



Australian Government

Department of Health, Disability and Ageing

Medicare Urgent Care Clinic Program Operational Guidance



Purpose and Scope

- The Medicare Urgent Care Clinic (Medicare UCC) Program Operational Guidance (the Guidance) sets the minimum requirements for Medicare UCCs including activities, infrastructure and staffing while allowing sufficient flexibility for services to adapt to local conditions and needs
- Medicare UCCs must be co-located/partnered with a General Practice that is accredited to a recognised and relevant standard such as the Royal Australian College of General Practitioner Standards for General Practice. This Guidance therefore focuses primarily on the particular aspects of urgent care rather than broader aspects of clinical governance and quality and safety in patient care.
- Strengthening Medicare and ensuring all Australians have access to affordable, high-quality primary care, when and where they need it, is a key priority for the Australian Government. A key objective of this commitment is to expand access to bulk billing services, both through the Medicare UCC Program and across the broader network of private care providers.
- To support this goal, Medicare UCCs must be co-located with, or partnered alongside, General Practices that offer full bulk billing, where local circumstances allow. Medicare UCC commissioners and providers will give preference to fully bulk billing General Practices. Commissioners will consider the bulk billing rates in their local area when commissioning Medicare UCCs, to help ensure that affordable General Practice care remains accessible to the community.
- Medicare UCCs may also consider accreditation to other relevant standards such as the National Safety and Quality Health Service Standards, and the National Safety and Quality Primary and Community Healthcare Standards, where appropriate.
- The Guidance does not extend to clinical guidelines or protocols (for example, management of specific conditions such as chest pain) as these areas are covered by other recognised guidelines.
- Where unique local context and needs require different operational parameters, formal requests must be submitted to the Department of Health, Disability and Ageing (the department). Operational arrangements that deviate from the Guidance must not be implemented prior to written approval.
 - For example, in remote areas of the Northern Territory, Medicare UCCs have different operating hours, signage and branding arrangements based on the unique environment and demand.
- The Guidance also supports broader relevant strategies to improve access to affordable, accessible primary health care services including the [Australia's Primary Health Care 10 Year Plan 2022–2032](#), the [Strengthening Medicare Taskforce Report](#), and the [National Aboriginal and Torres Strait Islander Health Plan 2021-31](#).
- This Guidance supersedes the Operational Guidance for Urgent Care Clinics, informed by lessons learnt through the initial Medicare UCC program phase, stakeholder feedback and the First Interim Evaluation Report. The Guidance is subject to regular updates to incorporate ongoing program learnings.

Acknowledgement

The Guidance was developed by the Commonwealth in collaboration with state and territory governments. It drew heavily on national and international standards, including the Royal New Zealand College of Urgent Care Urgent Care Standard, the Western Sydney Care Collective Urgent Care Service Standards, and the Australian College of Rural and Remote Medicine (ACRRM) Recommended Minimum Standards for small rural hospital emergency departments.

The Australian Government acknowledges the Traditional Owners and Custodians of Country throughout Australia. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people and acknowledge and respect their continuing connections and relationships to country, rivers, land and sea. We acknowledge the ongoing contribution Aboriginal and Torres Strait Islander people make across the health system and wider community. We also pay our respects to Elders past and present and extend that respect to all Traditional Custodians of this land.

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Definition of Terms

The definitions listed are specific to the Medicare UCC Program.

Term	Description
Commissioner	State or territory government or Primary Health Network responsible for commissioning Medicare UCCs and managing contracts with service providers.
HealthPathways	Online resource containing evidence-based guidance on treatment of chronic conditions, including referral pathways and adapted to the local area.
Medicare Benefits Schedule (MBS)	A listing of Medicare services subsidised by the Australian Government.
My Health Record	The My Health Record system is Australia's safe and secure online summary of a consumer's key health information, such as immunisations, prescription and dispensing information, hospital discharge summaries, pathology and diagnostic imaging reports, all in one place. Registered healthcare providers involved in a consumer's healthcare can access a consumer's My Health Record at the point of care. They can also upload and view key health information in a consumer's My Health Record to support clinical decision making and care coordination. A consumer has control over their My Health Record including being able to restrict access to their record and deciding which healthcare providers can access and view their record. The requirements of the use of the My Health Record system are outlined in the My Health Record Act 2012 and the Modernising My Health Record (Sharing by Default) Act 2025.
Triage	Preliminary assessment of patients to determine whether they are suitable to treat within a Medicare UCC, and the urgency of their treatment. While the guidance does not specify the triage system, Medicare UCCs are required to develop and implement a triage scoring system for clinical management of patients. Data on the urgency of presentations may be required to be recorded for monitoring and evaluation purposes and will be specified in contracts.

