroscopy, it is clinically governed and used safely to support timely, accurate clinical decision-making.

Criteria:

6.5.1 Staff performing slit lamp biomicroscopy and ocular assessment shall be trained, credentialled, and authorised to do so, and competency is reviewed at defined intervals.

Standard 6.6 - Plastering and Fracture Immobilisation

Plastering and fracture immobilisation, it is clinically governed and used safely to support timely treatment.

Criteria:

6.6.1 The scope of plastering services (e.g. upper limb, lower limb, back slabs, full casts, splinting) shall be formally defined and approved through clinical governance processes.

6.6.2 Staff performing plaster application and fracture immobilisation shall be trained, credentialled, and authorised to do so, and competency is reviewed at defined intervals.

6.6.3 Plaster application and fracture immobilisation shall be documented in the clinical record.

6.6.4 The service shall have systems to monitor outcomes of plaster application and fracture immobilisation and manage complications promptly.

Part 7 – Infection Prevention and Control

Overarching Outcome:

The urgent care service prevents, identifies, and manages infection risks through effective infection prevention and control practices that protect service users, whānau, staff.

Standard 7.1 – Infection Prevention and Control Programme (UCS15 – 4.2)

Infection risks are minimised through a coordinated infection prevention and control programme that protects service users, whānau, staff. (aligns with Nga Paerewa 5.0)

Criteria:

7.1.1 The service shall have a documented infection prevention and control (IPC) programme appropriate to the scope, size, and risk profile of urgent care. Policies shall include:

- a) Hand Hygiene
- b) Standard precautions
- c) Aseptic technique
- d) transmission-based precautions
- e) Sharps management
- f) Single use medical devices

7.1.2 The IPC programme shall align with national guidance and system expectations, including Health New Zealand infection prevention and control frameworks.

7.1.3 Roles and responsibilities for IPC leadership, advice, and implementation shall be clearly defined and supported.

7.1.4 Standard and transmission-based precautions shall be applied based on assessed infection risk, including early identification and separation of potentially infectious service users.

7.1.5 The service shall ensure appropriate use of personal protective equipment (PPE), including availability, training, and fit-for-purpose use.

7.1.6 Environmental cleaning and waste management shall be managed to reduce infection risk.

7.1.7 Staff shall receive education and training appropriate to their role on IPC principles, practices, and emerging risks.

7.1.8 IPC incidents, breaches, or near misses shall be reported, reviewed, and used to inform improvement.

7.1.9 The IPC programme shall be monitored and reviewed regularly to ensure effectiveness and ongoing alignment with current guidance.

Standard 7.2 – Pandemic, Epidemic and Communicable Disease Preparedness

The service is prepared to respond effectively to pandemics, epidemics, and communicable disease outbreaks, protecting service users, whānau, staff.

Criteria:

7.2.1 The service shall have plans and procedures in place to prepare for, respond to, and recover from pandemics, epidemics, and communicable disease outbreaks relevant to the role of urgent care.

7.2.2 The service shall have processes to rapidly adapt models of care, workflows, and physical environments (e.g. evidence-based mitigations against airborne transmission) to manage increased demand, infection risk, or changed clinical presentations during outbreaks.

7.2.3 Workforce arrangements shall support safe staffing, role flexibility, and staff wellbeing during outbreaks.
7.2.4 Arrangements shall exist to support continuity of service during outbreaks, including management of supply constraints, PPE availability, and service prioritisation.
7.2.5 The service shall review outbreak responses and identify lessons learned to inform improvements to response and recovery plans.

Standard 7.3 – Reprocessing of Reusable Medical Devices (UCS15 – 4.1)

Where reusable medical devices are reprocessed onsite, the process is safe, effective and minimises the risk of infection or harm.

Criteria:

7.3.1 The service shall identify which reusable medical devices are reprocessed and the level of reprocessing required.
7.3.2 Reprocessing practices shall align with recognised standards and guidance, including *AS/NZS 5369 Reprocessing of reusable medical devices and other devices in health and non-health related facilities,* as applicable to the service context.
7.3.3 Staff involved in reprocessing shall be trained, competent, and supported to perform reprocessing activities safely.
7.3.4 Equipment, environments, and consumables used for reprocessing shall be appropriate, maintained, and used according to manufacturer and standard requirements.
7.3.5 Reprocessing activities, incidents, or failures shall be monitored, reported, and reviewed to inform improvement.

Part 8 – Civil Defence Emergency Preparedness and Business Continuity

Overarching Outcome:

The urgent care service is prepared to respond to civil defence emergencies and disruptions and can maintain, adapt, or safely restore urgent care services to protect service users, whānau, and staff.

