Course Syllabus

English for Clinical Handover and Documentation · OBA-ENG-2026 · 9.0 CPD hours · fully self-directed online

DOCUMENT CONTROL

- Programme: English for Clinical Handover and Documentation (OBA-ENG-2026)
- Audience: Student and Facilitator
- Version 1.0 | Issued 20/09/2026 | Review due 20/09/2027
- Provider: OBA Nursing Academy

SCOPE OF PRACTICE AND CURRENCY

- This programme is professional development. It explains the Communicating for Safety Standard, the Commission's guidance on clinical handover and documentation, and the NMBA standards for practice that govern nursing documentation; it does not replace them, and it is not legal advice. It does not define your service's minimum information content for handover - Action 6.07 requires your organisation to do that in collaboration with clinicians, and your service's defined dataset, approved abbreviation list, escalation protocol and documentation policy override anything in this programme wherever they differ.
- Content verified 20/09/2026 against the NSQHS Communicating for Safety Standard (second edition), the Commission's current guidance pages on effective communication, clinical handover and documentation of information (last updated 29 April 2026), the Implementation Toolkit for Clinical Handover Improvement (2011), Recommendations for safe use of medicines terminology (November 2024), the Australian Charter of Healthcare Rights (second edition), and the NMBA registered nurse and enrolled nurse standards for practice. NOTE THE TWO CURRENCY LAYERS: the Commission's guidance pages are current to April 2026, while the Implementation Toolkit that carries the four principles of handover and the mnemonic finding was published in 2011 and predates the second edition of the NSQHS Standards. Where this programme relies on the Toolkit it says so.

1. Programme overview

English for Clinical Handover and Documentation is a fully self-directed, entirely online professional development programme delivered through the OBA Nursing Academy learning management system. There are no scheduled classes, no live sessions and no clinical placement. Learners complete eleven modules at their own pace, followed by a case study assessment and a single summative assessment.

THE SENTENCE THIS PROGRAMME HOLDS

- YOUR ENGLISH IS NOT THE PROBLEM. AND YOU STILL HAVE TO BE UNDERSTOOD AT THREE IN THE MORNING, BY SOMEBODY WHO IS BUSY, ON A TELEPHONE, ABOUT A PATIENT WHO IS DETERIORATING.
- Both halves are true, and a course that holds only one of them does harm. Hold only the first and you produce an accurate systemic analysis that leaves a nurse with nothing to say on a night shift.

Hold only the second and you produce the course a great many internationally qualified nurses have already been sent to - the one that locates the fault inside the learner and produces silence.

• SO THIS PROGRAMME DOES BOTH, in that order. Of the eleven actions in the Communicating for Safety Standard, EIGHT bind the health service organisation and three bind clinicians - so if your handover has no allocated time, no designated leader and no defined minimum information content, those are compliance gaps belonging to the service. And then the programme gives you the sentences anyway, because an accurate allocation of a problem does not get anybody through a shift.

• THE COMMISSION'S OWN FRAMING IS THE PERMISSION STRUCTURE FOR ALL OF IT: effective communication is 'a core clinical skill that can be developed and improved with practice, experience, continuous learning, mentorship, and support'. A SKILL - which makes a gap in it a training need rather than a characteristic, and which means two of those five named mechanisms are things other people owe you.

TWO COURSES THIS ONE IS OFTEN CONFUSED WITH

THIS IS NOT AN ENGLISH TEST COURSE, AND IT IS NOT AN ACCENT COURSE. It does not prepare you for OET, IELTS, PTE or TOEFL, and it has no relationship to the NMBA English language skills registration standard - which applies to applicants for INITIAL registration and does not apply to a nurse who is already registered. It does not teach you to sound Australian, and nothing in it treats an accent as a clinical risk. It is professional development in one clinical skill: communicating at handover, on the telephone, in an escalation, and in the healthcare record.

