



Carers WA Policy Submission
Draft NSQHS Standards (Third Edition)
September 2026

About Carers WA

Carers WA is the peak body representing the needs and interests of carers in Western Australia and is part of a national network of Carers Associations. Carers provide unpaid care and support to family members and friends with disability, mental health challenges, long term health conditions (including a chronic condition or terminal illness), have an alcohol or drug dependency, or who are frail aged. The person they care for may be a parent, partner, sibling, child, relative, friend or neighbour.

Caring is a significant form of unpaid work in the community and is integral to the maintenance of our aged, disability, health, mental health, and palliative care systems.

Some important facts about carers include:

- There are currently 3.04 million unpaid carers in Australia.
- There are more than 320,000 families and friends in a caring role in Western Australia.
- The replacement value of unpaid care, according to a report undertaken by Deloitte, Access Economics, "The economic value of unpaid care in Australia in 2020" is estimated at \$77.9 billion per annum.

Acknowledgement of Country

Carers WA acknowledges the Wadjuk Noongar Nation's lands, water, customs, and culture of which the Carers WA Head Office is located. Carers WA recognises our services reach beyond the Perth (Boorloo) region, and so we also acknowledge the cultural diversity of First Nation Peoples across our state and throughout Australia.



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1.0 Recommendations

1. A dedicated Partnering with Carers, Families and Consumers Standard be added to the final Standards.
2. The final Standards establish enforceable clear duties, practical implementation mechanisms and measurable outcomes to demonstrate whether carers are consistently identified, listened to, involved, prepared and supported.
3. The final Standards use mandatory and enforceable language for all core carer-related obligations, supported by clearly defined responsibilities, standardised implementation tools, auditable indicators and carer-specific experience and outcome measures.
4. The final Standards recognise the systematic identification, involvement and support of carers as a core safety and quality priority.
5. The Standards recognise carers as distinct partners in care and as individuals with their own rights, wellbeing, capacity and outcomes, supported by mandatory service requirements and measurable accountability.
6. The recommended dedicated Partnering with Carers, Families and Consumers Standard mandate early identification and recording of carers, assessment of willingness and capacity, meaningful involvement in decisions and governance, accessible information and practical preparation, and carer-specific experience, outcome, auditing and reporting requirements.
7. Strengthened coordination and discharge requirements so that carers are involved from the outset, their willingness and capacity to care are formally assessed, and care responsibilities are not transferred until information, training, equipment, referrals, follow-up and formal supports are in place. Where the proposed care arrangement is unsafe or unsustainable, an alternative plan should be developed.
8. A clear definition of *carer* be included within the NSQHS Standards, aligned with and referencing the *Carers Recognition Act 2010*, and recognising that carers may be relatives, partners, friends or other individuals providing unpaid care who may not self-identify as carers.
9. Inclusion of separate definitions of *consumer representative* and *carer representative*, supported by distinct governance requirements, participation mechanisms and expected organisational outcomes to ensure the unique perspectives and contributions of carers are appropriately recognised.
10. The final Standards explicitly distinguish carers from consumers, family members, next of kin and other support persons throughout the framework to provide clarity regarding rights, responsibilities, engagement processes and service obligations.
11. The draft Standards be revised to improve readability and implementation by reducing duplication, using consistent terminology, simplifying technical language, incorporating practical implementation examples, and clearly differentiating mandatory requirements from supporting guidance and examples of good practice.
12. Carer-related requirements be consolidated within a dedicated NSQHS Standard focused on partnerships with carers, to improve visibility, strengthen accountability, reduce duplication, and facilitate consistent implementation and assessment across health services.

13. If carer-related requirements remain distributed across multiple Standards, the Australian Commission on Safety and Quality in Health Care should develop a consolidated implementation guide or cross-reference framework that clearly identifies all carer-related obligations and demonstrates how requirements across the Standards operate together to support carer engagement and partnership.
14. The final Standards require health services to collect and report carer-specific experience and outcome data, involve carers in governance and quality improvement, and demonstrate what changed in response to carer feedback. Learning mechanisms should enable concerns to trigger timely review during the care journey, rather than operating only after an incident has occurred.
15. The final Standards include a consolidated set of mandatory carer requirements, standardised tools and aligned accreditation indicators.
16. The Commission support implementation of the final Standards through standardised identification and capacity-assessment tools, privacy and consent guidance, workforce training, culturally responsive resources, clear escalation pathways and auditable carer-specific indicators. Minimum obligations should remain clear while allowing application across diverse services, cohorts and caring arrangements.