Standard 8.1 – Civil Defence Emergencies and Business Continuity Planning (UCS15 – 4.2)

The service is prepared to respond to civil defence emergencies and disruptions in a way that maintains service user safety, workforce safety, and continuity of essential urgent care services.

Criteria:

8.1.1 The service shall have a civil defence emergency and business continuity plan appropriate to its scope, size, location, and risk profile.
8.1.2 Civil defence emergency and continuity planning shall consider a range of potential disruptions, including natural hazards, infrastructure failure and essential system outages.
8.1.3 Roles, responsibilities, and decision-making authority during civil defence emergencies shall be clearly defined and understood by staff.
8.1.4 The service shall have arrangements to coordinate civil defence emergency response and continuity actions with system partners.
8.1.5 The service shall ensure staff are familiar with civil defence emergency and continuity procedures relevant to their role, and the service undertakes training, drills, or exercises appropriate to its risk profile and associated evacuation plans (i.e. earthquake, tsunami, volcano)
8.1.6 Civil defence emergency responses, disruptions, or near misses shall be reviewed to identify lessons learned and inform improvements to preparedness and business continuity planning.

Part 9 – System Integration, Escalation and Transfer of Care

Overarching Outcome:

The urgent care service operates as part of an integrated urgent care system, enabling safe handover, escalation, and transfer of care.

Standard 9.1 – Integrated Urgent Care (UCS15 – 3.6)

Urgent care services operate as an integrated part of the local health system to support timely access, continuity of care, and appropriate use of health resources.

Criteria:

9.1.1 The service shall collaborate with relevant system partners to support coordinated access to urgent and after-hours care, including primary care, after-hours providers, and community services.

9.1.2 The service shall support appropriate service user streaming, redirection, or referral based on clinical need and system capacity.

9.1.3 The service shall participate in local planning, review, or improvement activities related to urgent and after-hours care delivery.

Standard 9.2 – Safe Transfer of Care

The urgent care service shall support timely escalation, safe transfer, and continuity of care through effective coordination.

Criteria:

9.2.1 The service shall have clear processes for clinical escalation, transfer, and referral when service users' needs exceed urgent care capability.

9.2.2 Clinical handover between urgent care and receiving services shall use a structured approach and include relevant clinical information, risks, investigations, treatments, and pending results.

9.2.3 Transfer arrangements shall support timely access to emergency care and recognise the role of ambulance, Primary Response in Medical Emergencies (PRIME), and integrated rural emergency responses where applicable.

9.2.4 Escalation and transfer events, including delays, adverse events, and near misses, shall be reviewed to support quality improvement and system coordination.

Part 10 – Digital Health, Information Management & Resilience

Overarching Outcome:

Digital health and information systems are governed and used to support safe care, access, continuity, confidentiality, and system resilience.

Standard 10.1 – Clinical Records and Continuity of Care (UCS15 – 3.5 & 3.7)

Clinical information is recorded, managed, and shared in a way that supports safe, timely, and coordinated care across the health system. **(aligns with Nga Paerewa 2.5)**

Clinical records are complete, accurate, and accessible to authorised users, and are retained, stored, and disposed of in line with NZ legal and sector requirements. (ISQua Principle 7)

Criteria:

10.1.1 The service shall maintain a clinical record of each consultation episode with sufficient information to describe the consultation and the plan of care, which also meets current evidence-based practice and legislative requirements.

10.1.2 The service shall ensure information is transferred to the primary care provider including case notes, laboratory referrals and tests requested.

10.1.3 The service users shall be given the option of not disclosing their consultations, diagnosis and test results to their usual primary care provider. The chosen option shall be documented.

10.1.4 Systems shall exist to support timely transfer of relevant clinical information when care is transferred, escalated, or shared with other services.

10.1.5 Clinical records shall be audited to support quality improvement and system reliability at least six monthly or more often when non-conformance is identified.

Standard 10.2 – Cybersecurity and Digital Resilience

Digital systems are governed and managed to support safe, reliable care delivery and protect against disruption, loss, or compromise of information. *(aligns with Nga Paerewa 2.5)*

The service maintains a documented cyber incident and data breach response process, including escalation and service user notification obligations where applicable. (ISQua Principle 7)

Criteria:

10.2.1 The service shall have governance arrangements that provide oversight of digital systems, information security, and digital risk appropriate to the size and complexity of the service.

10.2.2 The service shall identify and manages risks associated with digital system failure, cyber security threats, and loss of access to clinical information.

10.2.3 Downtime and recovery procedures shall be documented and support continuity of safe clinical care during planned or unplanned digital system outages.