Who it is for

- Internationally qualified nurses and midwives practising in Australia - for whom the clinical register, the escalation conventions and the documentation expectations are all new at once, and usually learned by being corrected
- Registered and enrolled nurses in every setting, at every stage - because handover and documentation are where most of the preventable harm in Australian health care is transmitted, and neither is taught well anywhere
- Nurses returning to practice after a break, or moving between sectors - acute to aged care, hospital to community - where the documentation conventions change completely
- Agency and casual nurses, who hand over to people they have never met, in services whose minimum dataset they have not been shown
- Nurse unit managers, educators and clinical leads - who own the handover process under Action 6.08 and whose service's defined minimum information content is the thing this course keeps pointing at
- Anybody who has ever escalated, been ignored, and then been told afterwards that they should have escalated
- Anybody who has written 'patient non-compliant' in a progress note and not thought about it since
- Nurses whose first language is not English, and nurses whose first language is English - because the softener is not a second-language habit. It is a nursing habit, and it is at least as common in people born here

How it is delivered

- Fully self-directed and entirely online, through the OBA learning management system. No scheduled classes, no live sessions, no clinical placement
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a formative knowledge check
- A case study assessment of five unfolding situations, and a single summative assessment
- Learners work at their own pace. Nothing is timed, and there is no completion deadline
- Every modelled utterance in the programme is one you can say out loud tomorrow. The phrasebook is the deliverable - not the theory behind it

How this programme treats the people taking it

Two things about how this programme is written. It locates the problem accurately: communication failure at transitions of care is overwhelmingly a system finding, and eight of the eleven actions in the Communicating for Safety Standard bind the health service organisation rather than the individual clinician. And it does not pretend that the system being at fault gets an individual nurse through a night shift - so it also gives you the sentences. A proportion of any cohort has been made to feel that their English is a liability, often by people who meant well. Nothing here reinforces that, and the support lines are on every student-facing document.

SUPPORT - FOR YOU, NOT FOR A PATIENT

- Nurse & Midwife Support - 1800 667 877. 24 hours, seven days. Free and confidential, for nurses, midwives and students - including if you have been bullied about your English, or are carrying an incident in which communication was blamed.
- Lifeline - 13 11 14. 24 hours, seven days. National crisis support.
- You may stop this programme at any point and come back. Nothing is timed and there is no penalty.

Programme outcomes

On completion, learners will be able to:

1. State both halves of the sentence this programme is built on, and explain why a course holding only one of them does harm
2. State the intention of the Communicating for Safety Standard, its four high-risk situations, and how many of its eleven actions bind the organisation rather than the clinician
3. State the definition of clinical handover and explain the significance of the word ACCOUNTABILITY
4. State the Commission's published position on handover mnemonics, and distinguish the required structure from the optional mnemonic from the underlying skill
5. Identify hedging in escalation language and replace it with a direct request carrying an explicit time
6. State what Action 8.06 provides about worry or concern as an escalation criterion, and use graded assertiveness when a request is declined
7. Apply the test that a record must be interpretable by a person who was not present, and distinguish an observation from a conclusion
8. Apply the nine-step telephone protocol, including read-back in both directions and asking for repetition without apologising
9. List the seven guiding principles for documentation and explain what READABLE and ENDURING require in practice

10. State what CONTEMPORANEOUS means in Action 6.11, and correct an error or label a late entry without creating a larger problem
11. Explain why a character label about a patient is a safety issue rather than a politeness issue, and replace ten common labels
12. Identify the do-not-use abbreviations, explain why 'U' and 'ug' produce tenfold and thousandfold errors, and apply the ambiguity test
13. State the requirement for accredited interpreter services, explain why a family member cannot interpret and why a child never can, and use teach-back
14. Identify which action a communication failure engages, report it so that it produces change, and answer the ten local questions this course leaves to you

2. Module structure

Module	Title	CPD hours	Knowledge check items
00	Orientation: Your English Is Not the Problem, and You Still Have to Be Understood	0.50	4
01	What the Standard Actually Requires, and Who It Binds	0.50	6
02	The Structure Is Required; the Mnemonic Is Not	0.50	6
03	Saying the Hard Thing: Hedging, and the Words That Get Ignored	0.50	7
04	Precision: Observation, Conclusion, and the Words That Mean Nothing	0.50	5
05	The Telephone: the Hardest Thing You Will Do in English	0.50	6
06	Documentation: the Seven Guiding Principles	0.50	6
07	What Must Never Be Written: Labels, Opinion as Fact, and Who Reads It Later	0.50	6
08	Abbreviations, Symbols and the Ones That Cause Tenfold Errors	0.50	5
09	Interpreters, Teach-Back and the Patient Who Does Not Speak English Either	0.50	5
10	The System Around It: Whose Action Is It, and What to Report	0.50	4
	Module subtotal	5.50	60
	Programme information documents	1.63	-
	Case study assessment (5 unfolding cases)	0.53	-
	Summative assessment	0.97	60
	CLAIMABLE CPD	9.0	

	TOTAL		

Module hours are the measured time for that module's video, learner guide, knowledge check and workbook activity. The table below shows how every figure was measured.

