Chinese Medicine Board
Ahpra

Accreditation standards:
Chinese medicine

Contents

1. Preamble

Since 1 July 2012, the Chinese medicine profession has been regulated by the Chinese Medicine Board of Australia (the Board) under the National Registration and Accreditation Scheme (the National Scheme). The Chinese Medicine Accreditation Committee (the Committee) is appointed by the Board as the accreditation authority for the Chinese medicine profession under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The Committee develops and reviews the accreditation standards, assesses whether programs of study and education providers are meeting the accreditation standards and decides whether or not to accredit the program. It also monitors accredited programs to ensure that they continue to meet the accreditation standards The Board approves and publishes, the accreditation standards and decides whether or not to approve accredited programs as providing qualifications for registration. Successful graduates of an accredited and approved Chinese medicine program have the knowledge, skills and professional attributes needed to qualify for general registration to practice Chinese medicine in Australia.

Under the National Law, the Committee must regularly review the approved accreditation standards to ensure they are contemporary and relevant to Chinese medicine practice and education in Australia.

A number of accredited and approved Chinese medicine programs lead to qualifications for general registration as an acupuncturist and/or a Chinese herbal medicine practitioner and a Chinese herbal dispenser. At the time of publication, there were no accredited and approved Chinese medicine programs that led to qualifications for general registration as a Chinese herbal dispenser only.

This document contains:

- The Chinese medicine accreditation standards and their related criteria
- Guidance on the information to be presented by education providers seeking accreditation of a Chinese medicine program, including:
  - examples of information for each criterion to be presented
  - explanatory notes, to help common understandings between accreditation assessment teams and education providers about the Committee's requirements
  - a glossary of key terms used, and
  - a list of acronyms.

Assessment teams and education providers should also refer to the Guidelines for accreditation of education and training programs for information about the accreditation processes and procedures used by the Committee to assess and monitor programs against the accreditation standards.

Overview of the Accreditation standards for Chinese medicine 2025

The *Accreditation standards: Chinese medicine (2025)* (the accreditation standards) recognise contemporary best practice in standards development across Australia and internationally. The accreditation standards focus mainly on the demonstration of outcomes. Where education processes are considered, the information required by the Committee concerns learning outcomes and related assessment tasks rather than demonstration of any specific process. The accreditation standards support a range of educational models and variations in curriculum design, teaching methods and assessment approaches. The focus is on demonstrating that student learning outcomes and assessment tasks map to all *Professional capabilities for Chinese medicine practitioners* (professional capabilities) and are appropriately fostered and supported by the curriculum structure and assessments.

Structure of the accreditation standards

The accreditation standards include five standards:

1. Assuring safety
2. Academic governance, quality assurance and resourcing of the program
3. Program design
4. Assessment
5. Preparing students for contemporary practice.

A standard statement states the key purpose of each standard.

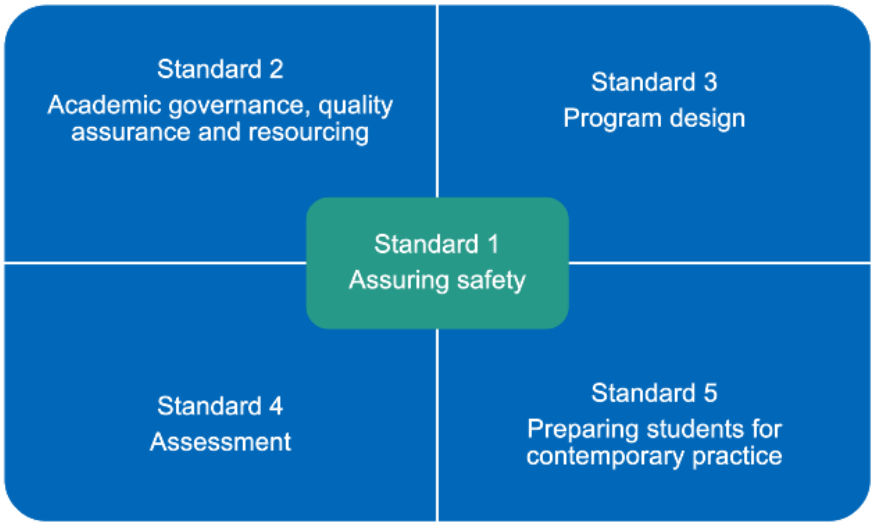
Each standard statement is supported by multiple criteria. The criteria are not sub-standards; they are indicators that set out what is generally needed to meet the standard.

The Committee considers whether the education provider and its program have met each standard. When the Committee determines whether the information presented by an education provider substantiates that a particular standard is met, it takes a balanced view of the findings for each criterion in the context of the whole standard and its intent.

Explanatory notes are included to provide further information for some accreditation criteria. They may outline minimum expectations of the committee (where stated) or provide more general context for consideration when designing curricula and developing accreditation assessment submissions.

The National Scheme's paramount principle of protecting the public and maintaining public confidence in the safety of services provided by health practitioners is specifically reflected in standard one – assuring safety, which includes clinically safe and culturally safe practice. It informs the other standards and must be embedded throughout programs of study, as shown in Figure 2.

Figure 1: Standard 1 - Assuring safety is central to all accreditation standards

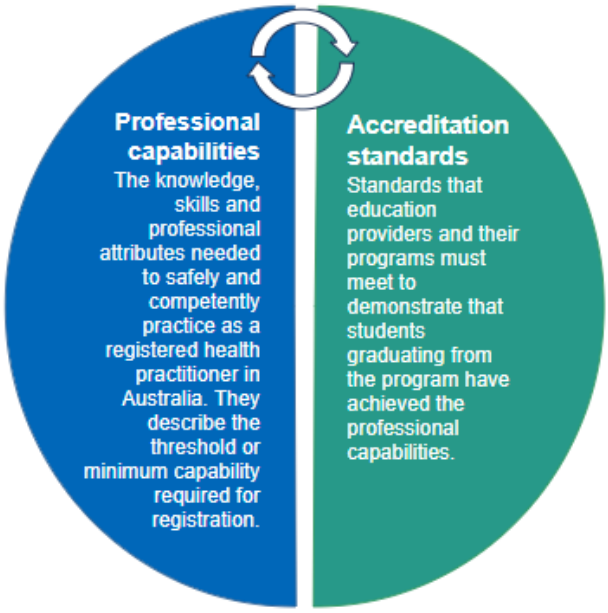


Mapping learning outcomes and assessment tasks to the professional capabilities for Chinese medicine practitioners

These accreditation standards refer to the professional capabilities. The professional capabilities identify the knowledge, skills and professional attributes needed to safely and competently practise as a Chinese medicine practitioner in Australia and establish the threshold level of professional capability needed for registration in Australia.

The accreditation standards require education providers to design and implement a program where unit/subject learning outcomes and assessment tasks map to all the professional capabilities (Figure1). Accreditation of a program provides assurance to the Board and the community that graduating students from the Chinese medicine program have the knowledge, skills and professional attributes needed to safely and competently practise as a Chinese medicine practitioner in Australia.

Figure 2: The relationship between accreditation standards and professional capabilities



The relationship between the Accreditation Committee and other regulators

The Committee recognises the role of the Australian Government Department of Education and the Department of Employment and Workplace Relations (DEWR), the Higher Education Standards Panel (HESP)[1], and Tertiary Education Quality Standards Agency (TEQSA)[2] in regulation and quality assurance of higher education in Australia. The Committee does not seek to duplicate the role of these bodies and does not assess against the standards from the *Higher Education Standards Framework (Threshold Standards) 2021* (threshold HES)[3]. The accreditation standards in this document are limited to aspects of the education provider and program that are directly related to ensuring students have the knowledge, skills and professional attributes needed to safely and competently practise as a Chinese medicine practitioner in Australia.

Guidance on the presentation of information for accreditation assessment and its evaluation by assessment teams and the Accreditation Committee

Expert assessment teams established by the Committee evaluate the information presented by the education provider during the accreditation process and experiential information collected during site visits and discussions with a range of stakeholders including:

- students
- staff at the education provider
- work-integrated learning supervisors and other staff at clinics and/or practices used for work-integrated learning, and
- graduates of the program and their employers.

[1] Information on the Higher Education Standards Panel, is available from The Australian Government Department of Education website, accessed 27 June 2024.
[2] Information on TEQSA, is available from the TEQSA website, accessed 27 June 2024.
[3] Information on the Higher Education Standards Framework (Threshold Standards) 2021, is available from the Australian Government Federal Register of Legislation website, accessed 24 June 2024.

The information is evaluated using the principles of fairness, validity, flexibility, transparency, sufficiency and reliability. Assessment teams report their evaluation findings to the Committee for careful and diligent review.

The Committee decides whether the accreditation standards are met. The Committee also decides whether accreditation of the program is in accordance with section 48 of the National Law. That is, programs may be accredited, accredited with conditions and/or specific monitoring requirements, or not accredited. The obligation is on the education provider to present information that demonstrates how the Chinese medicine program meets each of the accreditation standards.

Guidance on presenting an explanation and examples of information for accreditation assessment

The education provider should explain how they meet each standard and:

- make clear in their explanation, the purpose and relevance of each piece of expected information
- highlight where the relevant information can be found in the expected information documents i.e. provide the page number and paragraph number, and
- reference the criterion (or criteria) to which each piece of expected information relates.

Education providers are encouraged to provide supporting information in whatever format they consider most appropriate, so the administrative burden of the accreditation process is kept to a minimum. For example, an assessment report from another body (such as TEQSA) does not need to be reformatted for submission to the Committee. Some documents listed in the expected information may be applicable across multiple standards and criteria, but serve different purposes for each criterion, therefore the accompanying explanation could be different for each criterion.

Consistent with accreditation standards that are outcome focused, it is for the education provider to determine with justification what information to provide to demonstrate that their program(s) meet the standards.

staffing profile template

A template for the staffing profile for Criterion 2.8 is available from the Program Accreditation Team (program.accreditation@ahpra.gov.au). Education providers should complete one profile that covers all details identified in the examples of information across the relevant criteria.

Mapping document template

The mapping document template for criteria 3.2 and 4.1 is available for education providers to complete and should map all assessment tasks, simulation activities, all unit/subject learning outcomes and all professional capabilities for Chinese medicine practitioners. [4]

Providing examples of assessments

Education providers must provide examples of assessments for multiple standards and criteria. The examples are expected to include a sample of different assessment tools or modalities. For each tool or modality, provide a range of de-identified examples from students across the range of performance. Where possible this will include at least one and possibly more examples of a satisfactory or pass, and an example of unsatisfactory or fail.

Implementation of formal mechanisms

The Committee recognises that it is likely that TEQSA has assessed the education provider's policy and procedure portfolio. The Committee requires information that demonstrates the implementation of formal mechanisms at the program level i.e. the outputs and/or outcomes, not just a description of the process, or copies of policy and procedure documents i.e. the inputs.