10.2.4 Staff shall be aware of, and trained in, downtime procedures and safe workarounds relevant to their role.

10.2.5 Access to digital systems shall be managed through appropriate authentication (I.e. Data Level Protection and Multi-Factor Authentication) and role-based controls to reduce the risk of unauthorised access.

10.2.6 Processes shall exist to detect, respond to, and recover from cyber security incidents or data breaches, including escalation to relevant authorities where required.

10.2.7 Digital incidents, outages, or near misses shall be reviewed to identify learning and improvement opportunities.

Standard 10.3 – Telehealth and Virtual Care for Access, Triage and Care Delivery

Where the service has implemented telehealth and virtual care services, the system is used safely and effectively to support access to care, demand management, and integrated urgent and after-hours service delivery. Telehealth and virtual care services are provided in addition to the minimum clinical staffing requirements.

Criteria:

10.3.1 Where telehealth services are used, clear clinical governance and policy arrangements define scope of practice, clinical limitations, escalation thresholds, communication pathways, and accountability for care decisions.

10.3.2 The service considers the use of telehealth and virtual care to support timely access to urgent and after-hours care, assessment, and advice where appropriate.

10.3.3 Telehealth and virtual care models support demand management and system sustainability, particularly in rural or remote settings, without compromising minimum clinical staffing levels, service user safety, quality of care, or equity of access.

10.3.4 Telehealth and virtual care services support safe substitution for in-person care where clinically appropriate and ensure timely referral, escalation, or in-person assessment when required.

10.3.5 The service supports integration and coordination with relevant national or regional services, including telephone-based clinical advice and triage services such as Healthline, to enable consistent advice and coordinated service user pathways.

10.3.6 Telehealth and virtual care delivery models consider the needs of priority populations and address barriers related to connectivity, access to technology, digital literacy, language, culture, disability, or other factors that may affect equitable access to care.

10.3.7 Clinical information arising from telehealth and virtual care interactions is appropriately documented, communicated, and shared to support continuity, coordination, and safe ongoing care.

10.3.8 The safety, effectiveness, utilisation, and impact of telehealth and virtual care services are monitored and reviewed to support quality improvement and service development.

Standard 10.4 – Health Information Management and Confidentiality (UCS15 – 2.3 & 3.3)

Service user health information is collected, used, stored, and shared lawfully, securely, and respectfully to support safe care, continuity, and service user trust. (aligns with Nga Paerewa 2.5)

Criteria:

10.4.1 The service shall manage health information in accordance with applicable New Zealand legislation and codes.

10.4.2 Health information shall be collected, accessed, used, and disclosed only for legitimate clinical, operational, or legal purposes, and in a manner consistent with service user rights and expectations.

10.4.3 Access to service user information shall be restricted to authorised personnel based on role and responsibility, and safeguards are in place to protect against unauthorised access, loss, or misuse.

10.4.4 The service shall have processes to ensure the accuracy, completeness, and timeliness of clinical information, including correction of errors where identified.

10.4.5 Use of unique service user identifiers, including the National Health Index (NHI) number, shall support accurate identification, continuity of care, and safe information sharing, and is managed in accordance with national requirements.

10.4.6 Service users shall be informed, in an appropriate and accessible manner, about how their health information is collected, used, stored, and shared, including circumstances where information may be shared without consent as permitted by law.

10.4.7 Information sharing with system partners (including Health New Zealand services, ambulance services, ACC, and other providers) shall be lawful, purposeful, and limited to what is necessary to support care, safety, or system requirements.

10.4.8 Actual or suspected breaches of health information privacy or confidentiality shall be identified, managed, escalated, and reviewed in accordance with documented procedures and legal notification requirements.

Standard 10.5 – Artificial Intelligence (AI) and Emerging Technologies in Patient Care

Where the service has implemented the use of artificial intelligence (AI) and emerging technologies in patient care, they ensure AI is used safely, ethically, and within appropriate clinical governance frameworks, consistent with best practice guidance.

Where artificial intelligence or algorithmic tools are used, the service considers risks related to bias, reliability, transparency, and unintended consequences. (ISQua Principle 7)

Criteria

10.5.1 The service shall have a process to consult with staff delivering care, prior to the introduction of AI systems and emerging technologies.

10.5.2 The service shall maintain documented governance arrangements, policies, and quality improvement processes relating to the use of AI.

10.5.3 Clinicians shall retain responsibility for all clinical decisions and clinical documentation and do not rely solely on AI-generated recommendations and records.

10.5.4 AI systems used in service user care shall be appropriate for their intended purpose, regularly reviewed, and supported by processes for identifying and managing risks, errors, or adverse events.