Indicative workload, and how the CPD hours were arrived at

The CPD figure for this programme is not asserted. It is measured from the content: narration at 135 words per minute, reading at 130 words per minute for dense professional prose, knowledge checks timed to include reading every rationale, and the assessments timed as measured reading plus a stated decision allowance. Individual learners vary, and a learner who claims a different figure should claim their actual time.

Component	Measured time	How it was measured
Module videos (11)	67 min	Narration word count at 135 wpm
Student learner guides (11)	142 min	Guide word count at 130 wpm
Module knowledge checks (11)	50 min	Stem, options and every rationale, read and answered
Reflective workbook activities (11)	88 min	Writing time for the prompts in each module
Programme information documents	98 min	Rendered page word counts at 130 wpm
Case study assessment	32 min	19 minutes measured reading plus 30 seconds per decision across 25 steps
Summative assessment	58 min	28 minutes measured reading plus 30 seconds per item across 60 items
MEASURED TOTAL	535 min (8.92 h)	Sum of the above
CLAIMABLE CPD	9.0 hours	The measured total, to the nearest half hour

The measured total is 8.92 hours and the claimable figure is 9.0 - the measured total to the nearest half hour, INCLUDING DOWNWARDS. The programme has not been padded to reach a rounder number, because the whole point of deriving the figure is that it is not chosen.

The five optional practice tools - say it again without the hedge, observation or conclusion, would you write that, who does this action belong to, and the communication scope self-check - add approximately a further 85 minutes. They are deliberately excluded from the claimable figure because they are optional. A learner who completes them may claim that time as additional self-directed CPD.

Module 00 - Orientation: Your English Is Not the Problem, and You Still Have to Be Understood

What the programme covers and the sentence it is built on - which has two halves, and a course that holds only one of them does harm. Communication failure at handover is overwhelmingly a SYSTEM finding: eight of the eleven actions in the Communicating for Safety Standard bind the health service organisation, not you. AND you still have to be understood at three in the morning, by somebody who is busy, on a telephone, about a patient who is deteriorating. Then the six documents every statement here is traceable to; the Commission's own framing of

communication as a CORE CLINICAL SKILL that can be developed rather than a trait you have or lack; and the two things this course is emphatically not - English test preparation, and accent training.

Learning outcomes

- State both halves of the sentence this programme is built on, and explain why each fails without the other
- Explain why effective communication is described as a core clinical skill rather than a trait
- Name the six documents this programme is built on
- State what this course is not - and why the NMBA English language skills registration standard is irrelevant to a registered nurse
- Describe the two directions in which this programme's content rules point
- Locate the ten local questions this course cannot answer for you

Key terms: clinical handover; documentation; communicating for safety; escalation; clinical communication; transfer of accountability; healthcare record

Module 01 - What the Standard Actually Requires, and Who It Binds

The Communicating for Safety Standard, read properly. Its stated intention; the four high-risk times it identifies; and all eleven actions with the subject of each sentence marked - because EIGHT of the eleven bind the health service organisation and only THREE bind clinicians. Then the definition that changes how you think about handover: it is 'the transfer of professional responsibility and accountability', which means that until somebody has accepted it, the patient is still yours. And the NMBA standards that make all of this a registration obligation rather than an accreditation one - EN Standard 7 in full, RN Standards 1.6 and 2.2.