[4] Please contact Ahpra's Program Accreditation Team at program.accreditation@ahpra.gov.au to obtain the most up-to-date version of the mapping template.

Monitoring accredited programs

After the Committee accredits a program, it has a legal responsibility under Section 50 of the National Law, to monitor whether the program continues to meet the accreditation standards.

The Committee must remain satisfied that the program and education provider continue to meet the accreditation standards if students are enrolled in the accredited program.

If the Committee is not reasonably satisfied the accredited program continues to meet the accreditation standards, it may seek further information through discussions with the education provider and/or through a site visit.

Further information

For further information on this document please contact:

Program Accreditation Team

Email: program.accreditation@ahpra.gov.au
Website: www.chinesemedicineboard.gov.au/Accreditation

Review of accreditation standards

The accreditation standards will be reviewed as necessary. This will generally occur at least every five years.

Date of effect: 1 January 2026

Navigating this document

Where explanatory notes have been included to provide further information, links have been added to the criteria or examples of information to the relevant explanatory note located towards the end of this document. Links are also included in the explanatory notes to allow you to navigate back to the standards.

2. The accreditation standards, criteria and examples of information for inclusion with an accreditation application

Standard 1: Assuring safety

Standard statement: Assuring safe and ethical practice and culturally safe practice is paramount in program design, implementation and monitoring.

This standard addresses physical, psychological and culturally safe practice that is free of racism and the safe and ethical care of patients/clients. The focus is on educating students to ensure that they practise safely during work-integrated learning and when they become registered practitioners. This standard also focuses on assuring the safety of staff and students throughout the program.

Criteria		Examples of information for inclusion with accreditation application
Safe practice		
1.1	Physically and psychologically safe and ethical practice is integrated into the design and implementation of the program and is articulated in the learning outcomes of the program, including any work-integrated learning elements. See explanatory notes: Safe practice and Ethical practice	• Program materials and unit/subject profiles/outlines that show protection of the public and safe and ethical practice, are addressed in the curriculum. • A sample of different assessment tools or modalities which show that safe practice, is being taught and assessed in the clinical setting. For each tool or modality, include at least three de-identified examples from students across the range of performance. Where possible include an example of a satisfactory or pass, and an example of unsatisfactory or fail. • Examples of implementation of formal mechanisms used to identify, report on, monitor and address issues affecting physically and psychologically safe practice in program design, implementation and monitoring, including work-integrated learning.
1.2	Formal mechanisms exist and are applied to ensure that students are physically and psychologically fit to practise safely at all times.	• Examples of implementation of formal mechanisms used to monitor whether students are fit to practise safely throughout the duration of the program and manage situations where safety issues are identified. • A sample of de-identified examples of implementation of formal mechanisms used to ensure students are safe to engage in practice before work-integrated learning. This includes confidential disclosure of issues by students, vaccinations and, where mandated, completion of police checks and working with children checks.
1.3	Students in the program have access to the education provider's cultural, health and learning support services, to ensure staff and students are physically and psychologically safe, including during work-integrated learning. See explanatory note: Student support services and facilities to meet learning, welfare and cultural needs	• Examples of the implementation and availability of adequate support services to meet the needs of students in the program.

Criteria		Examples of information for inclusion with accreditation application
1.4	The education provider requires students in the program to comply with the Code of conduct of the Chinese Medicine Board of Australia's expectations of safe and professional practice.	• Information provided to students that refers to the requirements for them to comply with the Board's registration standards and guidelines[5] on ethical and professional conduct. • Mechanisms are provided for students to familiarise themselves with any changes to relevant Board guidelines as they arise. • Examples of implementation of formal mechanisms used for mandatory and voluntary notifications about students to Ahpra. • Examples of mechanisms used to monitor compliance with the Board's Code of conduct.
1.5	The education provider complies with its obligations under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) and other laws.	• Examples of implementation of formal mechanisms that show compliance with the: – National Law and other laws, and – relevant legislation including restrictions on the administration of scheduled medicines by students. • Examples that show students are informed about any restrictions on their administration of scheduled medicines as a practitioner.
Culturally safe practice		
1.6	Culturally safe practice that is free of racism and discrimination is integrated into the design and implementation of the program and is articulated in the learning outcomes of the program, including any work-integrated learning elements, with an emphasis on Aboriginal and Torres Strait Islander cultures and cultural safety in the Australian Healthcare setting. See explanatory notes: • Culturally safe practice for Aboriginal and Torres Strait Islander Peoples • Cultural safety for all communities, and • Integration of culturally safe practice in the design and implementation of Chinese medicine programs.	• Program materials and unit/subject profiles or outlines that show culturally safe practice, is addressed in the curriculum. • A sample of different assessment tools or modalities which show that culturally safe practice, is being taught and assessed across the curriculum, including in work-integrated learning elements. For each tool or modality, give a range of de-identified examples of student assessment. Where possible give an example of a satisfactory or pass, and an example of unsatisfactory or where the benchmark is not yet met. • Examples of implementation of formal mechanisms used to identify, report on and address issues affecting culturally safe practice in program design, implementation, monitoring and assessment.
1.7	Program materials and assessment in the program specifically reference relevant national safety and quality standards, in relation to culturally safe healthcare that is free of racism and	• Program materials, unit/subject profiles/outlines and assessment tasks that show where the relevant national safety and quality standards are specifically addressed in the program and

[5] Chinese Medicine Board of Australia, *Shared Code of Conduct for Health Practitioners* (2022). Available on the Chinese Medicine Board website. Chinese Medicine Board of Australia, *Guidelines: Mandatory notifications about registered health practitioners* (2020) and *Guidelines: Mandatory notifications about registered students* (2020). Other guidelines issued by the Chinese Medicine Board of Australia relevant to safe practice include but may not be limited to: *Guidelines for safe practice of Chinese herbal medicine (2023), Infection prevention and control guidelines for acupuncture practice (2023), and Guidelines: Informing a National Board about where you practise* (2018). The Board's policies, codes and guidelines are available from the Chinese Medicine Board website, accessed 26 June 2024.

Criteria		Examples of information for inclusion with accreditation application
	discrimination, particularly for Aboriginal and Torres Strait Islander Peoples.	where student learning outcomes are assessed against those standards.
1.8	The education provider and program has formal mechanisms in place to ensure staff and students learn and work in environments that are culturally safe and responsive and free of racism and discrimination, including during work-integrated learning elements. See explanatory note: The staff and student work and learning environment	Examples of: • the implementation of formal mechanisms used to monitor and assess that staff and students work and learn in an environment that is culturally safe and free of racism, including in face-to-face, work-integrated learning and online environments. • de-identified feedback from students and staff about the cultural safety of the environment in which they work and learn. • resolving any issues that compromised the cultural safety of the environment for staff and students.
1.9	The education provider actively draws on staff or other individuals with the knowledge, expertise and culturally safe practice to facilitate learning in Aboriginal and Torres Strait Islander health.	Examples of: • any targeted recruitment of Aboriginal and Torres Strait Islander staff. • the implementation of formal mechanisms used to recruit staff, including an equal employment opportunity policy for employment of Aboriginal and Torres Strait Islander Peoples. • the implementation of formal mechanisms used to draw on staff or other individuals with the knowledge, expertise and culturally safe practice to facilitate learning in Aboriginal and Torres Strait Islander health. • education provider's Indigenous Strategy and Reconciliation Action Plan (RAP), where available, including actions taken to comply with the Indigenous Strategy and RAP and the outcomes of such actions. See explanatory note: Reconciliation Action Plan
1.10	There are specific strategies to support the recruitment, admission, participation and completion of the program by Aboriginal and Torres Strait Islander Peoples. This includes providing cultural support services.	Examples of the implementation of formal mechanisms for: • the recruitment and admission to the program by Aboriginal and Torres Strait Islander Peoples. • supporting the retention of Aboriginal and Torres Strait Islander Peoples.

Standard 2: Academic governance, quality assurance and resourcing of the program

Standard statement: Academic governance, quality improvement arrangements and resourcing are effective in developing and implementing sustainable, high-quality education at a program level.

This standard addresses the organisation and governance of the Chinese medicine program. The Accreditation Committee acknowledges TEQSA's role in assessing the education provider's governance as part of their registration application.

Education providers who offer programs that are accredited by TEQSA are encouraged to provide the same information, where relevant to reduce regulatory burden.

The focus of this standard is on the overall context in which the program is implemented, specifically the administrative and academic organisational structure which supports the program. This standard also focuses on identifying the degree of control that the academics who lead and implement the program, the Chinese medicine profession and other external stakeholders have over the relevance and quality of the program, to produce graduates who are safe, demonstrate culturally safe practice and are competent to practise.

Criteria		**Examples of information for inclusion with accreditation application**
2.1	The program is accredited by the Tertiary Education Quality and Standards Agency (TEQSA) or, for education providers with self-accrediting authority, the program has been approved by the education provider's relevant board or committee responsible for program approval. The program is approved at the Australian Qualifications Framework (AQF) level of bachelor degree (AQF Level 7) or higher.	• If TEQSA has not granted self-accrediting authority: – TEQSA's report on accreditation of the program – disclosure of any issues concerning the program that TEQSA has identified and details of any conditions imposed, and – subsequent dialogue with TEQSA about addressing the conditions. • If TEQSA has granted self-accrediting authority: – copy of the program approval decision made by the education provider's relevant board or committee, such as a record of resolution in meeting minutes – disclosure of any issues concerning the program that the board or committee has identified, and – subsequent dialogue with the board or committee about addressing the issues.
2.2	Program information for prospective and enrolled students is complete, accurate, clear, accessible and up-to-date.	• Program information and/or links to website pages provided to prospective students (before enrolment) and enrolled students about the program, including information on recognition of prior learning. • Description of inherent requirements and associated reasonable adjustments to allow them to complete their studies. Including the application and monitoring of inherent requirements and opportunities for student appeal. See explanatory note: Inherent requirements • Explanation about when and how prospective and enrolled students are provided with full details about registration requirements,