10.5.5 The service shall have a process to obtain consent where AI tools are used to support patient care.

10.5.6 The service shall consider potential bias or inequitable impacts arising from AI data that is not reflective of regional diversity and how this may impact Māori and priority populations.

10.5.7 Staff using AI systems shall receive appropriate training in their safe use, limitations, and associated privacy obligations.

Part 11 – RNZCUC Vocational Training Site Accreditation

Overarching Outcome:

Where the service is an RNZCUC approved vocational training site, education and training activities are governed in a way that ensures service user safety, high-quality learning, and alignment with vocational medical specialist programmes.

Overarching Outcome:

Service providers approved as RNZCUC training sites provide high-quality vocational training that meets MCNZ accreditation requirements and supports RNZCUC trainees to achieve fellowship.

Standard 11.1 - Training Site Approval

Service providers seeking accredited training site status demonstrate eligibility through formal application and assessment and maintain ongoing compliance with approval requirements.

Criteria:

11.1.1 Service providers seeking approval as an RNZCUC accredited training site shall:
(a) Meet all requirements of this Urgent Care Standard
(b) Apply to RNZCUC for training site approval
(c) Demonstrate capacity to provide training that meets MCNZ and RNZCUC requirements
(d) Undergo RNZCUC training site assessment
(e) Maintain approval through ongoing compliance and periodic reassessment.

11.1.2 The training site provides a clinical environment with sufficient case volume, breadth of presentations, and educational resources to enable trainees to develop competence across the full scope of urgent care practice.

11.1.3 The training site provides a structured supervision framework that aligns with RNZCUC supervision policy that ensures trainees receive appropriate levels of clinical oversight matched to their stage of training, competency, and the complexity of clinical situations.

11.1.4 The training site utilises supervisors that are approved under the RNZCUC Supervisor Policy, or an equivalent medical college policy.

11.1.5 The training site ensures each trainee has a dedicated educational supervisor(s) who oversees their learning, monitors progress against curriculum requirements and supports their professional development.

11.1.6 The training site and RNZCUC shall collaborate to enable structured workplace-based assessments to occur across a range of clinical domains, with sufficient trained assessors available to meet curriculum requirements.

11.1.7 The training site provides a supportive, safe, and positive learning environment that prioritises trainee wellbeing, encourages a culture of learning from experience, and maintains open communication.

11.1.8 The training site has processes in place to identify trainees experiencing difficulty early, provide appropriate support and remediation, enable trainees to raise concerns safely, and manage fitness to practise issues in accordance with regulatory requirements.

11.1.9 The training site ensures comprehensive and accurate documentation is maintained for all aspects of trainee education, supervision, assessment, and progress, enabling effective monitoring and reporting. This may be achieved by utilising existing systems (i.e. UCCIS or ePort).

11.1.10 The training site ensures that formal training agreements between the site, trainee, and RNZCUC are in place.

11.1.11 The training site maintains regular, open communication with RNZCUC, promptly notify relevant matters affecting training or accreditation.

11.1.12 The training site participates in regular audits in line with RNZCUC accreditation requirements, to ensure compliance with training standards, identify areas for improvement, and demonstrate continuous quality improvement in training delivery.

Part 12 – Outsourced Clinical Services

Overarching Outcome:
Outsourced clinical services are evaluated to ensure safe, coordinated, and high-quality care.

Standard 12.1 – Oversight of Outsourced Clinical Services

Where the service has implemented outsourced clinical service arrangements, they are evaluated to ensure safe, high-quality, and coordinated care.

Criteria:

12.1.1 Outsourced clinical services operate within agreed scopes of practice, service expectations, and clinical governance arrangements consistent with the urgent care service's standards.
12.1.2 The service undertakes appropriate due diligence to ensure outsourced clinical services are competent, appropriately credentialled, and meet relevant regulatory and professional requirements.
12.1.3 Information sharing and communication arrangements support safe coordination of care, including timely access to relevant clinical information and results.
12.1.4 Performance, quality, and safety of outsourced clinical services are monitored and reviewed, including incidents, complaints, or adverse events.
12.1.5 Where issues are identified, corrective actions are implemented and reviewed to ensure ongoing safety and effectiveness.

Part 13 – Facilities and Physical Environment

Overarching Outcome:

Facilities and the physical environment are fit for purpose, safe, accessible, and support dignified, effective urgent care delivery.