Learning outcomes

- State the intention of the Communicating for Safety Standard and its four high-risk situations
- Identify which actions bind the organisation and which bind clinicians, and explain why that distinction matters
- State the definition of clinical handover and explain the significance of 'accountability'
- Name the requirement for at least three approved patient identifiers and when it applies
- State what EN Standard 7 and RN Standards 1.6 and 2.2 require
- Distinguish a national requirement from a local arrangement in your own service

Key terms: communicating for safety; eleven actions; high-risk situations; transitions of care; approved identifiers; accountability; EN Standard 7

Module 02 - The Structure Is Required; the Mnemonic Is Not

Almost every Australian nursing course teaches ISBAR as though it were a national requirement. It is not. The Commission's own Implementation Toolkit says, in terms, that THERE IS NO EVIDENCE THAT ANY MNEMONIC IS BETTER THAN ANOTHER, and that the choice should be fit for purpose for the local context. What IS required is a structured process, and a MINIMUM INFORMATION CONTENT that your organisation defines in collaboration with clinicians under Action 6.07. This module separates the three things that get confused - the structure (required), the mnemonic (local and optional), and the skill (neither, and the subject of the rest of this course). Then the four principles of handover and the six limbs of Action 6.08, which are what a compliant handover process actually looks like.

Learning outcomes

- State what Action 6.07 requires, and who it binds
- State the Commission's published position on handover mnemonics
- Distinguish the required structure from the optional mnemonic from the underlying skill
- List the four principles of handover and the six limbs of Action 6.08
- Explain why a handover can follow a mnemonic perfectly and still fail
- Identify what your own service's minimum information content is, or that it does not exist

Key terms: minimum information content; ISBAR; structured handover; Action 6.07; Action 6.08; minimum data set; principles of handover

Module 03 - Saying the Hard Thing: Hedging, and the Words That Get Ignored

The most consequential module in this course. Hedging - 'just', 'sorry to bother you', 'when you get a chance', 'it's probably nothing' - is grammatically perfect, socially correct, and reliably fatal to an escalation, because it tells the listener the content is optional. This module explains why every nurse does it (hierarchy, uncertainty, and for some learners transfer from a first language - none of which is a vocabulary problem), reframes the fix as REGISTER rather than rudeness, and then gives the sentences: the shape of an escalation, the hedge-to-replacement table, and graded assertiveness for when the answer is no. Plus the fact that decides more escalations than any other: under Action 8.06, WORRY OR CONCERN IS AN ESCALATION CRITERION IN ITS OWN RIGHT.

Learning outcomes

- Identify hedging in your own and others' escalation language
- Explain the three reasons nurses hedge, and why none of them is a language deficiency
- Replace ten common hedges with the direct form
- State the shape of an effective escalation, with the request placed first and a time attached
- Use graded assertiveness when a request is refused or deferred
- State what Action 8.06 says about worry or concern as an escalation criterion

Key terms: escalation; hedging; mitigated speech; graded assertiveness; Action 8.06; rapid response; clinical review criteria

Module 04 - Precision: Observation, Conclusion, and the Words That Mean Nothing

One test settles almost every wording question in clinical communication, and the Commission supplies it: a record must be 'interpretable by a person who is not present at the time of the recording'. From that follows the distinction this module is built on - OBSERVATION (what happened, reproducible) versus CONCLUSION (what you decided, which is legitimate and must be labelled as yours). Then the vague words that survive in nursing language because they sound clinical and commit to nothing - 'stable', 'ate poorly', 'a bit off', 'uneventful' - with the replacement for each. And the technique that carries the most information per word in the whole course: the patient's own words, in quotation marks.

Learning outcomes

- State the test for whether a record or a handover is precise enough
- Distinguish an observation from a conclusion, and record each appropriately
- Replace ten vague expressions with specific alternatives

- Use direct quotation where the person's own words are the finding
- Explain why 'uneventful' and 'stable' are the least informative words in nursing documentation
- Apply the precision test to your own most recent entry

Key terms: objective documentation; observation; clinical judgement; quantification; direct quotation; baseline; enduring

Module 05 - The Telephone: the Hardest Thing You Will Do in English

If you find the telephone harder than speaking face to face, you are describing the medium accurately rather than failing at it. You lose the face, the lips and the gesture; the line removes exactly the frequencies that distinguish consonants; the other person is doing something else; and it is almost always 0300. This module gives the nine-step protocol - confirm who you have, name yourself without apologising, problem before story, numbers twice, spell what can be confused, read-back in both directions, ask for repetition without apologising, close the loop with a time, and document the call immediately. Plus the one technique in this course with no downside at all: READ-BACK. And the rule most nurses have never been told - the medicines terminology recommendations apply to WHAT IS SAID OUT LOUD.