Criteria		Examples of information for inclusion with accreditation application
		program fees, refunds and any other costs involved in the program. See explanatory note: Registration requirements
2.3	The education provider has robust academic governance for the program that includes systematic monitoring, review and improvement, and a committee or group with the responsibility, authority and capacity to design, implement and improve the program to enable students to meet the needs of the Board's professional capabilities. See explanatory note: Committees/groups responsible for program design, implementation and quality assurance	• Overview of formal academic governance arrangements for the program, including an organisational chart of governance for the program. • Current list of members of the committee or group responsible for program design, implementation and quality assurance, including their role titles and the organisation/group they are representing. • Examples of implementation of formal mechanisms relating to academic governance for the program. • Explanation of how monitoring and review improves the design, implementation and quality of the program so students meet professional capabilities • Examples of implementation of a monitoring and evaluation framework used to monitor and review the design, implementation and quality of the program. • Schedule for monitoring, review and evaluation of the design, implementation and quality of the program, with examples from the past three to five years. • A sample of records of previous meetings of the key committee or group that has responsibility for design, implementation and quality of the program. • Record of the most recent internal course review of the program.
2.4	Formal mechanisms are applied to evaluate and improve the design, implementation and quality of the program, including through feedback from students, work-integrated learning supervisors, internal and external academic and professional peer review, and other evaluations.	• Examples of implementation of formal mechanisms used to evaluate and improve the design, implementation and quality of the program. • Details of outcomes and actions from internal or external reviews of the program in the past five years. • Summary of staff and student feedback and actions taken to improve the design, implementation and quality of the program.
2.5	Students, academic staff and work-integrated learning supervisors in the program have opportunities to contribute to program design and quality improvements.	• Details of any student, academic staff, and work-integrated learning supervisor representation in the governance and curriculum management arrangements for the program. • Examples that show consideration of information contributed by students, academic staff, and work-integrated learning supervisors when decisions about program design, implementation and quality are being made. • Examples of the use of student, academic staff and work-integrated learning supervisor

Criteria		Examples of information for inclusion with accreditation application
		satisfaction data or other feedback to improve the program design.
2.6	There is formalised and regular external stakeholder input to the design, implementation and quality of the program, including from representatives of the Chinese medicine profession, other health professions, prospective employers, health consumers and graduates of the program. See explanatory note: Effective engagement with external stakeholders	• Terms of reference of a current stakeholder group responsible for input into the design, implementation and quality of the program, including the list of representatives on the group and their current positions. • Examples of effective engagement with a diverse range of external stakeholders (including representatives of Aboriginal and Torres Strait Islander communities and other relevant health professions) about program design and implementation. • Minutes of previous meetings over the last two years. • Examples of feedback from: – employers – graduates – internal/external reviews, and – external stakeholders • An explanation of the outcomes and actions taken in response to the feedback. • Records of other stakeholder engagement activities showing participation, decisions made and implemented.
2.7	The education provider assesses and actively manages risks to the program, program outcomes and students enrolled in the program.	• Examples of: – the implementation of a risk management plan – the implementation of formal mechanisms for assessing, mitigating and addressing risks to the program and program outcomes – minutes of relevant committee meetings that consider risks to the program. (*Examples of risks to the program include pandemics; increasing or decreasing student enrolment numbers; decreasing student fees; student to staff ratio; casual academic staffing; simulation and clinical equipment; work-integrated learning issues and reduced international student enrolment/fees.*)
2.8	The education provider appoints academic staff at an appropriate level with suitable experience and qualifications to assess students in the program and to implement and lead the program.	• Staffing profile for staff responsible for assessing students in the program and implementing and, leading the program, identifying: - their academic level of appointment and/or equivalent - their management or leadership role in the program - the fraction (full-time, part-time) and type (ongoing, contract, casual) of their appointment - their qualifications and experience relevant to their management and leadership responsibilities

Criteria		Examples of information for inclusion with accreditation application
		- relevant registration status where required (for health practitioners) - , and - their engagement in further learning related to their role and responsibilities. • Description of and examples that show the mechanisms by which the education provider ensures staff demonstrate culturally safe practice in the delivery of programs. See explanatory note: Staffing
2.9	Staff managing and leading the program have sufficient autonomy to request the level and range of human resources, facilities, equipment and financial resources in the program.	• Examples of correspondence or meetings that show staff managing and leading the program are requesting the allocation of human resources, facilities, equipment and financial resources when necessary, and the response from the decision-makers.
2.10	The program has the resources and range of facilities and equipment to sustain the quality and scope of education needed for students to achieve all the professional capabilities for Chinese medicine practitioners.	• Letter from the Vice Chancellor (or delegate) confirming ongoing support for the quality and resourcing of the program, including the roles of professional staff managing simulation facilities. • Demonstrate that the equipment and facilities used for teaching and learning in the program are adequate for the delivery of the program and enable students to achieve culturally safe practice and all the professional capabilities.
2.11	The education provider supports staff engagement in learning that aims to maintain knowledge of contemporary practice and principles of health professions education.	Details of: – staff engagement in development opportunities – percentage of staff participation, and – engagement in evidence-based research • Examples of types of development engaged in, and methods of engagement.

Standard 3: Program design

Standard statement: The program design including curriculum, learning and teaching and work-integrated learning enables students to achieve all the professional capabilities for Chinese medicine practitioners.

This standard focuses on how the program is designed and implemented to produce graduates who have demonstrated all the professional capabilities for Chinese medicine practitioners.

This standard also addresses work-integrated learning and supervision and the way the education provider effectively manages internal or external work-integrated learning environments to ensure quality and reliable outcomes for both patients/clients and students.

Criteria		Examples of information for inclusion with accreditation application
Curriculum		
3.1	The program design and implementation is informed by contemporary educational theories and practices. See explanatory note: Program design	• Rationale of the educational theories and practices which inform the program design and implementation, including examples of how they inform the delivery of the program. • Overview of the program identifying relationships between units/subjects in and between years of the program.
3.2	Unit/subject learning outcomes in the program address all the professional capabilities for Chinese medicine practitioners.	• Mapping document that shows alignment of unit/subject learning outcomes to: – all the professional capabilities[6] – assessment tasks for work-integrated learning elements, and – use of simulation in the program. • Detailed profiles/outlines for each unit/subject taught in the program.
3.3	Unit/subject learning outcomes in the program address the principles of the quality use of medicines as they apply to Chinese medicine practice. See explanatory note: Quality use of medicines	• Details of units/subjects demonstrating learning outcomes relevant to the quality use of medicines • Detailed information demonstrating that learning in relation to the safe use of medicines takes account of cultural and social influences and determinants of health. • Mapping document that shows alignment of unit/subject learning outcomes to the relevant professional capabilities required for the safe and effective use of medicines in the relevant context of Chinese medicine practice.
3.4	Relevant national safety and quality standards are specifically referenced and embedded in program materials and assessment of the program. See explanatory note: Referencing the national safety and quality standards	• Program materials, unit/subject profiles/outlines and assessment tasks that show where the relevant national safety and quality standards are specifically addressed in the program and where student learning outcomes are assessed against those standards.
Learning and teaching		

[6] Please contact Ahpra's Program Accreditation Team at program.accreditation@ahpra.gov.au to obtain the most up-to-date version of the mapping template.

Criteria		Examples of information for inclusion with accreditation application
3.5	Teaching approaches lead to the development of the appropriate level of critical thinking, technical and communication skills. See explanatory note: Learning and teaching approaches	• Provide examples of where explicit teaching on critical thinking, technical and communication skills occur.
3.6	Opportunities for students to integrate their knowledge, skills and professional attributes are provided throughout the program, including in work-integrated learning, simulation and practice/case-based learning.	• Unit/subject profiles/outlines that show where opportunities exist for students to integrate their knowledge and skills. • A description of how simulation and practice/case-based learning is used to integrate student's knowledge, skills and professional attributes and examples of how it has improved student performance.
3.7	Students are provided with opportunities to learn from other health professionals to foster ongoing collaborative practice throughout the program.	• Examples of interprofessional learning experiences across a range of learning and teaching methods,
Work-integrated learning See explanatory note: Work-integrated learning		
3.8	Legislative and regulatory requirements relevant to the Chinese medicine profession are taught prior to and complied with during periods of work-integrated learning in the program. See explanatory note: Teaching and assessment of legislative and regulatory requirements	• Examples of where relevant legislative and regulatory requirements are taught in the program, including assessment of application during work-integrated learning, and examples of the outcomes of the assessments. • De-identified sample of assessments that demonstrate that legislative and regulatory requirements are understood by students prior to work-integrated learning.
3.9	Students are required to achieve all relevant capabilities before each period of work-integrated learning. See explanatory note: Achievement of relevant capabilities before work-integrated learning	• Documents showing the relevant learning outcomes to be achieved before each period of work-integrated learning in the program. • A sample of different assessment tools or modalities which show assessment of relevant learning outcomes. For each tool or modality, include at least three de-identified examples from students across the range of performance. Where possible, an example of a satisfactory or pass, and an example of unsatisfactory or fail should be included.
3.10	Health practitioners who supervise students in the program during work-integrated learning hold current registration in Australia for the clinical elements they supervise, with no conditions or undertakings on their registration relating to performance or conduct. For overseas placements,	• Examples of implementation of formal arrangements internally and with any external clinics and/or practices (for example, an agreement) that ensure practitioners supervising students hold current registration (for example, a formal contract and/or other written communication securing the work-integrated learning arrangements).

Criteria		Examples of information for inclusion with accreditation application
	equivalent registration in their country is required where relevant.	
3.11	Clinics and/or practices used for work-integrated learning maintain workplace safety standards, including relevant accreditation and licensing and/or registration required in the relevant state or territory. See explanatory note: Relevant accreditation and licensing	• Examples of: – the implementation of formal mechanisms that show clinics and/or practices used for work-integrated learning maintain relevant accreditation and licences. – how the education provider monitors the currency of accreditation and licences. – the implementation of formal mechanisms used for clinical and workplace safety, including screening and reporting and control of infectious diseases. • Register of agreements (formal contracts and/or other written communication securing work-integrated learning) between the education provider and external clinics and/or practices used for work-integrated learning.
3.12	The education provider engages with the practitioners who provide instruction and supervision to students during work-integrated learning in a timely and effective manner.	• Examples of: – engagement between the education provider and practitioners who provide instruction and supervision to students during work-integrated learning – how engagement between the education provider and work-integrated learning supervisors is maintained throughout the duration of work-integrated learning elements, and – guidance provided to work-integrated learning supervisors on how to provide formative feedback and manage student performance.
3.13	Work-integrated learning experiences provide students in the program with regular opportunities to critically reflect on their practice. See explanatory note: Critical reflection	• A sample of de-identified reflective journals, or equivalent, completed by students during periods of work-integrated learning and responses to those reflections.
3.14	The quality, duration and diversity of student experience during work-integrated learning in the program is sufficient to produce a graduate who has demonstrated the knowledge, skills and professional attributes to safely and competently practise Chinese medicine. See explanatory note: Diverse work-integrated learning	• Explanation about how the education provider monitors the quality, duration and diversity of student experience during work-integrated learning. • Examples of implementation of formal mechanisms used for monitoring the quality, quantity, duration and diversity of student experience during work-integrated learning. This should include examples of work-integrated learning placement allocation for the duration of the program.