Term	Description
Usual General Practitioner (GP), usual health professional, or usual General Practice	Where 'usual GP' or 'usual General Practice' terms are utilised, they are also intended to refer to a patient's usual primary care provider which may include but is not limited to Aboriginal Community Controlled Health Services (ACCHS).

1. Scope of Services and Conditions

- 1.1. Medicare UCCs provide short term, episodic care for urgent conditions that are not immediately life-threatening¹.
- 1.2. Medicare UCCs must accept walk-in patients without the need for appointments.
- 1.3. Services provided at Medicare UCCs must be bulk billed, resulting in no out-of-pocket costs to patients.
 - 1.3.1. This also applies to diagnostic imaging and pathology services that are part of the patient's presentation to the Medicare UCC unless these services are not covered by Medicare. Patients must be notified about any potential costs and alternative options where relevant.
- 1.4. Medicare UCCs are encouraged to triage and treat Medicare ineligible patients. Any service provided must be free of charge to patients. Where Medicare UCCs make a business decision to not routinely treat Medicare ineligible patients, they must facilitate patient referral to appropriate care.
- 1.5. Medicare UCCs must triage patients of all ages, including children under 12 months of age.
- 1.6. Medicare UCCs must treat patients of all ages, including children under 12 months of age who present with conditions that fall within the scope of services. Where the patient presents with a condition that falls outside of Medicare UCC scope of services, they must be referred to other appropriate services.
- 1.7. Medicare UCCs must be equipped to treat presentations requiring urgent care including:
 - 1.7.1. Minor illnesses including respiratory illness, gastrointestinal illness and urinary tract infection
 - 1.7.2. Minor injuries including closed fractures, simple lacerations, simple eye injuries and minor burns
- 1.8. Medicare UCCs must be equipped to provide the following procedures requiring urgent care including:
 - 1.8.1. Wound management including gluing, suturing and dressings (including minor burns)
 - 1.8.2. Incision and drainage of abscesses
 - 1.8.3. Basic fracture management including application of backslabs and plasters
 - 1.8.4. Intravenous cannula insertion to allow for IV antibiotics and IV rehydration fluids
 - 1.8.5. Urinary catheter management and changes for males and females
 - 1.8.6. Removal of foreign bodies from the ear and nose
- 1.9. Medicare UCCs must provide care for acute exacerbations of chronic conditions (such as infective exacerbation of chronic obstructive pulmonary disease) but should not provide ongoing chronic disease care including chronic disease care plans or health assessments.

¹ This includes providing care for conditions which are being palliated, where treatment is aligned with a person's goals of care.