Learning outcomes

- Explain why telephone communication is harder for every speaker, not only for second-language speakers
- Apply the nine-step telephone protocol
- Use read-back in both directions, and explain why it carries no implication of incompetence
- Ask for repetition and spelling without apologising
- State that the medicines terminology recommendations apply to spoken as well as written communication
- Document a telephone call so that it is usable months later

Key terms: telephone; read-back; closed-loop communication; spelling protocol; verbal orders; documentation of calls; medicines terminology

Module 06 - Documentation: the Seven Guiding Principles

The Commission publishes seven guiding principles for documentation - person-centred, compliant, complete and accurate, integrated and up to date, accessible, readable, enduring - and together they are the best short statement of what a good entry looks like that exists anywhere. This module goes through all seven, with the two that carry the most weight (READABLE and ENDURING) last. Then the word Action 6.11 uses and most people gloss: CONTEMPORANEOUS. And finally error correction - single line, initial, date, time, never obliterate, never backdate - because the commonest way a small documentation mistake becomes a serious one is the attempt to fix it.

Learning outcomes

- List the seven guiding principles for documentation
- Explain what 'readable' and 'enduring' require in practice
- State what 'contemporaneous' means in Action 6.11 and why it favours shorter entries
- Correct an error in the healthcare record correctly
- Label a late entry so that it remains an honest record
- Explain why obliterating or backdating converts a correctable mistake into a credibility problem

Key terms: guiding principles; contemporaneous; Action 6.11; error correction; late entry; progress notes; healthcare record

Module 07 - What Must Never Be Written: Labels, Opinion as Fact, and Who Reads It Later

THE EQUITY MODULE OF THIS COURSE, and the mechanism is a single word. 'Non-compliant.' 'Difficult.' 'Poor historian.' 'Frequent flyer.' Fluent, confident, clinical-sounding English that is read hundreds of times and arrives in the next clinician's head BEFORE they meet the patient. The harm is not hurt feelings - it is that the next complaint is taken less seriously, and the documented pattern is that this falls hardest on people with a mental health diagnosis, people with a substance use history, people who are not fluent in English, Aboriginal and Torres Strait Islander people, and women reporting pain. Ten labels with their replacements. Then opinion dressed as observation. And finally who actually reads a healthcare record - which now includes the patient.

Learning outcomes

- Explain why a character label is a safety issue rather than a politeness issue
- Replace ten common labels with what should be written instead
- Distinguish legitimate clinical judgement from opinion disguised as observation
- Record a refusal, a concern and an unverifiable statement safely
- Name who may read a healthcare record, including the patient
- Audit one of your own entries for labelling language

Key terms: labelling; non-compliant; objective documentation; clinical judgement; equity; discoverability; My Health Record

Module 08 - Abbreviations, Symbols and the Ones That Cause Tenfold Errors

The Commission's Recommendations for safe use of medicines terminology (November 2024) set out seventeen best-practice principles and a list of abbreviations that must not be used. Two of those abbreviations - 'U' for units and 'ug' for microgram - produce tenfold and thousandfold errors respectively, and both are still in daily use. Beyond medicines, the test the Commission applies is AMBIGUITY, NOT FAMILIARITY: an abbreviation everybody on your ward understands is still prohibited if it means something else on the ward you are transferring to. This module covers the do-not-use table, the general test, the trap for anybody who has worked in more than one country or sector, and the local approved abbreviation list you have probably never read.

Learning outcomes

- State that the medicines terminology recommendations apply to written, displayed AND spoken communication
- Identify the do-not-use abbreviations and write each correctly
- Explain why 'U' and 'ug' specifically produce tenfold and thousandfold errors
- Apply the ambiguity test to abbreviations outside the medicines list
- Explain why moving between countries or sectors increases abbreviation risk
- Locate and use your service's approved abbreviation list

Key terms: abbreviations; medicines terminology; do not use; ambiguity; units; microgram; approved abbreviation list

Module 09 - Interpreters, Teach-Back and the Patient Who Does Not Speak English Either

The Commission's wording is ACCREDITED interpreter services, and the word is doing work: a bilingual person who happens to be present is not an interpreter. This module covers why a family member cannot interpret a clinical conversation (and why a child must never interpret in any circumstance), what a family member IS for, and the position of a nurse who shares a language with the patient - which is a genuine clinical asset and is not the same job as interpreting. Then TEACH-BACK, the Commission's named technique, and the crucial detail that it checks YOUR explanation rather than their comprehension. Plus the Charter of Healthcare Rights - seven rights, published in 34 languages, which is the Commission's own answer to anybody who treats language access as a courtesy.