Criteria		Examples of information for inclusion with accreditation application
3.15	Formal mechanisms are applied to ensure the ongoing quality assurance of work-integrated learning instruction and supervision, and regular monitoring of the suitability of supervisors in the program, including evaluation of student feedback. See explanatory note: Work-integrated learning supervisors	• Examples of implementation of formal quality assurance mechanisms for work-integrated learning including: – mechanisms for training and monitoring work-integrated learning supervisors to ensure assessment meets the principles of assessment See explanatory note: Principles of assessment – providing feedback processes for students and supervisors that are free of power imbalances – mechanisms for the evaluation of work-integrated learning, including examples of ways in which feedback from students and supervisors is used, and – description of and examples that show the mechanisms by which the education provider ensures staff and work-integrated learning supervisors demonstrate culturally safe practice in the assessment of students. • Examples of responses to quality assurance findings.
3.16	Work-integrated learning supervisors assessing students in the program are suitably experienced, prepared for the role, and hold appropriate qualifications where required.	• Details of arrangements to monitor work-integrated learning supervisors to ensure assessment meets the principles of assessment. • Examples of work-integrated learning supervisors' engagement in learning related to their role and responsibilities, including in clinical pedagogy. • Description of and examples that show the mechanisms by which the education provider ensures staff and work-integrated learning supervisors demonstrate culturally safe practice in the assessment of students.
3.17	Formal mechanisms are applied to ensure the learning outcomes and assessment for all work-integrated learning activities are defined and known to both students and supervisors.	Examples of: • implementation of formal mechanisms used to ensure the learning outcomes and assessment for all work-integrated learning activities are defined and known to both students and work-integrated learning supervisors. • information provided to students and work-integrated learning supervisors about work-integrated learning and assessment. • guidance provided to work-integrated learning supervisors on how to use assessment tools to enhance the validity and reliability of their assessments.

Standard 4: Assessment

Standard statement: All graduates of the program have demonstrated achievement of the learning outcomes taught and assessed during the program.

This standard focuses on assessment, including quality assurance processes and the staff responsible for assessing students in the program. The education provider should ultimately show how they assure every student who passes the program has achieved all the professional capabilities, including capabilities for culturally safe practice, for Chinese medicine practitioners.

The education provider should use fit for purpose and comprehensive assessment methods and formats to assess learning outcomes, and to ensure a balance of formative and summative assessments throughout the program.

Criteria		Examples of information for inclusion with accreditation application
4.1	The professional capabilities for Chinese medicine practitioners are mapped to assessment tasks that effectively measure whether the professional capabilities and learning outcomes are being met at the appropriate AQF level.	• Mapping document to demonstrate alignment of all assessment tasks, all unit/subject learning outcomes and all professional capabilities.[7] • Detailed unit/subject profiles/outlines for each unit/subject for the entire program, including details of the assessment tasks for the relevant unit/subject. • A sample of different assessment tools or modalities used during work-integrated learning that show how students attain the professional capabilities. For each tool or modality, include an assessment rubric and a sample of de-identified examples from students across the range of performance. Where possible, include an example of a satisfactory or pass, and an example of unsatisfactory or fail.
4.2	A clear assessment strategy is established and includes multiple, robust contemporary, contextualised and scaffolded assessment tools and modes throughout the program. See explanatory note: Use of valid and reliable assessment tools, modes and sampling in the program	• Details of and rationale for the assessment strategy for each year of the program, identifying assessment tools and modes.
4.3	Multiple authentic and reliable assessment methods are used to evaluate the development of student capability and performance during work-integrated learning and meaningful feedback is provided on student performance.	• Details of the assessment strategy for each work-integrated learning element. • Examples of implementation of formal mechanisms that ensure authentic assessment of student capabilities enable practice. See explanatory note: Simulation-based assessment

[7] Please contact Ahpra's Program Accreditation Team at program.accreditation@ahpra.gov.au to obtain the most up-to-date version of the mapping template.

Criteria		Examples of information for inclusion with accreditation application
		• Examples of implementation of meaningful feedback mechanisms, used during work integrated learning elements, including examples of how this feedback is used by students to improve performance. • Information provided to students on completing any capstone assessments and a sample of de-identified, recently completed (within the last two years) capstone assessments.
4.4	Assessment moderation processes and external referencing mechanisms are applied to ensure assessment of student learning outcomes is valid, reliable, appropriate and reflects the principles of assessment. See explanatory note: Principles of assessment	• Examples of: – the formal assessment mechanisms used to determine student competence – assessment review processes and their use in quality improvement outcomes – assessment statistical data and how it is reviewed and used to improve implementation of assessment. – assessment moderation and validation, including peer validation. This should include the outcomes and responses to those outcomes, and – benchmarking of assessment methods including the outcomes.
4.5	Student requests for reasonable adjustments/accommodations for assessments are reviewed and actioned in a timely manner.	• De-identified adjustment/accommodation requests for assessment that includes: – the implementation of formal mechanisms for ensuring the suitability of any reasonable adjustments/accommodations, and – the implementation of formal mechanisms for communicating arrangements with students.

Standard 5: Preparing students for contemporary practice

Standard statement: Graduates of the program are equipped with the knowledge and skills to adapt to practice that is shaped by social, cultural, environmental and technological factors.

This standard focuses on preparing students for practice and consideration of contemporary and relevant issues and principles that will affect their practice.

Criteria		Examples of information for inclusion with accreditation application
5.1	Formal mechanisms are applied to prepare for and respond to contemporary developments in Chinese medicine and related health professions and the education of health practitioners, within the curriculum of the program.	• Examples of implementation of formal mechanisms, including staff research and research translation, used to anticipate and respond to contemporary developments in: – Chinese medicine practice – chronic disease management, mental health and injury prevention and control, and – the education of health practitioners within the curriculum of the program.
5.2	Program materials address contemporary principles of:	• Program materials and unit/subject profiles/outlines that show where the listed

Criteria		Examples of information for inclusion with accreditation application
	– cultural safety and decolonisation of curricula – interprofessional education – collaborative practice – reflective practice – co-design approaches to practice, and – embedding lived experiences of healthcare in teaching and assessment. These principles are incorporated into the program, including in work-integrated learning elements. See explanatory notes: Interprofessional education, Interprofessional collaboration, co-design and lived experience	contemporary principles are included and reflected in student learning outcomes, including in relation to the safe and effective use of medicines.
5.3	Unit/subject learning outcomes in the program address social and cultural determinants of health and are consistent with the needs of priority populations that experience health inequities. See explanatory note: Social and cultural determinants of health	• Program materials and unit/subject profiles/outlines that show where social and cultural determinants of health are addressed, including but not limited to the care of: – Aboriginal and Torres Strait Islander Peoples – victim-survivors of family, domestic and sexual violence[8] – people experiencing sex and gender bias and disparities in healthcare – people living in remote and rural locations, and – the individual across the lifespan including frailty, disability, palliative care and person-centred care. • Program materials and unit/subject profiles/outlines that focus on the care of patients who have experienced trauma and/or violence. • Examples of how education providers create safe and empowering environments in both clinical and educational settings.
5.4	Formal mechanisms are applied to ensure that the use of clinical and educational technologies is effective, including during work-integrated learning, and the program and education provider: – support its safe and ethical use by students in practice	• Details on how the education provider/program ensures: – equitable access to relevant technology for students, and – the ethical use of technology by students. • Provide detailed information on how learning is enhanced and monitored through the use of technology.

[8] See *Joint Position on Family Violence by Regulators of Health Practitioners*, available on the Ahpra website, accessed 8 January 2025.

Criteria		Examples of information for inclusion with accreditation application
	– sufficiently resource relevant technology and ensure equitable access for students, and – ensure the use of technologies in assessment is appropriate. See explanatory note: Clinical and educational technologies	
5.5	The program addresses principles of environmentally sustainable and climate resilient healthcare. See explanatory note: Environmentally sustainable and climate resilient healthcare	• Provide details of: – where environmentally sustainable healthcare is addressed, with particular reference to resource optimisation, waste reduction and environmentally conscious practices, – how the impact of climate change on healthcare is addressed, and – relevant staff research related to environmental sustainability and climate resilience in healthcare.

3. Explanatory notes

Safe practice

There are many dimensions to safe practice such as knowing about the policy context; best practice guidance; knowing how to manage risk effectively; managing personal, physical and psychological health; practising cultural safety; practising safety in the use of medicines; and the responsibilities as a student and as a registered practitioner. The education provider must assure safe practice in the program by implementing formal mechanisms relating to work-integrated learning environments and to teach students in the program about the different aspects of safe practice, including but not limited to, cultural safety, workplace health and safety (including how to respond to occupational violence), manual handling, psychological health of patients and Chinese medicine practitioners, and infection prevention and control.

Ethical practice

Ethical practice promotes the consideration of values in the prioritisation and justification of actions by health professionals, researchers and policymakers that may impact on the health and wellbeing of patients, families and communities. A health ethics framework aims to ensure systematic analysis and resolution of conflicts through evidence-based application of general ethical principles, such as respect for personal autonomy, beneficence, justice, utility and solidarity.[9]

The requirements for the ethical and professional conduct of Chinese medicine practitioners to assure safe practice in Australia are set out in the *Professional capabilities for Chinese medicine practitioners*, and in the *Code of conduct*[10] for registered health practitioners, published by the Board.

Return to Standard 1

Student support services and facilities to meet learning, welfare and cultural needs

The education provider must be able to demonstrate the implementation of adequate student learning, welfare and cultural support services provided at the level of the program.

Demonstrating how the learning, social and cultural needs of students are met may include providing information on how students in the program access student academic advisers as well as more informal and readily accessible advice from individual academic staff.

Culturally safe practice for Aboriginal and Torres Strait Islander Peoples

The National Registration and Accreditation Scheme's (the National Scheme's) Aboriginal and Torres Strait Islander Health Strategy Group (the Health Strategy Group). The Aboriginal and Torres Strait Islander Health Strategy Group developed the *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* (the Strategy) as a step towards making cultural safety the norm for Aboriginal and Torres Strait Islander Peoples and eliminating racism from the health system, of which accreditation standards play a role. The Statement highlights the Health Strategy Group's intent to achieve equity in health outcomes between Aboriginal and Torres Strait Islander Peoples and other Australians and to close the gap by 2031. Their vision is that patient safety for Aboriginal and Torres Strait Islander Peoples is the norm.

The definition of cultural safety below has been developed for the National Scheme and adopted by the National Health Leadership Forum. The Aboriginal and Torres Strait Islander Health Strategy Group developed the definition in partnership with a public consultation process.

Return to Standard 1

[9] World Health Organization, Western Pacific, Health Topics, Ethics in the Western Pacific. Available from the World Health Organization website, accessed 8 January 2025.
[10] Chinese Medicine Board of Australia *Shared Code of conduct* (2022). Available from the Board's website, see www.chinesemedicineboard.gov.au/Codes-Guidelines/Code-of-conduct. accessed 28 June 2024.