- 1.9.1. Medicare UCCs will provide bridging prescriptions for chronic conditions (such as hypertension) where not doing so would place the patient at clinical risk, however, these prescriptions will be for the shortest time possible, with the aim that longer prescriptions will be provided by the patient's usual primary care provider.
- 1.10. Medicare UCCs must treat chronic wounds where there is an urgent need, including considerations on timely access to other services.
- 1.11. Medicare UCCs must provide treatment for people with mental health conditions including acute exacerbations of mental health conditions and for co-occurring physical conditions requiring urgent care, where this can be done safely within the Medicare UCC.
- 1.12. Medicare UCCs can provide treatment for workplace injuries requiring urgent care.
 - 1.12.1. Medicare benefits are not payable where the medical expenses for the service are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability.
 - 1.12.2. Where a patient presents for an injury that is part of an ongoing workplace compensation claim, referral to GP for ongoing management is required.
- 1.13. Medicare UCCs may provide opportunistic vaccination (e.g., for seasonal influenza, COVID-19 or tetanus) as part of the acute treating episode. In addition, any administration of vaccines must be communicated to the patient's usual General Practice and entered into the Australian Immunisation Register.
- 1.14. In general, Medicare UCCs are not intended to conduct follow up care and instead, patients should be referred to their usual GP. However, in certain circumstances it may be appropriate for Medicare UCCs to provide follow up care including where a patient:
 - 1.14.1. Is not able to see their usual GP within an appropriate time frame (including follow up of urgent diagnostic results). Follow up should only occur until management of the condition can be transferred back to the patient's usual GP.
 - 1.14.2. Has a condition that requires care outside of their usual GP's capacity or capability or there is preference for the Medicare UCC to do this (for example, removal of sutures or fracture management).
 - 1.14.3. Does not have a usual GP and the Medicare UCC has not been able to connect the patient with a usual GP.
- 1.15. Medicare UCCs are not intended to treat potentially life-threatening problems (such as cardiac chest pain, severe shortness of breath or altered conscious state) or manage labour and birth.
 - 1.15.1. Medicare UCCs must have the capacity to identify, stabilise and manage patients presenting with life-threatening conditions, labour or birth whilst awaiting transfer to hospital, including providing resuscitation as required.
- 1.16. Medicare UCCs can provide urgent treatment including for Blood Born Viruses (BBVs) or Sexually Transmitted Infections (STIs). However, referral to usual GP and other services for ongoing management, support and treatment is required, noting consideration of the patients' accessibility to these services.
- 1.17. Medicare UCCs should participate in public health initiatives in response to Communicable Disease Incident of National Significance (CDINS). For example,

providing opportunistic testing of syphilis in pregnant people in response to the declaration of syphilis as a CDINS within Australia.

- 1.18. Medicare UCCs are not expected to manage patients whose behaviours can compromise their safety, the safety of staff and/or other patients. Medicare UCCs must develop protocols to de-escalate difficult behaviours and safely refer patients with these behaviours to other more appropriate services as required.
- 1.19. Medicare UCCs must not provide pre-employment or training medicals, GP mental health care plans, routine antenatal care, routine or travel-related vaccinations.
- 1.20. Medicare UCCs must only provide referrals for radiology, pathology or specialist care where they constitute part of the acute treating episode. Additionally, Medicare UCCs can also provide referrals for radiology, pathology or specialist care necessary for the participation in public health initiatives in response to CDINS as outlined in 1.17.

2. Triage and demand management

- 2.1. Medicare UCCs must conduct initial assessment, triage patients and determine priority of treatment according to the severity of the patient's condition.
- 2.2. Medicare UCCs must develop and implement a triage system which ensures:
 - 2.2.1. Appropriate triage decision making, categorisation and waiting times
 - 2.2.2. Patients are seen according to clinical urgency
 - 2.2.3. Identification and rapid referral of life-threatening conditions, or other conditions requiring immediate attention, when patients arrive at the Medicare UCC
 - 2.2.4. Reception staff alert clinical staff when patients present with life-threatening symptoms
 - 2.2.5. That patients who are waiting are re-triaged regularly to determine if their condition changes
 - 2.2.6. The waiting area is regularly monitored to identify any changes in patients' condition
 - 2.2.7. That patients are directed to call for an ambulance when they telephone about life-threatening symptoms
- 2.3. Medicare UCCs must maintain a system (including clear and accessible signage) that clearly identify the Medicare UCCs and:
 - 2.3.1. Directs patients to the Medicare UCC reception area on arrival
 - 2.3.2. Lists life-threatening symptoms and informs patients that they should advise clinic personnel immediately when they present with life-threatening symptoms
 - 2.3.3. Lists symptoms of infectious respiratory diseases and informs patients that when they present with these, they should immediately put on a mask and inform clinic personnel
 - 2.3.4. Informs patients of the triage system and waiting times and that this is subject to change based on the clinical urgency of other patients
 - 2.3.5. Informs patients when the waiting times change
 - 2.3.6. Informs patients when their condition is not within scope of the Medicare UCC, can be safely and more appropriately managed via a usual GP (taking into account timely access), with alternative care options given