Learning outcomes

- State the Commission's requirement for accredited interpreter services
- Explain why a family member cannot interpret a clinical conversation, and why a child never can
- Describe what a family member IS for, including under Action 6.10
- Explain the position of a nurse who shares a language with the patient
- Use teach-back, and explain why it checks the explanation rather than the person
- Name the seven rights in the Australian Charter of Healthcare Rights

Key terms: interpreter; TIS National; teach-back; health literacy; Charter of Healthcare Rights; Action 2.08; language access

Module 10 - The System Around It: Whose Action Is It, and What to Report

The module that closes the loop opened in Module 00. When handover fails, the finding is almost never that somebody spoke badly - it is that there was no protected time, no designated leader, no venue in which confidential information could be said, no defined minimum information content, or no interpreter available. Every one of those is an action in Standard 6, and every one belongs to the organisation. This module gives you the five things worth reporting and HOW TO NAME THEM, because naming the action number converts a complaint into a compliance gap and services respond very differently to the second. Then the ten local questions, and the close: both halves, one last time.

Learning outcomes

- Explain why communication failure at transitions of care is predominantly a system finding
- Identify which of the eleven actions a given failure engages
- Report a communication near miss so that it produces change
- Name an action number when raising a gap with a manager or educator
- State the ten local questions and where to find each answer
- State both halves of the sentence the programme opened with

Key terms: system findings; incident reporting; quality improvement; Action 6.01; Action 6.02; local questions; under-reporting

3. Assessment

Component	Type	Weighting	Attempts
Module knowledge checks (11)	Formative, immediate feedback with rationales	Not graded	Unlimited
Reflective workbook	Formative, self-directed	Completion required	n/a
Case study assessment	Formative, branching decisions with feedback	Completion required	Unlimited
Summative assessment	60 single-best-answer items	100% - pass mark 80%	2

Summative assessment blueprint

Module	Items
00	4
01	6
02	6
03	7
04	5
05	6
06	6
07	6
08	5
09	5
10	4
TOTAL	60

Pass mark is 80 per cent (48 of 60). Learners have 2 attempts. The certificate of completion is issued automatically on a pass.

The assessment is bound by the same rules as the rest of the programme, and eight of them are enforced mechanically by bank.py rather than trusted to the author. NO KEYED ANSWER MODELS A HEDGED, APOLOGETIC OR DEFERRABLE ESCALATION - the primary rule, because a keyed answer is a sentence a learner may repeat verbatim at three in the morning. None frames an accent or a first language as a clinical risk. None uses a character label about a patient. None presents a handover mnemonic as a national requirement. None uses a do-not-use abbreviation as though it were acceptable. None accepts a family member or a child as an interpreter. None advises backdating, obliterating or altering a record. And no keyed answer states a numeric obligation that frameworks.SOURCED_OBLIGATIONS does not contain, checked as a (number, unit) pair. Each guard is fired against known-bad text by check_bank_negative_control.py before a clean result is trusted.

4. Standards and regulatory mapping

Framework	Elements addressed	Where
NSQHS Communicating for Safety Standard (second edition)	Eleven actions across four criteria; the four high-risk situations; at least three approved patient identifiers	Every module, and Modules 01, 02 and 10 in particular