Definition[11]

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

To ensure culturally safe and respectful practice, health practitioners must:

a. Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;
b. Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;
c. Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;
d. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues

All health practitioners in Australia, including Chinese medicine practitioners, need a working knowledge of factors that contribute to and influence the health and wellbeing of Aboriginal and Torres Strait Islander Peoples. These factors include history, spirituality and relationship to land, and other social determinants of health in Aboriginal and Torres Strait Islander communities. Health practitioners also need to take into consideration the different needs of First Nations People, including geographical differences, gender, age and culture.

Return to standard 1

Cultural safety for all communities

The section above defines cultural safety for Aboriginal and Torres Strait Islander Peoples specifically for their status as First Nations Peoples. Culturally safe and respectful practice is important for all communities.

In this context, culturally safe care recognises that individuals are all unique with different lived experiences. This can include social, cultural, linguistic, religious, spiritual, psychological and medical needs that can vastly affect the care, support and services they need.

Effectively delivering culturally safe care can:

- enable individuals to retain connections to their culture and traditions, including connection to land, family, law, ceremony and language
- reduce social isolation, loneliness and feelings of marginalisation
- engender trust in a graduate's ability to provide safe care for individuals from diverse backgrounds, including Aboriginal and Torres Strait Islander Peoples
- empower individuals to make informed decisions and be active participants in their care, and
- increase mutual respect and enhanced relationships with the workforce and community.[12]

Chinese medicine practitioners in Australia must be able to work effectively with people from various cultures, that may differ from their own. Culture may include, but is not limited to, age, gender, sexual orientation, race, socio-economic status (including occupation), religion, physical, mental or other impairments, ethnicity and health service culture. A holistic, patient and family-centred approach requires practice to be culturally safe.

[11].Ahpra and the National Boards, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*. Available on the Ahpra website, accessed 26 August 2024.
[12] Adapted from: Australian Government, Aged Care Quality and Safety Commission, *Flip Guide on Inclusive and Culturally Safe Governance*. Available on the Aged Care Quality and Safety Commission website, accessed 13 June 2024.

Integration of culturally safe practice in the design and implementation of Chinese medicine programs

The Australian Government Department of Health's *Aboriginal and Torres Strait Islander Health Curriculum Framework* (the Framework) supports higher education providers to implement Aboriginal and Torres Strait Islander health curricula across their health professional training programs.[13]

There is an expectation that relevant aspects of the Framework are incorporated into the design and implementation of Chinese medicine programs to prepare graduates to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples. This is reflective of a broader focus on Aboriginal and Torres Strait Islander cultures and cultural safety in education of healthcare practitioners in Australia.

Education providers should inform students of Indigenous data sovereignty which refers to the right of Indigenous people to exercise ownership over Indigenous data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Indigenous data.[14]

Program materials relating to Aboriginal and Torres Strait Islander health and wellbeing are developed by, or in consultation with, Aboriginal and Torres Strait Islander Peoples.

Return to Standard 1

Reconciliation Action Plan

In partnership with Reconciliation Australia, a Reconciliation Action Plan (RAP) enables organisations to sustainably and strategically take meaningful action to advance reconciliation.

Based around the core pillars of relationships, respect and opportunities, RAPs provide tangible and substantive benefits for Aboriginal and Torres Strait Islander Peoples, increasing economic equity and supporting First Nations self-determination.

Reconciliation Australia's RAP Framework provides organisations with a structured approach to advance reconciliation. There are four different types of RAP that an organisation can develop: Reflect, Innovate, Stretch and Elevate. Each type of RAP is designed to suit an organisation at different stages of their reconciliation journey.[15]

The staff and student work and learning environment

The work environment includes any physical or virtual place staff attend to carry out their role in teaching, supervising and/or assessing students in the program. The learning environment includes any physical or virtual place students attend to learn and/or gain clinical experience in the program. Examples include offices, classrooms, lecture theatres, online learning portals, simulated environments, work-integrated learning clinics and/or practices.

Return to standard 1

Inherent requirements

Inherent requirements are the core activities, tasks or skills that are essential to a workplace in general, and to a specific position or role. These activities and/or tasks cannot be allocated elsewhere, are a core element of the position or role, and result in significant consequences if they are not performed.

The HES state that 'Prospective students must be made aware of any inherent requirements for doing a course, or parts of a course, that may affect those students in special circumstances or with special needs (such as a particular type of practicum), especially where a course of study leads to a qualification that may lead to registration as a professional practitioner by a registering authority.'[16]

---

[13] Australian Government, Department of Health Aged Care *Aboriginal and Torres Strait Islander Health Curriculum Framework*, see the Department of Health and Aged Care website, accessed 28 June 2024.
[14] Further information on Indigenous Data sovereignty can be found on the Maian nayri Wingara website, accessed 14 July 2025.
[15] For more information on Reconciliation Action Plans see the Reconciliation Australia website. accessed 24 June 2024.
[16] Domain 1 of the HES Framework. Available from the TEQSA website, accessed 24 June 2024.

Registration requirements

The education provider should clearly and fully inform prospective students about the Board's practitioner registration requirements before the students enrol in the program. Students enrolled in the program should also be reminded of the requirements.

Information should refer to the following registration standards[17] set by the Board:

- Continuing professional development registration standard
- Criminal history registration standard
- English language skills registration standard
- Professional indemnity insurance arrangements registration standard, and
- Recency of practice registration standard.

Committees/groups responsible for program design, implementation and quality assurance

The education provider will regularly monitor and review the program and the effectiveness of its implementation and engage with and consider the views of a wide range of stakeholders. This includes membership on its committtees of the following stakeholder groups:

- Aboriginal and Torres Strait Islander Peoples, including students, health professionals and community members, or consultation with Aboriginal and Torres Strait Islander groups/communities
- representatives of the Chinese medicine profession
- students
- graduates
- academics
- work-integrated learning supervisors, and
- employers and other health professionals when relevant.

The education provider will also implement formal mechanisms to validate and evaluate improvements in the design, implementation and quality of the program.

Return to standard 2

Effective engagement with external stakeholders

The education provider will engage with any individuals, groups or organisations that are significantly affected by, and/or have considerable influence on, the education provider and its program design and implementation. This may include, but is not limited to, representatives of the local community and relevant Aboriginal and Torres Strait Islander communities, people from multi-cultural backgrounds, representatives from the LGBTIQA+ community, representatives from geographically diverse communities, health consumers, relevant health services and health professionals, relevant peak bodies and industry.

Education providers should be considered in their approach to stakeholders, ensuring that their engagement is diverse and does not burden any one stakeholder group. The Committee acknowledges that there are numerous ways education providers engage with their stakeholders, for example through e-mail, video and teleconferencing, questionnaires and surveys (verbal or written), online and physical forums, and face-to-face meetings. Engagement with external stakeholders will occur regularly through one or more of these mechanisms, at least once every six months.

All environments related to the program must be physically and culturally safe for both staff and students.

Staffing

A template for the staffing profile is available[18] for education providers to complete. Use of this template is optional, and the information can be set out in a different format, as long as it includes the details identified in the expected information for Criterion 2.8.

---

[17] Chinese Medicine Board of Australia *Registration Standards*. Available on the Board's website, accessed 28 June 2024.

[18] Please contact Ahpra's Program Accreditation Team at program.accreditation@ahpra.gov.au to obtain the most up-to-date version of the staffing profile.

The education provider should be able to clearly demonstrate that all staff with responsibilities for leadership and implementation of the program have:

a) knowledge of contemporary developments in Chinese medicine, which is informed by current and continuing scholarship or research or advances in practice
b) skills in contemporary teaching, learning and assessment principles relevant to Chinese medicine, their role, modes of implementation and the needs of particular student cohorts, and
c) a qualification in a relevant discipline at least one level higher than the program, or equivalent relevant academic or professional or practice-based experience and expertise.

If information at the level of the program has been provided to and assessed by TEQSA, the outcome of TEQSA's assessment is sufficient.

Return to standard 2

Program design

The Committee considers that the two key goals of the Chinese medicine program leading to qualification for general registration are:

- to ensure graduates can safely, competently and independently practise Chinese medicine at the level needed for general registration, and
- to provide the educational foundation for lifelong learning in Chinese medicine.

To deliver on the educational outcomes, the education provider is encouraged to present an overview about how the curriculum is structured and integrated to produce graduates who have demonstrated all the professional capabilities for Chinese medicine practitioners.

The education provider should make explicit statements about the learning outcomes at each stage of the program, to provide guides for each unit/subject that set out the learning outcomes of the unit/subject, and to show how the learning outcomes map to the professional capabilities for Chinese medicine practitioners.

Return to standard 3

Quality use of medicines

The Committee acknowledges that all health practitioners in Australia should understand the principles of the quality use of medicines. The standards require the education provider to ensure that students are achieving the professional capabilities for Chinese medicine practitioners related to the safe and effective use of medicines. The relevant context of safe and effective use of medicines in Chinese medicine means that a student is expected to understand the responsibility of the registered practitioner to recognise and work within the limits of their competence.

The Health Professions Accreditation Collaborative Forum's *Framework for the safe and effective use of medicines* affords education providers with guidance on possible learning outcomes for students regarding the safe and effective use of medicines.[19]

The principles underpinning the quality use of medicines are one of the central objectives of Australia's National Medicines Policy and are applied when prescribing medicines.[20] Quality use of medicines means:

- Selecting management options wisely by:
  - considering the place of medicines in treating illness and maintaining health, and
  - recognising that there may be better ways than medicine to manage many disorders.
- Choosing suitable medicines if a medicine is considered necessary so that the best available option is selected by taking into account:
  - the individual

[19] Health Professions Accreditation Collaboration Forum, *Framework for accreditation requirements for the safe and effective use of medicines,* 2021, p6. Available from the HPACF website, accessed 28 June 2024.
[20] Australian Government, Department of Health and Aged Care *National Strategy for Quality Use of Medicines* 2002 available from the Department of Health and Aged Care website, accessed 28 June 2024..

  - the clinical condition
  - risks and benefits
  - dosage and length of treatment
  - any co-existing conditions
  - other therapies
  - monitoring considerations
  - costs for the individual, the community and the health system as a whole.
- Using medicines safely and effectively to get the best possible results by:
  - monitoring outcomes,
  - minimising misuse, over-use and under-use, and
  - improving people's ability to solve problems related to medication, such as negative effects or managing multiple medications.

Return to standard 3

Referencing the national safety and quality standards

At a minimum, the education provider should be referencing within the program curriculum the relevant national safety and quality standards published by the:

- Australian Commission on Safety and Quality in Health Care, including the National Safety and Quality Health Service Standards and the National Safety and Quality Primary and Community Healthcare Standards
- Aged Care Quality and Safety Commission, and
- National Disability Insurance Scheme Quality and Safeguards Commission as well as other relevant agencies.