- 2.4. A staff member must be present and monitoring the waiting area at all times to ensure patients are re-triaged as needed based on any changes to their clinical presentation and urgency.
- 2.5. Medicare UCCs must have processes in place to minimise closures and reaching capacity. This includes continually monitoring demand and adjusting staffing levels accordingly.
 - 2.5.1. Where a closure is unavoidable, Medicare UCCs must notify relevant stakeholders of any closures and when clinics reach capacity.
- 2.6. Medicare UCCs must have processes in place to manage end-of-day demand and ensure all eligible patients are treated. Where it's not possible to commence treatment before the Medicare UCC closes, the Medicare UCC must triage, consider the urgency of the patient's presentation and ensure they are provided with appropriate and accessible alternative care options.

3. Accessibility

- 3.1. Medicare UCCs are expected to be open fourteen hours a day, every day (including public holidays). Where unique local context and demand requires different operating hours, the department's agreement must be sought prior to implementation.
- 3.2. Medicare UCC facilities must have:
 - 3.2.1. Car parking sufficient for the expected volume of patients, within a reasonable distance of the Medicare UCC, that allows wheelchair access to the Medicare UCC and has adequate night-time lighting
 - 3.2.2. Clinic external approaches and interior areas that are accessible by wheelchair
 - 3.2.3. Waiting area with specialised seating (elevated and with arms)
 - 3.2.4. At least one toilet with mobility access
 - 3.2.5. A designated area for ambulances to stop and obtain ready access to the resuscitation area
 - 3.2.6. Ready accessibility via public transport, preferably on or within easy walking distance of a main transport route. Any routes or linkages (e.g., pavements) with public transport should be wheelchair accessible
- 3.3. Medicare UCCs must ensure that they are welcoming, accessible, and safe spaces for priority population groups, in accordance with RACGP Standards for general practices – Criterion C2.1 – Respectful and culturally appropriate care; Australian Commission for Safety and Quality in Healthcare's Primary and Community Healthcare Standards. This includes:
 - 3.3.1. Providing culturally safe health services for the First Nations community
 - 3.3.2. Partnering with First Nations groups in a culturally safe and responsive manner when planning initiatives that may have a significant impact on the needs of Medicare UCC patients
 - 3.3.3. Providing culturally sensitive and safe care for those from Culturally and Linguistically Diverse and non-English Speaking Backgrounds
 - 3.3.4. Ensuring services are accessible and inclusive for people with disabilities (both physical and intellectual) of all ages

- 3.3.5. Ensuring services are welcoming and inclusive for people identifying as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and more (LGBTQIA+)
- 3.3.6. Ensuring that presenting victims of violence are provided with care that minimises the possibility of exacerbating any existing trauma and includes the provision of appropriate support and referral to other services and specialist care
- 3.3.7. Staff undertaking cultural awareness and other training relevant to local context and need
- 3.4. Medicare UCCs must maintain connections and embed partnerships with relevant services to support quality and continuity of care to priority population groups. Connections need to be tailored to the Medicare UCCs local setting and patient population served, and must be regularly reviewed. This includes:
 - 3.4.1. Developing and maintaining linkages with Aboriginal Community Controlled Health Services, refugee support organisations and other relevant local services
 - 3.4.2. Having onsite and/or access to appropriate individuals, such as an Aboriginal and Torres Strait Islander Health Worker and/or interpreter
- 3.5. Medicare UCCs must have documented processes and policies for staff to easily access interpreters (including the Translating and Interpreting Service) and to ensure patients are offered an independent interpreter when appropriate.