Standard 13.1 – Fit-for-purpose Clinical Facilities (UCS15 – 4.1)

Facilities support the scope, capability, and volume of services delivered. (Aligns with Nga Paerewa 4.1)

Facilities, utilities, and wayfinding arrangements support safe access and are maintained and safety-checked, proportionate to service capability. (ISQua Principle 4)

Criteria:

13.1.1 The service shall operate from facilities that are appropriate for the scope and acuity of urgent care services provided and comply with applicable building, safety, and local authority requirements relevant to healthcare premises.
13.1.2 Designated clinical spaces shall be sufficient in size, layout, and configuration to enable safe assessment, treatment, observation, including allowing clinicians unobstructed access to both sides of the service user, immediate access to emergency equipment where required, and sufficient space for the safe use and movement of clinical equipment during treatment, resuscitation and emergency response.
13.1.3 The service shall ensure directional signage and wayfinding enable effective service user flow.
13.1.4 The service shall have a Building Warrant of Fitness and an evacuation plan approved by the Fire and Emergency New Zealand (FENZ). Planned trial evacuations shall be undertaken at least annually.
13.1.5 The service shall have a system that ensures any medical equipment meets legislative and manufacturer requirements in regard to function testing, calibration, validation, maintenance and electrical safety.
13.1.6 The service shall ensure that all designated patient areas where medical electrical equipment is used are electrically protected in accordance with AS/NZS 3003, including the provision of appropriate residual current device (RCD) protection for Body-Protected Areas and Cardiac-Protected Areas.

Standard 13.2 – Privacy, Dignity and Cultural Appropriateness (UCS15 – 4.1)

Facilities support service user privacy, dignity, cultural safety, and whānau-centred care.

Criteria:

13.2.1 Facilities shall provide appropriate private spaces with auditory and visual privacy for clinical assessment, treatment, and sensitive discussion.
13.2.2 Facilities shall include access to private, safe, and dignified spaces for breastfeeding or expressing milk.
13.2.3 Facilities shall support culturally safe care, including respect for tikanga and diverse cultural needs.

Standard 13.3 – Environmental Safety (UCS15 – 4.1)

Facilities minimise environmental risk.

Criteria:

13.3.1 Clinical areas shall minimise environmental risks, including appropriate hand hygiene facilities and cleaning processes.

13.3.2 Facilities shall enable safe separation of clean and contaminated workflows.

13.3.3 Environmental risks (e.g. slips, sharps, hazardous substances) are identified and managed.

Standard 13.4 – Storage of Medicines, Equipment and Clinical Supplies (UCS15 – 4.1)

Medicines, equipment, and clinical supplies are stored and managed safely.

Criteria:

13.4.1 Medicines shall be stored securely, appropriately, and in accordance with legislative and professional requirements.

13.4.2 Temperature-sensitive medicines shall be stored with appropriate monitoring and controls.

13.4.3 Clinical equipment and consumables shall be stored to maintain cleanliness, accessibility, and safety.

13.4.4 Facilities shall support safe storage and preparation of materials used for procedures, including wound care and plastering.

Standard 13.5 – Procedural and Treatment Areas (UCS15 – 4.1)

Facilities support safe and effective delivery of urgent care procedures.

Criteria:

13.5.1 The service shall ensure there is a designated resuscitation room which includes:

- a) Ambulance access (wheelchair and stretcher compatible)
- b) Adequate clinical space that allows full access to the service user
- c) A bed or trolley that enables treatment
- d) Readily accessible emergency resuscitation equipment
- e) An emergency system to call for assistance
- f) Adequate lighting.

13.5.2 The service shall ensure there is a designated plaster room available to support fracture management which includes:

- a) Wheelchair and stretcher compatibility
- b) Adequate clinical space that allows full access to the service user
- c) A bed or trolley that enables treatment
- d) Access to fracture management and plastering equipment
- e) An emergency system to call for assistance
- f) Adequate lighting.

13.5.3 There service shall ensure there are procedural areas that support service user safety, staff ergonomics, and infection control.

Standard 13.6 – Diagnostic X-ray Services (UCS15 – 4.1)

Diagnostic X-ray services are used safely, lawfully, and effectively to support urgent care assessment and decision-making.

Criteria:

13.6.1 The service shall ensure X-ray services are available on site or within a short, covered walkway suitable for wheelchair access.

- a) open weekdays for 6 hours per day as minimum and,
- b) open for a minimum of 3 hours per weekend, or
- c) operate an on-call service for at least 6 hours per weekend.

13.6.2 The service shall ensure X-ray services are available during weekday clinic hours of operation, or 6 hours per day as a minimum.

13.6.3 The service shall ensure X-ray services is utilised and available during weekend clinic hours of operation, or at a minimum 3 hours per weekend, or an on-call service for at least 6 hours per weekend.