This may include through learning materials given to students, and during lectures.

Learning and teaching approaches

The Committee encourages innovative and contemporary methods of teaching that promote the educational principles of active student participation, problem solving and development of communication skills. Problem and evidence-based learning, technology-assisted learning, simulation and other student-centred learning strategies are also encouraged. Education providers may demonstrate how these approaches are realised and incorporated into the curriculum to facilitate student achievement of the learning outcomes and the professional capabilities for Chinese medicine practitioners.

Teaching and assessment of legislative and regulatory requirements

Legislative and regulatory requirements relevant to the Chinese medicine profession must be taught in the program and for their application to practice to be assessed during work-integrated learning. This should include the range of legislative and regulatory requirements that apply to professional practice; not just those related to the profession of Chinese medicine, these may include but are not limited to:

- medical device laws and regulations
- funding schemes
- medicines and poisons legislations, and
- personal information protection.

Return to standard 3

Work-integrated learning

The Committee recognises that education providers design and carry out work-integrated learning in a variety of ways. The education provider must present documentary and experiential information that shows how their arrangements meet the accreditation standard. [21]

The education provider should provide opportunities for students to give feedback on their work-integrated learning experiences, such as mid and post-placement surveys.

The education provider should have access to at least one clinic and/or practice, the size of which depends on the number of students. The clinic and/or practice is expected to have a sufficient number of well-equipped consulting rooms to provide adequate work-integrated learning experience for students in the direct care of patients/clients. External clinics and/or practices, including those used in overseas student placements, that are used to provide work-integrated learning experiences are also expected to be well-equipped.

Return to standard 3

Achievement of pre-clinical capabilities before work-integrated learning

To enable students in the program to practise safely, students should achieve the pre-clinical capabilities that are relevant to their subsequent period of work-integrated learning, before providing patient/client care and undertaking work-integrated learning assessment tasks, including case studies and reflections. Achievement of these pre-clinical capabilities is needed to minimise risk, particularly because supervision alone cannot assure safe practice.

All students in the program must have an appropriate level of English language skills to communicate effectively with patients/clients, work-integrated learning supervisors, and other staff in the work-integrated learning setting. Additionally, students must be able to show they can:

- perform needling techniques safely before providing acupuncture to patients/clients, and
- identify and dispense/weigh herbal medicine in simulated environments before dispensing to patients.

Relevant accreditation and licensing

The education provider should implement formal mechanisms that ensure each clinic and/or practice in Australia used for work-integrated learning in the program:

1. complies with all relevant licensing requirements, such as applicable public health laws for acupuncture practice, and
2. where relevant, is accredited by an approved accreditation agency[22] that accredit to the *National Safety and Quality Health Service (NSQHS) Standards* and the *National Safety and Quality Primary and Community Healthcare Standards*.

These mechanisms may include relevant clauses in an agreement between the education provider and the clinic and/or practice. Agreements with clinics and/or practices outside Australia must include clauses to cover relevant accreditation and licensing in that country.

Critical reflection

Critical reflection is active personal learning and development that promotes engagement with thoughts, feelings and experiences. It helps to examine the past, look at the present and then apply learnings to future experiences or actions.[23] The education provider should guide students in using relevant tools and models to inform how they critically reflect on their practice.

Return to standard 3

[21] Further information is available in the Independent Accreditation Committee's publication, *Information paper: good practice approaches to embedding clinical placements, pedagogical innovations and evidence-based technological advances in health practitioner education. Available on the Ahpra website, accessed 25 February 2025.*

[22] Approved accrediting agencies contact details are available on the Australian Commission on Safety and Quality in Healthcare website. accessed 24 June 2024.

[23] Adapted from Deakin University Library, *Critical reflection for assessments and practice.* Available from the Deakin University website, accessed 31 July 2024.

Diverse work-integrated learning

Students should be provided with extensive and diverse work-integrated learning experiences with a range of patients/clients and clinical presentations. This should include, but not be limited to:

- Aboriginal and Torres Strait Islander Peoples
- people living in geographically diverse locations including rural or regional areas of Australia
- people from multicultural backgrounds
- people with a disability, including cognitive disability, and/or their advocates[24]
- neurodiverse people
- older people
- young people, and
- lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse (LGBTIQA+) people.

Students should also be exposed to patients/clients with different clinical presentations, such as musculo-skeletal issues, internal disorders, gynaecological disorders etc.

The Committee considers that direct patient/client encounters throughout the program will help to ensure students achieve the professional capabilities for Chinese medicine practitioners. Education providers are expected to explain how the entire spectrum of work-integrated learning experiences will ensure graduates achieve the professional capabilities. Where assessments address meeting the Chinese medicine Board of Australia's professional capabilities early in the duration of a course of study, proficiency in these capabilities should be continually demonstrated throughout work-integrated learning placements.

Return to standard 3

Work-integrated learning supervisors

Work-integrated learning conducted in Australia must be supervised by practitioners who hold current registration with the National Board, in the relevant division of the Chinese medicine practitioner register. For programs that lead to qualifications for general registration in more than one division, work-integrated learning supervisors are expected to hold current registration in the division related to the clinical elements that they supervise.

The education provider is responsible for implementing and monitoring the quality of overseas work-integrated learning. The Committee acknowledges that overseas work-integrated learning supervisors may not hold registration with the National Board. It is expected that they are suitably experienced and qualified and that the Australian standards of practice are recognised and upheld, including effective communication.

The education provider should have consistent two-way communication with practitioners acting as work-integrated learning supervisors. The examples of engagement provided by the education provider should show that work-integrated learning supervisors have an opportunity to provide feedback to the education provider on students' work-integrated learning experiences.

Return to standard 3

Principles of assessment

The principles of assessment are a set of measures to ensure that assessment of students is:

- Fair
  - The individual student's needs are considered in the assessment process
  - Where appropriate, reasonable adjustments are applied by the education provider/program to consider the individual student's needs

[24] Department of Health and Aged Care, *Intellectual Disability Health Capability Framework* (2024). Available on the Department of Health and Aged Care website.

  - The education provider/program informs the student about the assessment process and provides them with the opportunity to appeal the result of assessment and be reassessed if necessary.

- Flexible

  Assessment is flexible to the individual by:
  - reflecting the student's needs
  - assessing capabilities held by the student no matter how or where they have been acquired, and
  - drawing from a range of assessment methods and using those that are appropriate to the context, the unit/subject learning outcomes and associated assessment requirements, and the individual.

- Valid

  Validity requires:
  - assessment against the unit/subject learning outcomes covers the broad range of skills knowledge and professional attributes that are essential to meet the learning outcomes
  - assessment of knowledge, skills and professional attributes is integrated with practise in a clinical setting
  - assessment to be based on the demonstration that a student could practise the skills, knowledge and professional attributes in other similar situations, and
  - judgement of assessment is based on student performance that is aligned to the unit/subject learning outcomes.

- Reliable
  - Assessments are consistently interpreted and assessment results are comparable irrespective of the assessor conducting the assessment.[25]

The education provider should implement an assessment strategy that reflects the principles of assessment. When the education provider designs and implements supplementary and alternative assessments in the unit and/or subject, these must contain different material from the original assessment.

The education provider should describe in detail its assessment processes, including:

- how academic integrity is upheld
- how assessment tasks ensure that all learning outcomes have been met
- how work is assessed (including an assessment rubric), and where relevant
- how thresholds for passing a unit/subject with multiple assessment tasks are implemented.

Return to standard 4

Simulation-based assessment

The benefits of assessing by simulation include:

- exposure to active, experiential, reflective and contextual learning approaches allowing students to see the direct relevance of their educational experience to their future practice
- enabling educators to assess a student's preparedness for work-integrated learning
- technology-based forms of simulation that can enable instant feedback to students, and
- providing effective means of evaluating students' competencies, such as their professionalism, as well as their content knowledge.[26]

Simulation-based assessment should:

- be aligned with the learning outcomes
- provide students (ideally in the course outline) with clear and explicit information as to what is expected
- ensure that the task is authentic and real-world-based. (this may include inviting subject-matter experts to come in as real-time resources for students to consult, as they might consult mentors in a professional setting)

---

[25] Adapted from Australian Skills Quality Authority (ASQA), *Accredited Course Standards Guide, Appendix 6: Principles of Assessment*. Available from the ASQA website, accessed 19 June 2024.

[26,27] Adapted from the University of New South Wales, *Assessing with role plays and simulations.* Available from the University of New South Wales website, accessed 30 July 2024.

- scaffold the learning experience, breaking tasks down to manageable size, and
- use simulations for both formative feedback and summative assessment, rather than introducing them only at the end of the course as a summative assessment. [27]

Use of valid and reliable assessment tools, modes and sampling in the program

The education provider should implement an assessment strategy that incorporates the use of valid and reliable assessment tools, modes and sampling. It is also expected that when the education provider designs and implements supplementary and alternative assessments in the program that these contain different material to the original assessment.

Return to standard 4

Interprofessional education

Interprofessional education is important for preparing students of Chinese medicine to work with other health professionals in a collaborative team environment. Interprofessional teams involving multiple health professionals can improve the quality of patient care and improve patient outcomes, particularly for patients who have complex conditions or comorbidities.

Interprofessional education allows students from two or more professions to learn about, from and with each other to enable effective collaboration and improve health outcomes.[28]

Examples of interprofessional learning might include, but are not limited to:

- small groups working together on an interactive patient case
- simulation-based learning
- clinical settings such as interprofessional learning placements

The principles of interprofessional education include valuing and respecting individual discipline roles in healthcare with the goal of facilitating multi-disciplinary care and the ability to work in teams across professions for the benefit of the patient.

Interprofessional collaboration (Also known as Interprofessional collaborative practice)

Refers to healthcare practice where multiple health workers from different professional backgrounds work together, with patients, families, carers and communities to deliver the highest quality of care that is free of racism and other forms of discrimination.[29]

Return to standard 5

Co-design

A process where people with professional and lived experience partner as equals to improve health outcomes by listening, learning and making decisions together.[30]

The principles of co-design are:

- Inclusive – includes a wide variety of stakeholders groups
- Respectful – the input of all participants is valued and equal
- Participative – the process is open, empathetic and responsive
- Iterative – ideas and solutions are continually tested and evaluated with the participants
- Outcomes focused – the process of designed to achieve an outcome or series of outcomes where potential solutions can be rapidly tested and effectiveness measured.[31]

---

[28] Independent Accreditation Committee, *Glossary of accreditation terms* (2023). Available on the Ahpra website, accessed 19 June 2024.
[29] Independent Accreditation Committee, *Glossary of accreditation terms* (2023). Available on the Ahpra website, accessed 19 June 2024.
[30] Adapted from Queensland Government, Metro North Health, *What is co-design?* Available from the Queensland Government website, accessed 15 January 2025.
[31] NSW Council of Social Service (NCOSS) Principles of Co-design (2017). Available from the NCOSS website, accessed 16 January 2025.