4. Patients follow up and communications with usual GP

- 4.1. Medicare UCCs must maintain systems that inform patients when their condition is not within scope of the Medicare UCC and can be safely and more appropriately managed by the patient's usual GP. This may include conditions identified at triage; future episodes of conditions treated at the consultation; and/or follow up care.
 - 4.1.1. Medicare UCCs must consider the patient's situation and accessibility when assessing if a condition can be safely and more appropriately managed via the usual GP.
- 4.2. Medicare UCCs must provide patients with plain language educational and follow up information, that enables self-translation as required.
- 4.3. Medicare UCCs must maintain systems and networks that facilitate:
 - 4.3.1. Patients to book in with their usual GP
 - 4.3.2. Connecting patients with a usual GP and to book appointments (where a patient does not identify a usual GP) with consideration to the patient's needs and preferences. This is to support developing a long-term relationship with this GP
 - 4.3.3. Where timely follow up with a patient's usual GP is required, Medicare UCCs should facilitate booking an appointment as required
- 4.4. Medicare UCCs must have a robust system in place to request and document the patient's informed consent for the disclosure of information to their usual GP.
 - 4.4.1. Medicare UCCs must document patients' requests not to disclose all or part of their consultation to their usual GP or GP practice.
- 4.5. Medicare UCCs must provide medical discharge summaries for all patients. Medical discharge summary information must include case notes, referrals, requested tests and any other relevant information.

- 4.6. Medicare UCCs must provide discharge summary/clinical handover to the patient's usual GP within 24 hours (through electronic transfer), unless requested otherwise by the patient.
 - 4.6.1. If electronic transfer is not possible, and/or the patient does not identify a usual GP, a hard copy of the discharge summary must be given to the patient.
 - 4.6.2. Medicare UCCs must copy the patient's usual GP into all diagnostic test requests and other referrals.
- 4.7. Medicare UCCs must also upload an event summary to the My Health Record – unless requested not to do so by the patient.
- 4.8. Medicare UCCs should also offer the patient a hard copy or electronic copy of the discharge summary.

5. Follow up of diagnostic tests and referrals

- 5.1. Medicare UCCs must maintain a documented system for timely follow up and actioning of all patient tests and referrals.
 - 5.1.1. A clinician must review and action patient results within 24 hours of being received.
 - 5.1.2. Medicare UCCs must notify patients of abnormal test results and follow up requirements within appropriate time frame. Follow up is preferably provided by the patient's usual GP.
 - 5.1.3. The patient's results, follow up requirements and actions taken must be documented in the patient record.
- 5.2. Medicare UCCs must document the patient's preferred patient mode of notification for test results (e.g., SMS, telephone, email or mail) in the patient's record. Medicare UCCs should also utilise My Health Record for patient communication.
- 5.3. Medicare UCCs must maintain a system to notify the patient's usual GP of all results and referrals.

6. Referral pathways and integration with other health services

- 6.1. Medicare UCCs must work with jurisdictions and commissioners to ensure Medicare UCCs are integrated with local health services.
- 6.2. Medicare UCCs must be part of a referral network that ensures patients are directed to the most accessible and efficient service for their need.
- 6.3. Referral processes should be developed with stakeholders to facilitate warm hand-off of patients to other health services.
- 6.4. All referral pathways into and out of Medicare UCCs should be driven by local need and co-designed with relevant stakeholders including local general practices and allied health practices.
 - 6.4.1. These referral pathways should be reviewed and developed further based on changes in local context and need at least on a quarterly basis.
- 6.5. In addition to Medicare UCCs accepting patients who self-refer, referral pathways into Medicare UCCs must also include:
 - Ambulance
 - Local emergency departments

- Local general practices and primary care practices
 - Local after-hours services
 - Other non-GP primary health care services such as allied health and community-based nursing services
 - Health direct and other telehealth triage services such as 13 HEALTH (in Queensland)
- 6.6. Medicare UCCs must have clear escalation and referral pathways to local hospital emergency departments and should have pathways with other local hospital services for acute care including:
- Inpatient services including expedited access to specialist advice (including systems to organise direct admission where appropriate)
 - Direct referral to outpatient clinics (e.g., fracture clinic)
- 6.7. Medicare UCCs should have pathways and direct referral for follow up care to hospital and community-based services including:
- Mental health services including digital mental health services where appropriate
 - Community health
 - Hospital in the home
 - Outpatient services (for example, fracture clinic)
 - Other community support services (for example, sexual assault service providers, family violence services, homelessness services)
 - Virtual care options (for example healthdirect and virtualKIDS)
 - Local Residential Aged Care Homes
 - Disability Accommodation
 - Private hospitals and other private providers including medical specialists and optometrists (for example for investigation and treatment of acute eye complaints that are outside the scope of Medicare UCCs).
- 6.8. Where referral to private provider or transport via ambulance is necessary (for example, private optometrist due to unavailability of public hospital optometrist services), referral must be based on patient preference and awareness of any potential costs.
- 6.9. Referral pathways into and out of Medicare UCCs should be outlined in regional HealthPathways and/or equivalent.
- 6.10. Clinical directors and staff of Medicare UCCs should participate in relevant local and national communities of practice and networks.