13.6.4 X-ray services shall comply with applicable radiation safety legislation and licensing requirements.

13.6.5 Radiation exposure shall be minimised, particularly for children and pregnant people, consistent with best practice.

Standard 13.7 – Accessibility and Inclusivity (UCS15 – 4.1)

Facilities are accessible and inclusive for all service users and whānau.

Criteria:

13.7.1 Facilities shall be accessible for people with disabilities and enable safe and dignified use of the service.

13.7.2 Facilities for service users with disability or mobility limitations shall include:

a) Designated car parking with adequate night time lighting
b) Clinic external approaches and interior areas that are accessible by wheelchair
c) Waiting area with specialised seating (elevated and with arms)
d) A toilet with mobility access.

Standard 13.8 – Safety, Security and Staff Wellbeing

Facilities support the safety and wellbeing of service users, whānau, and staff.

Criteria:

13.8.1 The service provider shall have arrangements for the safety and security of service users, staff and the clinic facility, including a system to summon timely emergency assistance.

13.8.2 Facilities shall support management of behavioural disturbance, including access to safe spaces and exit routes where required.

13.8.3 Environmental controls shall support wellbeing, including rest areas where appropriate.

Standard 13.9 – Prominent signage. (UCS15 – 4.1)

Service users can identify and access the Urgent Care Clinic, understand the services available and associated fees, and obtain timely information about how to access urgent care services when the clinic is closed.

Criteria:

13.9.1 The service shall ensure signage clearly identifies the facility as an Urgent Care Clinic and provides service users with clear information regarding:

a) clinic name and urgent care designation
b) clinic opening hours
c) consultation fees and charges.
d) services available on-site (such as laboratory, pharmacy, podiatry, dental, physiotherapy, audiology, and optometry)
e) how to access urgent care services when the clinic is closed, including alternative urgent care providers and after-hours telephone services

Normative Appendix 1 – Essential Equipment for Urgent Care Clinic RNZCUC Accreditation

1. Assessment and Diagnostic Equipment

Vital Signs and General Assessment

- Pulse oximeter
- Scales
- Sphygmomanometer with full range of cuffs
- Stethoscope
- Tape measure
- Thermometer

Neurological Assessment

- Reflex hammer

Ear, Nose and Throat Assessment

- Otoscope with adult and child earpieces
- Tuning forks (256 Hz and 512 Hz)

Eye Assessment

- Blue light
- Fluorescein
- Ophthalmoscope
- Slit lamp
- Snellen eye chart

Laboratory and Specimen Collection

- Blood taking equipment
- Spatulas
- Syringes and needles
- Urinalysis testing equipment
- Microbiology swabs

Point-of-Care Testing

- Blood glucose testing equipment

Respiratory Assessment

- Peak flow meters and mouthpieces (all ranges)

Gastrointestinal and Genitourinary Assessment

- Proctoscope
- Urinary catheterisation sets and catheters (male and female, multiple sizes)

2. Airway, Breathing and Resuscitation Equipment

Airway Management

- Airway suction
- Cricothyroidotomy set
- Laryngoscope
- Oropharyngeal airways (all sizes)
- Supraglottic airways (all sizes)

Ventilation and Oxygen Therapy

- Bag-mask ventilators
- Mobile examination/resuscitation bed or trolley

- Oxygen supply with regulator, tubing, nebulisers and masks

Medication Delivery Devices

- Mucosal atomiser device (for intranasal medication administration)
- Spacer devices

3. Cardiac and Emergency Monitoring

- 3-lead ECG monitor/recorder
- 12-lead ECG machine
- Manual defibrillator or AED with manual function

Note: AED alone without ECG monitoring capability is inadequate.

4. Shock and Intravenous Therapy

Intravenous Access and Infusion Equipment

- IV administration sets (including metrisets)
- IV luer plugs
- IV setup and infusion equipment
- IV cannulas (14–26 gauge)

Intravenous Fluids

- IV fluids – 0.9% saline
- Sterile water for injection

5. Wound and Minor Surgical Procedures

Wound Examination and Lighting

- Angle poised lamp

Procedural Instruments

- Scalpel blades
- Scalpel handles
- Forceps

Wound Closure

- Fine needles
- Monofilament nylon sutures (3/0–6/0)
- Skin closures
- Suturing equipment
- Wound glue

Dressings

- Adhesive dressings

6. Fracture and Musculoskeletal Management

Splinting and Immobilisation

- Dorsal blocking splint equipment
- Knee splints or Robert Jones bandaging materials
- Mallet finger splints (all sizes)
- Moonboots (all sizes)
- POP splints
- Wrist, hand and thumb splints (all sizes)