Lived experience

Lived experience refers to the personal perspectives on, and experiences of being a consumer or carer, and how this becomes awareness and knowledge that can be communicated to others.

Engagement that values lived experience focuses on recognising life context, culture, identity, risks and opportunities, it's about working together in partnership to identify what's appropriate for consumers, carers, families and kinship groups, and then acting on this.

Acknowledging lived experience perspectives facilitates high quality person-centred care that is embodied in the principles of recovery, dignity of risk, trauma-informed care, cultural safety and co-production. [32]

Return to standard 5

Social and cultural determinants of health

The education provider should consider social and cultural determinants of health as they relate to the design, implementation and quality improvement of the program. These include:

- Aboriginal and Torres Strait Islander Peoples' connection to family and community, land and sea, culture and identity[33],as well as health and wellbeing across their lifespan, including frailty, disability, palliative care and patient-centred care
- family, domestic and sexual violence (FDSV) as a significant and widespread problem with serious and lasting impacts on individuals, families and communities. Consistent with the National Plan to End Violence Against Women and Children 2022-2032, it is recognised that FDSV affects people of all genders, all ages and all backgrounds, but it predominantly affects women and children, and[34]
- sex and gender bias and disparities in healthcare. Gender inequity in health refers to the unfair, unnecessary, and preventable provision of inadequate health care that fails to take account of the differences between women and men in their state of health, risks to health, and participation in health work.[35]

The World Health Organization lists the following examples of social determinants of health that can influence health equity:

- income and social protection
- education
- unemployment and job insecurity
- working life conditions
- food insecurity
- housing, basic amenities and the environment
- early childhood development
- social inclusion and non-discrimination
- structural conflict, and
- access to affordable health services of decent quality.[36]

Education providers/programs must develop students' knowledge, skills and professional attributes to:

- identify patients who may be experiencing health inequities
- build trust and create a supportive and safe environment for patients to feel safe to disclose
- use trauma-informed approaches to have conversations about health inequities
- work in partnership to respond to the patient's immediate and ongoing support/safety needs
- meet their obligations under local mandatory reporting laws, and

[32] National Mental Health Commission, *Mental Health Safety and Quality Engagement Guide (2021)*. Available from the National Mental Health Commission website, accessed 15 January 2025.
[33] Australian Government, Department of Health and Aged Care, Social and Cultural Determinants of Indigenous Health. *Implementation Plan Advisory Group Consultations 2017 Discussion Paper*. Available on the Department of Health and Aged Care website, accessed 28 June 2024.
[34] Australian Government Department of Social Services. *National plan to end violence against women and children 2022-2032*. Available from the Department of Social Services website, accessed 19 June 2024.
[35] Pan American Health Organization, Gender Equality in Health. Available from the PAHO website, accessed 24 February 2025.
[36] Word Health Organization, Social determinants of health. Available from the World Health Organization Website, accessed 19 June 2024.

- refer patients to specialist services, where appropriate.

Return to standard 5

Clinical and educational technologies

Clinical and educational technologies might include, for example, learning management systems, assessment management systems, electronic portfolio systems and contemporary technology used in the education and practise of the profession. This includes simulation and virtual care.[37]

Increasingly, the use of technologies includes Artificial Intelligence (AI) and specifically generative AI.

Generative Artificial Intelligence is an AI model capable of generating text, images, code, video and audio. Large Language Models (LLMs) such as ChatGPT and Copilot produce text from large datasets in response to text prompts.[38]

Generative AI impacts on learning, teaching, assessment and clinical practice, and education providers need to be able protect the integrity of their awards and produce graduates with both discipline-expertise and the ability to use gen AI tools effectively and ethically[39].

Designing and implementing assessment with the emergence of AI presents additional challenges and opportunities. TEQSA's *Assessment reform for the age of artificial intelligence* describes guiding principles that capture the essence of the considerations required for higher education assessment and AI, these are:

- assessment and learning experiences equip students to participate ethically and actively in a society where AI is ubiquitous, and
- forming trustworthy judgements about student learning in a time of AI requires multiple, inclusive and contextualised approaches to assessment. [40]

Education providers/programs must provide students with ethical guidance on the use of AI. Any AI applications that are required in order for students to meet the learning outcomes of the program must be provided at no extra cost to the students to ensure equitable access.

Return to standard 5

Environmentally sustainable and climate resilient healthcare

Climate change presents a fundamental threat to human health. It affects the physical environment as well as all aspects of both natural and human systems – including social and economic conditions and the functioning of health systems.[41]

Actions to address the health impacts of climate change must also take a health equity approach, because some groups, such as rural and remote communities and Aboriginal and Torres Strait Islander Peoples, are at a disproportionately increased risk of adverse health impacts from climate change due to existing inequities.[42]

Health professionals have a responsibility to develop environmentally sustainable healthcare systems. This may be achieved by avoiding wasteful or unnecessary medical interventions; developing innovative

---

[37] Independent Accreditation Committee, *Information paper: good practice approaches to embedding clinical placements, pedagogical innovations and evidence-based technological advances in health practitioner education*. Available from the Ahpra website, accessed 8 April 2025.
[38] Australian Academic Integrity Network (AAIN), *Generative artificial intelligence guidelines* (2023). Available from the TEQSA website, accessed 19 June 2024.
[39] Tertiary Education Quality and Standards Agency, *Gen AI strategies for Australian Higher Education: Emerging practice* (2024). Available from the TEQSA website, accessed 6 February 2025.
[40] Tertiary Education Quality and Standards Agency, *Assessment reform for the age of artificial intelligence* (2023). Available from the TEQSA website, accessed 6 February 2025.
[41] World Health Organization, *Fact sheets - Climate change*. Available from the World Health Organization website, accessed 19 June 2024.
[42] Australian Commission on Safety and Quality in Health Care (ACSQHC), Interim Australian Centre for Disease Control and Council of Presidents of Medical Colleges, *Joint Statement: Working together to achieve sustainable high-quality health care in a changing climate (2024).* Available from the ACSQHC website, accessed 15 January 2025.

and more integrated models of care; optimising the use of new technologies; preventing avoidable activity; and strengthening primary care, self-management and patient empowerment. [43]

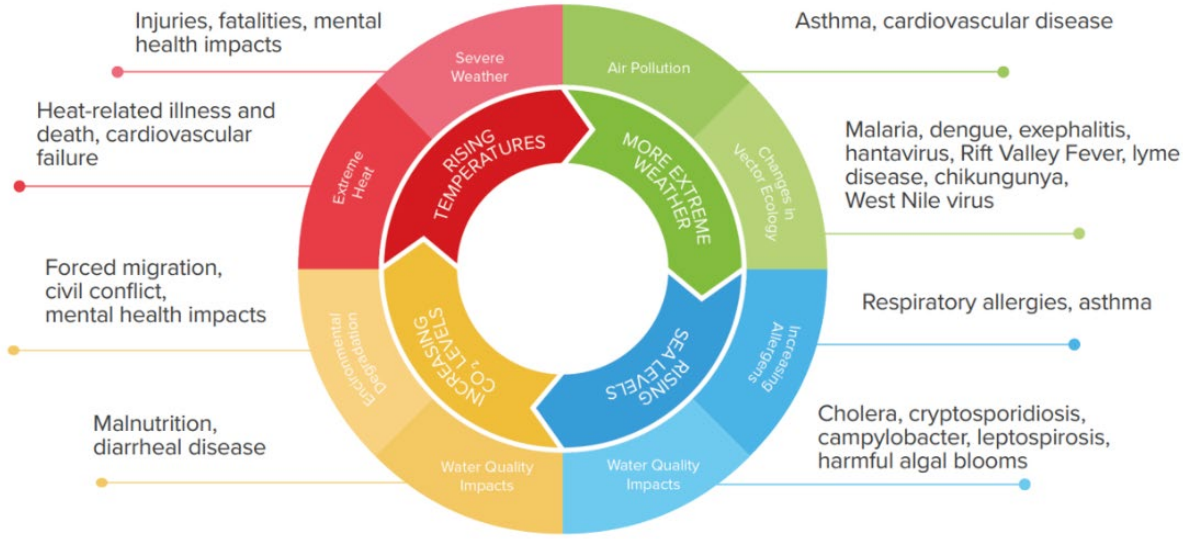
Education providers and programs may already implement environmentally sustainable practices which may include:

- following recommendations of an institutional sustainability strategy
- following a waste management plan, including use of recyclable products
- considering how equipment that may no longer be suitable for its initial purpose may be used in a different context
- established service and maintenance plans to prolong the use of equipment, and
- providing students with guidance and options on the cost and quantities of resources required.

Environmentally sustainable healthcare systems improve, maintain or restore health, while minimising negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and wellbeing of current and future generations.[44]

Figure 3 shows the impacts of climate change on health outcomes.

Figure 3: Impacts of climate change on health outcomes. [45]



Return to standard 5

[43] The Royal Australian College of Physicians, *Environmentally Sustainable Healthcare Position Statement* (2016). Available from the RACP website, accessed 19 June 2024.
[44] World Health Organization, *Environmentally sustainable health systems: a strategic document* (2017). Available from the World Health Organization website, accessed 20 June 2024.
[45] Australian Commission on Safety and Quality in Health Care (ACSQHC), *Environmental Sustainability and Climate Resilience Healthcare Module.* Available from the ACSQHC Website, accessed 15 January 2025.

4. Glossary

Accreditation standards	A standard(s) used by an accreditation authority to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia.
Acupuncturist	A person registered by the Chinese Medicine Board of Australia in the acupuncturist division of Chinese medicine practitioner registration. Acupuncturists provide the full range of acupuncture-related intervention methods (such as acupuncture, moxibustion, cupping, tuina, ear acupuncture and plum-blossom needle) to members of the public who consult them for such a service. This includes the differential diagnosis of the patient's/client's condition and the design and implementation of treatment specific to the patient's/client's condition.
Assessment benchmarking	A structured, collaborative, learning process for comparing practices, processes or performance outcomes. Its purpose is to identify comparative strengths and weaknesses, as a basis for developing improvements in academic quality. Benchmarking can also be defined as a quality process used to evaluate performance by comparing institutional practices to sector good practice.[46]
Assessment moderation	Quality assurance, control processes and activities such as peer review that aim to assure: consistency or comparability; appropriateness; and fairness of assessment judgments; and the validity and reliability of assessment tasks, criteria and standards. Moderation of assessment processes establishes comparability of standards of student performance across, for example, different assessors, locations, units/subjects, education providers and/or programs of study.[47]
Assessment team	An expert team, assembled by the Accreditation Committee, whose primary function is the analysis and evaluation of the Chinese medicine program against the accreditation standards.
Assessment validation	Validation is a quality review process that confirms the assessment system can produce outcomes that consistently confirm a student holds the necessary knowledge and skills described in the learning outcomes.[48]
Chinese herbal dispenser	A person registered by the Chinese Medicine Board of Australia in the Chinese herbal dispenser division of Chinese medicine practitioner registration. Chinese herbal dispensers operate in dispensary clinics or shops and dispense herbal medicines according to prescriptions from Chinese herbal medicine practitioners.
Chinese herbal medicine practitioner	A person registered by the Chinese Medicine Board of Australia in the Chinese herbal medicine practitioner division of Chinese medicine practitioner registration.