7. Staffing

- 7.1. Medicare UCCs will be GP led, and minimum staffing must include:
- a Vocationally Registered General Practitioner (VR GP);
 - a Registered Nurse (RN) or Nurse Practitioner (NP) or paramedic; and
 - a staff member undertaking reception and administrative duties (this may include receptionists, Enrolled Nurses or others).

- 7.2. The VR GP, RN, NP and/or paramedic must have further relevant training and skills in urgent care and emergency medicine sufficient to ensure the Medicare UCCs full scope of services can be delivered safely. Training may be required to ensure staff have the required skills ahead of initiating work at Medicare UCCs.
- 7.3. In addition to the minimum staffing requirements listed in 7.1., Medicare UCCs can choose to employ additional staff who have appropriate skills and experience, based on availability, local context and need.
- 7.3.1. This may include (but is not limited to) administrative staff, nurse practitioners, paramedics, allied health practitioners such as physiotherapists, Aboriginal and Torres Strait Islander Health Workers or Practitioners, and other suitably qualified medical practitioners. This is not an exhaustive list.
- 7.4. Medicare UCCs must have sufficient staff on-site during Medicare UCC hours of operation in order to meet demand, program requirements and deliver full scope of services in a clinically and culturally safe environment. All staff must comply with their scope of practice, any supervision and/or other relevant requirements.
- 7.5. Medicare UCCs must be staffed during all hours of operation to ensure they are able to meet functional requirements and operational parameters. This includes (but not limited to) ensuring the following competencies are covered:
- Receptionist first aid (receptionists shall have a documented guideline for identifying life- threatening conditions)
 - Clinical use of radiology
 - Clinical use of ECGs
 - IV cannulation
 - Plastering
 - Wound care (including suturing and gluing)
 - Minor burns management
 - Treatment of musculoskeletal injuries including fractures where reduction is not required
 - Urinary catheter management
 - Identification and management of potentially life-threatening problems whilst patients await transfer to hospital
 - Infection control practices for sterilisation and disinfection, for personnel responsible for managing infection control
 - Other presentations requiring urgent care
- 7.6. All clinical staff members must hold current Basic Life Support (BLS) (renewed on annual basis) or advanced life support (ALS). If a Medicare UCC is situated in an area where there is likely to be a delay in accessing hospital emergency care (based on local context and need), ALS should be used as the minimum requirement.
- 7.7. Medicare UCCs must have a clinical director who is responsible for clinical oversight including robust clinical governance processes, review of medical records, clinical performance of other staff and response to adverse events.

8. Monitoring activity and clinical safety

8.1. Medicare UCCs must have systems in place to improve clinical quality and safety including:

- An incident management system
- Practising open disclosure
- Robust informed consent processes
- Feedback and complaints management
- Patient reported outcome measures (PROMs), and patient reported experience measures (PREMs)
- Providing evidence-based care, including clinical audits
- Systems for escalation of concerns for staff performance, including following guidance for notification as per the Australian Health Practitioner Regulation Agency

8.2. Systems for medications and equipment (including S8 medications) on-site safe storage, management, administration and monitoring on site in line with relevant legislations and guidelines.

