



Australasian College for Emergency Medicine

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Submission to the Australian Commission on Safety and Quality in Healthcare – National Safety and Quality Health Service Standards September 2025

1. Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide this submission to the Australian Commission on Safety and Quality in Healthcare (ACSQHC; 'the Commission' henceforth) on the development of the National Safety and Quality Health Service (NSQHS) Standards (third edition).

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring that the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

2. Summary of ACEM's submission

The College's response has been informed by the advice of specialist Emergency Physicians, whose experience and expertise are crucial to enhanced clinical decision-making and the delivery of safe, high-quality emergency care.

Feedback received by ACEM's members on the future direction of the Standards emphasise the importance of ensuring high-quality benchmarks are coupled with opportunities for professional development and system learning. Key areas of focus for emergency medicine specialists include improving access to care and addressing systemic risks.

There is a clear expectation that the Standards evolve to support emerging models of care, particularly virtual care, and to ensure that digital medical record systems are designed for safe, efficient clinical use. Workforce development was highlighted as essential, with a need to embed psychological safety and continuous learning into the Standards.

3. Responses to consultation questions

Q1. What existing and emerging safety and quality risks should the Commission be considering in the third edition?

Systemic risks

ACEM's members emphasise the need to broaden the definition of safety beyond individual adverse events. Collective and systemic risks such as [access block](#) and ED overcrowding, understaffing, and environmental sustainability should be recognised as central to patient safety given that they are among the most significant contributors to harm in EDs.

Access block is the most serious issue facing EDs in Australia and Aotearoa New Zealand in terms of providing safe, timely and quality medical care to patients. Access block is the principal factor responsible for ED overcrowding and adversely impacts all aspects of acute medical system performance, most notably increasing

the risk of serious adverse outcomes, including death. On average, two-thirds of ED patients awaiting admission experience access block, and annual ED data demonstrates that access block is not improving – but rather growing – despite the ongoing and known risk of adverse patient outcomes.

Diagnostic safety is an existing safety and quality risk that deserves specific attention in our National Safety and Quality Health Service Standards. The World Health Organisation World Patient Safety Day and theme for 2024 was improving diagnosis for patient safety. The field of diagnostic safety and excellence has advanced significantly in the past decade following the publication of the National Academy of Medicine Improving Diagnosis in Health Care publication in 2016. Diagnostic safety does not just relate to individual diagnostic safety events but relates to designing systems and processes to ensure diagnostic safety and manage uncertainty in the diagnostic process. ACEM believes that a focus on human factors and designing for safety in the diagnostic process should be an integral part of our National Standards.

The population burden of disease is changing too, and as a result, the complexity of patient presentations and the type of workforce and infrastructure required to provide safe, high-quality care has also changed. Due to a lack of viable alternatives in aged care, disability support and community health services, a significant proportion of the population relies on public EDs and hospital-based care while the number of hospital beds per capita is decreasing.

Environmental sustainability and climate change are also neglected but pressing safety concerns due to the healthcare's sizeable contributions to greenhouse gas emissions and unsustainable practices around single-use items which contribute to low value care as described below.

Over-investigation and over-treatment

The harms of 'over-investigation' and 'over-treatment' are rarely acknowledged within current patient safety frameworks. There is a prevailing culture of risk intolerance and fear of litigation, which drives patterns of ordering excessive tests, interventions, or medications.

Current safety processes heavily focus on identifying risks that arise from missed diagnoses or failures to treat. On the flipside, there is little recognition of the risks associated with unnecessary investigations and treatments. These include direct harm to patients (for example, complications, radiation exposure, side effects), indirect harm through delays and resource diversion, and broader system impacts such as rising costs and clinician workload.

Q2. How can the third edition have a greater impact on driving high performance?

Improved measurement and accountability

There is an opportunity for the Commission to raise the bar by setting clearer and more ambitious benchmarks that will lift the expectations across the system. Suggestions include incorporating measurable targets such as [ACEM's Hospital Access Targets](#), shifting the focus from avoiding omissions to also addressing low value care as previously stated.

Furthermore, there is a need to shift from 'trailing indicators' – such as incident reports and complaints – to 'leading indicators' that measure resilience, preparedness, and proactive safety. National guidance is needed on meaningful performance indicators and benchmarking tools that reflect real-world complexity. It is necessary that such metrics are defined for health services, rather than being self-defined. This approach would allow the Standards to identify satisfactory clinical benchmarks, compare performance across equivalent healthcare organisations and identify outliers. It would also ensure that the performance indicators allow the identification of performance/efficiency trade-offs.

Q3. How can the third edition support integration of services, within and across health services?

Technology and transitions of care

The Standards must ensure the effective integration of new technologies into mainstream care pathways, particularly in terms of safety, equity and continuity of care. Virtual care has emerged as a growing domain that requires thoughtful integration into the Standards – particularly in terms of safety, equity and continuity of care. Digital medical records, while essential, are often poorly designed and contribute to risk, particularly in medication safety. Other emerging technologies, including AI, require robust governance and ethical oversight. Transitions of care remain a high-risk area, despite recent improvements. The Standards must continue to evolve to ensure safe, coordinated handovers across settings.

Workplace culture

The culture within healthcare settings plays a critical role in safety and quality. Workplace environments marked by incivility, blame, and avoidance were identified by ACEM's members as significant risks. The Standards must reflect the importance of collegiality, respectful communication, and workforce planning that aligns with actual service demand.

Q4. How can the third edition support a continuous learning approach and minimise a compliance mindset?

Training and professional development

Clinicians expressed a preference for meaningful professional development over mandatory compliance-based training. The Standards should support lifelong learning, reflective practice, and skill development that enhances clinical judgement and adaptability.

Including the patient voice

The Standards require a stronger inclusion of patient voices and lived experience, ensuring that the Standards remain connected to real-world clinical contexts rather than being reduced to administrative exercises. This would help counter compliance-driven behaviours and embed a culture of continuous learning and improvement.

4. Contact

Thank you again for the opportunity to provide this submission. ACEM recognises that the new Standards will be pivotal in shaping high-quality patient-centred care for the next decade. ACEM is committed to supporting the work of the Commission throughout the process. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Hamish Bourne, Manager, Policy (hamish.bourne@acem.org.au).

Yours sincerely,



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