Cast Application and Removal

- Electric plaster saw
- Plaster scissors

- Plaster splitter

Mobility Aids

- Crutches
- Wheelchair

Orthopaedic Support Equipment

- Ring cutter

7. Women's Health and Obstetric Equipment

- Fetal doppler
- Pregnancy testing kits
- Vaginal specula
- Maternity delivery pack
- Sponge forceps for vaginal examination

8. ENT Procedures

Epistaxis Management

- Nasal packing equipment (lighting, speculae, forceps, packing)

9. Medications

Emergency and Resuscitation Medications

- Adrenaline
- Amiodarone
- Aspirin
- Atropine
- Glucagon
- Glucose 10% (injectable)
- Glyceryl trinitrate
- Naloxone hydrochloride
- Oral and injectable corticosteroids
- Salbutamol

Analgesia, Sedation and Procedural Medications

- Benzodiazepine (injectable or rectal)
- Eye local anaesthetic
- Fentanyl
- Lignocaine
- Local anaesthetic
- Midazolam
- Narcotic (injectable)
- Paracetamol

Anti-Infective and Immunisation Agents

- Antibiotics (injectable)
- Tetanus toxoid

Allergy and Symptom Management

- Antiemetics
- Antihistamine

Cardiovascular and Fluid Management

- Frusemide

Specialised and Reversal Agents

- Benztropine
- Flumazenil
- Vitamin K injection

Injectable Preparations and Adjuncts

- Sterile water for injection

10. Instrument Reprocessing, Sterilisation and Sterile Supply (Where a clinic reprocesses onsite)

Pre-treatment and Cleaning

- Enzymatic cleaning solution or approved instrument detergent
- Instrument cleaning brushes
- Instrument drying equipment and materials
- Personal protective equipment (gloves, eye protection, aprons)
- Sink facilities for instrument cleaning
- Ultrasonic cleaner (where applicable)

Inspection and Preparation

- Illuminated inspection area
- Instrument maintenance and lubrication products
- Magnification device for instrument inspection

Sterile Packaging

- Heat sealer (where applicable)
- Labelling and traceability materials
- Sterilisation indicator strips and tapes
- Sterilisation pouches and wraps

Sterilisation Equipment

- Bench-top steam steriliser (autoclave) compliant with relevant standards
- Biological indicators (where required)
- Chemical indicators
- Steriliser logbook or electronic tracking system

Sterile Storage

- Closed storage cupboards or containers for sterile stock
- Designated clean storage area
- Sterility maintenance and stock rotation system

11. Recommended but Not Essential

Analgesia

- Methoxyflurane Penthrox (Green Whistle)

Emergency Vascular Access

- Intraosseous (IO) equipment

Imaging and Diagnostics

- Point-of-care ultrasound (POCUS)

Informative Appendix 2 – Relevant Legislation, Regulation and Standards

This appendix identifies key legislation, regulations, codes, and standards relevant to the operation of urgent care services in Aotearoa New Zealand.

Urgent care services are responsible for complying with all applicable legal and regulatory requirements relevant to their scope, size, workforce, and service model. Not all requirements listed will apply to every service; applicability depends on context, activities undertaken, and statutory thresholds.

Core Health and Disability Legislation

- Health and Disability Commissioner Act 1994
- Code of Health and Disability Services Consumers' Rights (1996)
- Health and Disability Services (Safety) Act 2001
- Pae Ora (Healthy Futures) Act 2022
  (including establishment of Health New Zealand and system integration expectations)

Privacy, Information and Data Protection

- Privacy Act 2020
- Health Information Privacy Code 2020
- Public Records Act 2005
  (as applicable to retention and disposal of health records)
- National Health Index (NHI) Rules 2023 (and successor instruments)

Workforce Regulation and Professional Practice

Medical

- Health Practitioners Competence Assurance Act 2003
- Medical Council of New Zealand – Good Medical Practice
- Medical Council of New Zealand – Professional Standards and Guidance
- Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes (effective 1 July 2022)
- Medical Council of New Zealand training and supervision guidance (including updates effective from 2025)

Nursing

- Nursing Council of New Zealand – Competencies for Registered Nurses
- Nursing Council of New Zealand – Scope of Practice Framework
- Code of Conduct for Nurses

Other Regulated Health Professions

- Relevant standards, scopes, and competence frameworks issued by:
    - Paramedic Council
    - Physician Associate regulatory frameworks (where applicable)
    - Other responsible authorities under the HPCA Act

Medicines, Controlled Drugs and Therapeutics

- Medicines Act 1981
- Medicines Regulations 1984
- Misuse of Drugs Act 1975
- Misuse of Drugs Regulations 1977
- Medicines Care Guides and Prescribing Standards (as applicable to scope)
- National Standards for Vaccine Storage and Transportation for Immunisation Providers 2017