9. Facilities, infrastructure and equipment

9.1. Medicare UCCs must maintain facilities that include:

- A treatment area with sufficient privacy
- A designated resuscitation area with defibrillator, airway management equipment², ECG machine, mobile bed, IV fluid resuscitation equipment², and emergency medications (resuscitation equipment should be stored in a trolley or other receptacle able to be moved should resuscitation be required outside of the resuscitation area)
- A designated area for plaster application and removal
- A designated area for treatment of eye complaints and where required, slit lamp
- A designated area for nappy-changing
- A private area that can be used for breast-feeding
- Adequate lighting in all areas
- Medicine, medical equipment and medical supplies, stored according to the supplier's directions and relevant legislation, inaccessible to unauthorised persons, and sufficient to provide safe treatment of service users
- An alert system for identifying and managing service users who are seeking drugs of addiction
- Secure storage for medicines and accessible only to designated personnel
- Facilities for recording computerised clinical notes, such as an electronic patient record management system
- Adequate infrastructure for clinical communication within the Medicare UCC; between the Medicare UCC and other health providers; and the Medicare UCC and patients.

² In some facilities, this may include a cricothyroidotomy set.

- 9.2. Medicare UCCs must have an x-ray facility on-site or easily accessible across all hours of operation
- An x-ray image must be made available to the attending clinician immediately after the x-ray is taken
 - Medicare UCC clinicians must be able to access on-call assistance for interpretation of x-rays, with a formal report by a radiologist available within 24 hours.
- 9.3. Medicare UCCs must have timely access to ultrasound and CT across the majority of hours of operation
- 9.4. Medicare UCCs must have timely access to laboratory-based pathology across majority of hours and at a minimum basic results available on the same day.
- 9.5. Medicare UCCs must have referral pathways in place to support patients requiring urgent access to ultrasound, CT and laboratory-based pathology across all hours of operation.
- 9.6. Medicare UCCs must be equipped with appropriate equipment and drugs for diagnosis and treatment in order to meet core function and operational parameters. This includes having the capacity to provide treatment for life-threatening presentations including resuscitation where required whilst patients await transfer to hospital.
- 9.7. A list of equipment and medications is provided in Appendix 1. Medicare UCCs may substitute drugs or equipment with an equivalent substitute where the required item is not available.

10. Infection prevention and control

- 10.1. Medicare UCC facilities must be able to safely triage and treat people who potentially have a communicable disease in a manner that presents minimal risk of transmission to staff and patients including through:
- 10.1.1. Standard precautions for all patients and staff.
 - 10.1.2. Maximising physical distancing and ventilation in all patient assessment and waiting areas at all times regardless of levels of circulating disease in the community.
 - 10.1.3. Triage of all patients for respiratory symptoms (including through signage) and immediate direction to these patients to put on a mask and wait in a designated area.
 - 10.1.4. Designated rooms (or other appropriate areas) that are easy to clean and have sufficient ventilation whilst affording adequate privacy for consultation for assessment of patients with respiratory symptoms and other potential infectious disease requiring precautions (e.g., measles).
 - 10.1.5. Staff trained in use of personal protective equipment (PPE) and adequate stocks of PPE present in the clinic at all times.
 - 10.1.6. Protocols for cleaning down areas after providing care for potentially infectious patients
 - 10.1.7. Capacity and protocols to safely conduct remote triage and assessment to minimise time spent in contact with patients who may have a communicable disease

- 10.2. Medicare UCCs must maintain linkages with their local public health unit and other systems to keep staff informed of levels of COVID-19 and other infectious diseases, and protocols for increasing stringency of infection control protocols in response to increasing risk.
- 10.3. Medicare UCCs must comply with any regulations and guidelines in place in relation to contact tracing and notification of a disease where relevant.

11. Program Operations

- 11.1. Medicare UCCs must comply with all relevant legislations and regulations including Medicare Benefits Schedule (MBS) and the Health Insurance Act 1973.
- 11.2. When providing treatment for workplace injuries requiring urgent care, the MBS can only be billed for the service if the applicable state or territory workplace compensation claim is not approved.
- 11.3. Medicare UCCs must install and utilise the Medicare UCC Data Module with their Patient Management System and complete new fields where required.
- 11.4. In addition to data requirements for clinical care, Medicare UCCs must have secure systems in place for the collection and transmission of appropriate and timely structured de-identified data as specified by the Commonwealth to support Medicare UCC program planning, monitoring and evaluation.
 - 11.4.1. Specific variables and format of data required will be outlined in relevant contracts.
- 11.5. Medicare UCCs must participate in national communications activities and maintain an accurate online presence (including a website) which adequately incorporates Commonwealth Medicare UCC naming conventions and branding.
- 11.6. Medicare UCCs must comply with Commonwealth policies and requirements for Medicare UCCs including the Medicare UCC Branding Guidelines and Medicare UCC Style Guide.
- 11.7. Medicare UCCs must be adequately, and exclusively, branded as Medicare UCCs and are required to display the Medicare UCC logo externally to their facility, so the logo is visible, prominent, and noticeable from different angles and from a reasonable distance from the clinic.
- 11.8. Medicare UCCs must participate in Commonwealth assurance and compliance activities, including clinical assessments, operational information requests and other ongoing performance monitoring or compliance and assurance activities as required by the Commonwealth.
- 11.9. Medicare UCCs must participate in Commonwealth led evaluation, patient and providers survey activities.