[47] Adapted from TEQSA glossary of terms, Available on the TEQSA website,. accessed 1 July 2024.
[48] Adapted from ASQA's focus on compliance, series 2: Assessment validation. Available from the ASQA website, accessed 1 July 2024.

	Chinese herbal medicine practitioners provide the full range of administration methods and routes in Chinese herbal medicine to members of the public who consult them for such a service. This includes diagnosing the patient's/client's condition, designing and prescribing herbal formulae specific to each patient's/client's condition and/or prescribing manufactured herbal medicines. Registered Chinese herbal medicine practitioners can dispense Chinese herbal medicines to their own patients/clients as part of normal practice, and can supply or sell Therapeutic Goods Administration (TGA)-listed products to patients/clients. They do not need to be separately registered as a Chinese herbal dispenser in these circumstances.
Chinese Medicine Accreditation Committee	The committee appointed by the Chinese Medicine Board of Australia responsible for implementing and administering accreditation.
Climate resilience	Adapting health services by identifying environmental risks to enable the health sector to become more climate resilient and able to respond to the needs of those most effected by climate change.[49]
Co-design	A process where people with professional and lived experience partner as equals to improve health outcomes by listening, learning and making decisions together.[50]
Cultural determinants of Indigenous health	Cultural determinants originate from and promote a strength-based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety. Consistent with the thematic approach to the *Articles of the United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP)[51], cultural determinants include, but are not limited to: • self-determination • freedom from discrimination • individual and collective rights • freedom from assimilation and destruction of culture • protection from removal/relocation • connection to, custodianship, and utilisation of country and traditional lands • reclamation, revitalisation, preservation and promotion of language and cultural practices • protection and promotion of traditional knowledge and Indigenous intellectual property, and • understanding of lore, law and traditional roles and responsibilities.

[49] Adapted from the Australian Commission on Safety and Quality in Health Care (ACSQHC), *Environmental Sustainability and Climate Resilience Healthcare Module.* Available from the ACQSHC website. Accessed 15 January 2025.
[50] Adapted from Queensland Government, Metro North Health, *What is co-design?* Available from the Queensland Government website, accessed 15 January 2025.
[51] United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Available from the United Nations website, accessed 5 August 2024.

	Cultural determinants are enabled, supported and protected through traditional cultural practice, kinship, connection to land and Country, art, song and ceremony, dance, healing, spirituality, empowerment, ancestry, belonging and self-determination.[52]
Cultural safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. To ensure culturally safe and respectful practice, health practitioners must: • acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health; • acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism; • recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community; • foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues
Culturally safe environment	A culturally safe environment is where any person, including Aboriginal and/or Torres Strait Islander Peoples are not only treated well and in a culturally respectful manner, but they are also: empowered to actively participate in interactions, believing they are valued, understood and taken seriously and supported to carry out culturally significant tasks as part of service delivery or participation in the program.
Current and continuing scholarship or research	Current and continuing scholarship or research means those activities concerned with gaining new or improved understanding, appreciation and insights into a field of knowledge, and engaging with and keeping up to date with advances in the field. This includes advances in ways of teaching and learning in the field and advances in professional practice, as well as advances in disciplinary knowledge through original research.[53]
Education provider	The term used by the National Law (Australia) to describe universities, tertiary education institutions or other institutions or organisations that provide vocational training, specialist medical colleges and/or health professional colleges.
Environmental sustainability	Mitigating processes, practices and services that have high environmental impact to ensure an environmentally sustainable way of providing appropriate care and reducing waste.[54]

[52] Commonwealth of Australia, Department of Health (2017), *My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations December 2017*, Available from the Department of Health and Aged Care website, accessed 5 August 2024
[53] TEQSA *Guidance Note: Scholarship (2018)*. Available on the TEQSA website, accessed 19 June 2024..
[54] Adapted from the Australian Commission on Safety and Quality in Health Care (ACSQHC), *Environmental Sustainability and Climate Resilience Healthcare Module.* Available from the ACQSHC website. Accessed 15 January 2025.

Formal mechanisms	Activities that an education provider completes in a systematic way to effectively deliver the program. Formal mechanisms may or may not be supported by formal policy but will at least have documented procedures or processes in place to support their implementation.
Frailty	Frailty is conceptually defined as a clinically recognisable state in which the ability of older people to cope with every-day or acute stressors is compromised by an increased vulnerability brought by age-associated declines in physiological reserve and function across multiple organ systems.[55]
Inherent requirements	Prospective students must be made aware of any inherent requirements for undertaking a course, or parts of a course, that may affect those students in special circumstances or with special needs (such as a particular type of practicum), especially where a course of study leads to a qualification that may lead to registration as a professional practitioner by a registering authority.[56]
Interprofessional education	Refers to educational experiences where students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.[57]
Learning outcomes	The expression of the set of knowledge, skills and the application of the knowledge and skills a person has and is able to demonstrate as a result of learning.[58]
Lived experience	A broad term referring to the personal perspectives on, and experiences of being a consumer or carer, and how this becomes awareness and knowledge that can be communicated to others.[59]
Mandatory and voluntary notification about students	An education provider must notify Ahpra if the provider reasonably believes: a) a student enrolled in a program of study provided by the provider has an impairment that, in the course of the student undertaking clinical training as part of the program of study, may place the public at substantial risk of harm, or b) a student for whom the education provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm.[60] A voluntary notification about a student may be made to Ahpra on the grounds that: a) the student has been charged with an offence, or has been convicted or found guilty of an offence, that is punishable by 12 months imprisonment or more, or b) the student has, or may have, an impairment, or

[55] WHO Clinical consortium on Health Ageing, Topic Focus: frailty and intrinsic capacity, see Report of consortium meeting 1-2 December 2016 in Geneva, Switzerland. Available from the WHO website accessed 1 July 2024.
[56] TEQSA *HESF Domain 1: Student participation and attainment.* Available on the TEQSA website, accessed 26 August 2024.
[57] Independent Accreditation Committee, *Glossary of accreditation terms* (2023). Available on the *Ahpra website*, accessed 19 June 2024.
[58] Independent Accreditation Committee, *Glossary of accreditation terms* (2023). Available on the Ahpra website, accessed 19 June 2024.
[59] National Mental Health Commission, *Mental Health Safety and Quality Engagement Guide (2021)*. Available from the National Mental Health Commission website, accessed 15 January 2025.
[60] Section 143(1) of the National Law.

	c) that the student has, or may have, contravened a condition of the student's registration or an undertaking given by the student to a National Board.[61] a) NOTE: The term 'impairment' has a specific meaning under the National Law in Australia. In relation to a person, it means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect: a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession, or b) for a student, the student's capacity to undertake clinical training: i. as part of the approved program of study in which the student is enrolled, or ii. arranged by an education provider.[62]
Mapping document	A document that shows the link between learning outcomes, assessment tasks. NSQHS standards and the Podiatry Board of Australia's professional capabilities.[63]
Medicines	Therapeutic goods that are represented to achieve or are likely to achieve their principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of a human. In this document, the term 'medicine' or 'medicines' includes prescription medicines, non-prescription or over-the-counter products and complementary medicines, including herbs, vitamins, minerals, nutritional supplements, homeopathic medicines and bush and traditional medicines.[64] In the context of Chinese medicine, the term medicines may refer to Chinese herbal medicine.
Principles of assessment	The principles of assessment are a set of measures to ensure that assessment of students is valid, reliable, flexible and fair.
Professional capabilities for Chinese medicine practitioners	Threshold capabilities needed to safely and competently practise as a Chinese medicine practitioner in Australia.
Program of study	A program of study (program) provided by an education provider. Note the term 'course' is used by many education providers.
Simulation	Interactive educational methods or clinical experiences that evoke or replicate real-life characteristics of an event or situation as the basis for developing skills, confidence and problem-solving abilities in a safe, controlled and monitored environment.[65]
Social determinants of health	The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of

[61] Section 144(2) of the National Law.
[62] Section 5 of the National Law.
[63] Please contact Ahpra's Program Accreditation Team at program.accreditation@ahpra.gov.au to obtain the most up-to-date version of the mapping template.
[64] Definition adapted from National Prescribing Service *NPS MedicineWise. Prescribing Competencies Framework: embedding quality use of medicines into practice (2nd Edition). Sydney, 2021.* Available from the NPS MedicineWise website, accessed 19 June 2024.
[65] Independent Accreditation Committee, *Glossary of accreditation terms* (2023). Available on the Ahpra website, accessed 19 June 2024.

	forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.[66]
Unit/subject	A component of a Chinese medicine program. Note, the terms 'course' or 'topic' are used in many programs.
Work-integrated learning	An umbrella term for a range of approaches and strategies that integrate academic learning (theory) with its application to practise in a purposefully designed curriculum. The application to practice may be real or simulated and can occur in the workplace or at the education institution.
Work-integrated learning supervisor/supervision	A work-integrated learning supervisor, also known as a clinical supervisor, is an appropriately qualified and recognised professional who guides learners' education and training during work-integrated learning. The supervisor's role may encompass educational, support and organisational functions. The supervisor is responsible for ensuring safe, appropriate and high-quality patient/client care. Work-integrated learning supervision is a mechanism used by the education provider and workplace to assure the student is practising safely, competently and ethically. It involves the oversight by an appropriately qualified supervisor(s) to guide, provide feedback on, and assess personal, professional and educational development in the context of each learner's experience of providing safe, appropriate and high-quality patient/client care. Work-integrated learning supervision may be direct, indirect or remote according to the context in which the student's learning is being supervised.

[66] World Health Organisation, *Social determinants of health.* Available on the WHO website, accessed 11 February 2025.

5. List of acronyms

Ahpra	Australian Health Practitioner Regulation Agency
AQF	Australian Qualifications Framework
HES	Higher Education Standards
HESP	Higher Education Standards Panel
NSQHS Standards	National Safety and Quality Health Service Standards
TEQSA	Tertiary Education Quality and Standards Agency
TGA	Therapeutic Goods Administration