	(6.05); the defined minimum information content (6.07); the six limbs of structured handover (6.08); timely communication of critical information (6.09); patient and family escalation (6.10); and contemporaneous documentation (6.11)	
ACSQHC guidance on effective communication, handover and documentation (April 2026)	The definition of effective communication; communicating with patients; accredited interpreters and teach-back; the definition of clinical handover; and the seven guiding principles for documentation	Modules 01, 05, 06 and 09
ACSQHC Implementation Toolkit for Clinical Handover Improvement (2011)	The four principles of handover, the minimum data set concept, and the statement that no handover mnemonic is better than another	Module 02
ACSQHC Recommendations for safe use of medicines terminology (November 2024)	Seventeen best-practice principles; the unacceptable abbreviation list; and the rule that the recommendations apply to what is SPOKEN as well as written	Modules 05 and 08
NSQHS Partnering with Consumers Standard (second edition)	Action 2.03 charter of rights; Action 2.08 communication mechanisms tailored to consumer diversity; Action 2.10 information that meets patients' needs and is easy to understand	Modules 09 and 10
NSQHS Recognising and Responding to Acute Deterioration Standard	Action 8.06 - worry or concern in the workforce, the patient, or the family is an escalation criterion in its own right	Modules 03 and 10
Australian Charter of Healthcare Rights (second edition)	Seven rights; Information and Partnership in particular; published in 34 languages	Module 09
NMBA Registered nurse standards for practice	Standard 1.6 - accurate, comprehensive and timely documentation. Standard 2.2 - communicates effectively and is respectful of a person's dignity, culture, values, beliefs and rights	Modules 06, 07 and 09
NMBA Enrolled nurse standards for practice	STANDARD 7 IN FULL - communicates and uses documentation to inform and report care. Five indicators, and 7.4 names clinical handover expressly. Also 1.6, 2.8 and 3.6	Every module

	on clarifying and escalating	

5. Scope of practice

This programme is written for registered and enrolled nurses, midwives, care workers, and the managers and educators who hold the other half of the subject. Every module identifies what each role may and may not do, and under what condition. The full activity-by-role matrix is published separately as the Scope of Practice Mapping document (facilitator) and the Student Scope of Practice Card.

THE RULE THAT GOVERNS THE PROGRAMME

- Completing this course authorises nothing, and in this subject that sentence needs two extra lines. It is NOT ENGLISH TEST PREPARATION - not OET, IELTS, PTE or TOEFL - and it has no relationship to the NMBA English language skills registration standard, which applies to applicants for INITIAL registration and does not apply to a nurse who is already registered.
- AND IT IS NOT ACCENT TRAINING. Nothing in it treats an accent as a clinical hazard, offers accent reduction, or suggests that sounding Australian is the goal.
- It does not define your service's minimum information content for handover. Action 6.07 requires your ORGANISATION to do that, in collaboration with clinicians - and your service's defined dataset, approved identifiers, approved abbreviation list, escalation criteria and documentation policy override anything in this programme wherever they differ.
- Several rows of the communication matrix read 'No' for every role including the most senior - using a family member or a child as an interpreter, recording a character judgement about a patient, obliterating or backdating an entry, and softening an escalation so as not to bother a senior colleague.
- And where this programme and a Commission or NMBA document differ, that document applies. Every time.

6. Resources and further reading

A full directory, with live links, is published as the Further Reading and Organisation Directory. Four documents matter more than everything else and all are free. The NSQHS COMMUNICATING FOR SAFETY STANDARD is the authority - eleven actions, four high-risk situations, and the subject of each sentence worth counting for yourself. The COMMISSION'S FURTHER INFORMATION PAGE (last updated 29 April 2026) carries the definition of effective communication, the definition of clinical handover, and the SEVEN GUIDING PRINCIPLES FOR DOCUMENTATION. The IMPLEMENTATION TOOLKIT FOR CLINICAL HANDOVER IMPROVEMENT (2011) carries the four principles of handover and the statement that no handover mnemonic is better than another. And RECOMMENDATIONS FOR SAFE USE OF MEDICINES TERMINOLOGY (November 2024) carries the do-not-use abbreviation list and the rule that it applies to what is SPOKEN. Support lines are on every module: Nurse & Midwife Support 1800 667 877, Lifeline 13 11 14.

7. Completion and CPD

15. Complete all eleven module knowledge checks.
16. Complete the case study assessment.
17. Achieve 80 per cent or above in the summative assessment within 2 attempts.

18. The certificate of completion is then issued automatically, carrying the learner's name, the completion date, 9.0 CPD hours and a unique certificate identifier.
19. Registered and enrolled nurses should retain the certificate together with their reflective workbook as CPD evidence. The certificate evidences PARTICIPATION; the identified learning need, the plan and the reflection are yours to write, and the workbook is built for them.