Appendix A List of core equipment and drugs required by a Medicare UCC.

- 1.1. Diagnostic equipment within Medicare UCCs must include:
 - Specimen collection equipment, including blood and swab taking equipment
 - Disposable syringes and needles
 - Tongue depressor
 - Blue light
 - Fluorescein

- Topical anaesthetic
- Ophthalmoscope
- Otoscope earpieces, child and adult sizes
- Equipment for neurological examination, including to test reflexes and sensation
- Weighing scales
- Visual acuity chart
- Sphygmomanometer with a full range of cuffs and connections
- Stethoscope
- Tape measure
- Tuning forks, 256 Hz and 512 Hz
- Thermometer
- Pulse oximetry

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

- INR
- Blood glucose testing equipment
- Pregnancy testing kits
- COVID-19 and influenza
- RSV

1.3. Medicare UCCs should consider having Troponin POCT based on local context and need.

1.4. Resuscitation equipment within Medicare UCCs must include:

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

1.5. Cardiac equipment within Medicare UCCs must include:

- 12-lead ECG machine with ability to monitor patients heart rate through observational machine (for example, 3-lead ECG monitor/recorder)
- Automatic electronic defibrillator (AED) at a minimum
- IV administration sets – includes pump sets and metrisets
- IV fluids – 0.9% saline
- IV luer plugs
- IV set-up and infusion, 14-26 gauge

1.6. Wound care equipment within Medicare UCCs must include:

- Adhesive dressings
- Appropriate Specific dressings for burns
- Angle poised lamp

- Fine needles
- Local anaesthetic
- Monofilament nylon sutures, 3/0 – 6/0
- Skin closures such as steri strips
- Suturing equipment
- Wound glue

1.7. Fracture management equipment within Medicare UCCs must include:

- Crutches or access to accessible hire services within close proximity, open throughout all hours of Medicare UCC operation and free of charge to patients.
- If hiring services are utilised, the Medicare UCC must facilitate supply to patients as required.
- Electric plaster saw
- Mallet finger splints (all sizes)
- Plaster scissors
- Plaster splitter
- POP splints
- Slings/collar and cuff equipment
- Wrist, hand and thumb splints – all sizes
- Moonboots (all sizes)
- Soft neck collars (all sizes)
- Ring cutter
- Wheelchair
- Knee splints

1.8. Emergency drugs and antidotes within Medicare UCCs must include:

- Adrenaline
- Amiodarone
- Aspirin
- Atropine
- Glucagon
- Glucose 50% and 10% (injectable)
- Glyceryl trinitrate spray/tablets
- Insulin (fast acting)
- Corticosteroids (oral and injectable)
- Naloxone hydrochloride
- Benztropine
- Narcotic (oral and injectable)
- Salbutamol

1.9. Essential drugs within Medicare UCCs must include:

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

1.10. Miscellaneous equipment within Medicare UCCs must include:

- Nasal packing equipment including lighting, speculae, forceps and suitable packing
- Packs/equipment for unavoidable/emergency delivery of babies
- Urinary catheterization sets, catheters and catheter bags
- Rampley forceps
- Combined dTPa vaccine
- Doppler for foetal heartbeat detection
- Urinalysis testing equipment
- Vaginal speculae
- Ear syringing apparatus
- Mobile bed or trolley
- Gloves, gowns and masks (surgical and P2/N9)

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All information in this publication is correct as at November 2025