Diagnostic and Radiation Safety

- Radiation Safety Act 2016
- Radiation Safety Regulations 2016
- Office of Radiation Safety Codes of Practice (as applicable)

- Health Practitioners Competence Assurance Act 2003 (as it applies to diagnostic authorisation and competence)

Infection Prevention, Public Health and Safeguarding
- Health Act 1956
- COVID-19 Public Health Response Act 2020 (where applicable)
- Health (Infectious and Notifiable Diseases) Regulations
- Oranga Tamariki Act 1989
  (child protection and safeguarding obligations)
- Family Violence Act 2018

Health and Safety at Work
- Health and Safety at Work Act 2015
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- Health and Safety at Work (Hazardous Substances) Regulations 2017
- WorkSafe New Zealand guidance (including psychosocial risk)

Facilities, Buildings and Emergency Preparedness
- Building Act 2004
- Building Regulations 1992
- Building Warrant of Fitness (BWOF) requirements (where applicable)
- Fire and Emergency New Zealand Act 2017
- Approved Evacuation Schemes (where required)
- Local authority bylaws and compliance requirements relevant to healthcare premises

Reprocessing, Equipment and Environmental Standards
- AS/NZS 5369:2023 – Reprocessing of reusable medical devices and other devices in health and non-health related facilities
- Waste Minimisation Act 2008 (as applicable)

Quality, Safety and Accreditation Standards
- Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)
- ISQua External Evaluation Association (IEEA) Guidelines and Principles for the Development of Health and Social Care Standards – 6th Edition

Digital Health, Cybersecurity and Technology
- Health Information Governance frameworks issued by Health New Zealand
- New Zealand Information Security Manual (NZISM) (where applicable)
- Algorithm Charter for Aotearoa New Zealand (relevant to AI and decision-support use)

ACC-related Requirements (where applicable)
- Accident Compensation Act 2001
- ACC Operational Policies and Reporting Requirements
- ACC Injury-related Care Pathways and Quality Expectations

Additional Guidance and Sector Frameworks
- Health New Zealand urgent and after-hours care frameworks
- Ambulance sector handover and escalation guidance
- New Zealand Resuscitation Council (NZRC) / ANZCOR Guidelines

Electrical Regulations
- Electricity (Safety) Regulations 2010
- AS/NZS 3000 Wiring Rules
- AS/NZS 3003 Patient Areas standard
- AS/NZS 3551 for medical equipment management/testing.

Informative Appendix 3 – RNZCUC National Patient Satisfaction Survey Questions

Required:

Reception

1) The people at the front desk were nice, polite, and quick at their job.
2) The people at the front desk treated me well and respected me.
3) The people at the front desk listened to my questions and gave me helpful answers.

Nurse(s) / Doctor(s)

1) The nurse or doctor treated me well, respected me, and was polite.
2) The nurse or doctor listened carefully to my worries and questions.
3) The nurse or doctor spent enough time talking to me about my health problem.
4) I felt safe and trusted the nurse or doctor during my visit.
5) The nurse or doctor explained my sickness or health problem in a way that was easy for me to understand.
6) The nurse or doctor told me about different ways to treat my health problem, and I got to ask questions about them.
7) Me, my family or whānau were included in the decisions about my health plan.
8) I understood what the nurse or doctor said about any medicine I need to take or how to handle my health problem after I leave.
9) I know what to do next for my health (my follow-up plan) and when I should go back to see a doctor or get more help.
10) I know exactly who to call if I need help after my visit.

Privacy, Accessibility and Cultural Safety

1) My privacy was respected during my visit (meaning my private information wasn't shared without my permission).
2) The staff respected my culture, religion, and personal values and beliefs during my visit.
3) It was easy for me to get inside the clinic.
4) The clinic was neat, tidy, and looked like a good place to get care.

Optional:

1) It was easy for me to find car parking or drop someone off.
2) I was clearly informed about the expected waiting time.
3) I am satisfied with the clinic's opening hours.
4) I received clear information about how to make a complaint.
5) I felt comfortable in the waiting area.
6) I felt safe while I was at the clinic.
7) The clinic was clean.
8) Hygiene supplies (such as sanitiser and masks) were readily available.
9) Refreshments were available when I needed them.
10) I would recommend this clinic to others who need urgent medical care.
11) I understood the purpose of my appointment today.
12) I knew where to look for information about the care I might need.

Additional Questions:

1) I am an enrolled patient at this clinic.
2) I know that I can book my appointment online.
3) I know that I can view my test results online.