2.0 Introduction

Carers WA welcomes the opportunity to provide this submission to the Australian Commission on Safety and Quality in Health Care (ACSQHC) in response to its public consultation on the draft third edition of the National Safety and Quality Health Service (NSQHS) Standards. As the peak body representing unpaid carers in Western Australia, Carers WA supports the Commission's commitment to strengthening person-centred care, improving care coordination, embedding continuous learning and quality improvement, and recognising the important role that carers play in achieving safe, high-quality healthcare. This submission is informed by ongoing engagement with carers across Western Australia and targeted consultation undertaken through an online survey, online consultation and in-person consultation process.

Carers WA welcomes the improvements that have been made so far to the draft Standards. Carers are more visible throughout the framework, there is a stronger emphasis on person-centred practice, shared decision-making, communication, coordinated and connected care, and the draft includes a definition of a carer. We particularly note the stronger focus on care transitions, multidisciplinary teamwork, digital systems that support information sharing, and the shift from a compliance-based approach towards outcomes, learning and continuous improvement. Collectively, these changes provide a stronger foundation for recognising carers as partners in care and contributors to safe, high-quality health outcomes.

However, Carers WA is concerned that the draft Standards stop short of making carer recognition operational. While carers are acknowledged throughout the Standards, many of the mechanisms needed to ensure consistent implementation, accountability and measurable outcomes remain absent or insufficiently defined. In particular, the draft does not require health services to systematically identify carers; assess their willingness, wellbeing or capacity to provide care; involve them in decisions that transfer caring responsibilities; or measure carer experiences and outcomes. It also does not adequately distinguish carers from consumers or provide for dedicated carer representation in governance and co-design. Carers WA therefore supports the overall direction of the draft but recommends stronger, measurable requirements relating to carer identification, involvement, discharge planning, information and training, governance participation and accountability. These changes are essential to ensure that recognition of carers translates into meaningful improvements in practice and delivers safer, more coordinated and sustainable care for both consumers and carers.

For the purposes of this submission, a carer is a person who provides unpaid personal care, support and assistance to another person who has disability, a chronic or terminal illness, a mental health condition, alcohol or other drug dependency, or who is frail and aged¹. Carers may be family members, partners, friends or other unpaid supporters, may be of any age, and may undertake one or multiple caring roles. Consistent with carer recognition legislation across Australia, carers should be recognised not only as contributors to patient care, but also as individuals with their own rights, wellbeing and support needs that should be meaningfully recognised throughout the healthcare journey and within the third edition of NSQHS Standards.

¹ (Commonwealth of Australia, 2010)

3.0 General Feedback

3.1 Context

Australia has over three million unpaid carers,² who provide an estimated 2.2 billion hours of care each year, valued at \$77.9 billion annually³. WA contains 320,000⁴ of these carers, with 69.7% providing more than 60 hours of care per week. WA carers report levels of wellbeing 20% below that of other Australian, more than half have high or very high psychological distress and 47.9% have poor or only fair health⁵.

Under the current NSQHS Standards (second edition), the inclusion of a specific 'Partnering with Consumers' Standard has made a difference. However, research indicates that there is still opportunity for improvement.

During targeted consultation with WA carers for this submission, there was strong consensus that carers remain insufficiently recognised as distinct partners in care and that the standards continue to focus primarily on patients and consumers rather than carers as individuals with their own rights, needs and wellbeing. The results from the 2024 National Carer Survey below consolidate this feedback, indicating that while some improvement has occurred, there is continuing lack of recognition of carers, meaningful inclusion of carers, and that carers themselves are not asked about their own needs, despite their central role as part of the care team of the person they care for.

3.2 Recognition and inclusion of carers under the NSQHS Standards (second edition)

3.2.1 Recognition

Many WA carers report they do not feel recognised, valued or supported in their caring role. This is consistent across many different service types, and lower recognition is particularly apparent from government, the community, employers and service providers. The lowest level of recognition for WA carers was from government, where only 12% of WA carers said they felt recognised.⁶

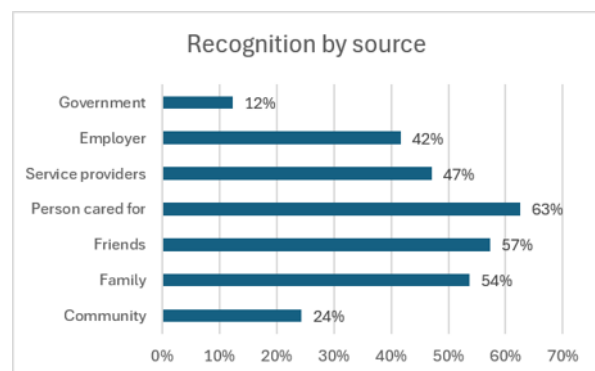


Figure 1 Proportion of WA carers who felt recognised from different sources (Carers NSW, 2024)

This matters because recognition has a real impact on wellbeing. When carers feel seen, valued and supported, they are more likely to feel connected, less isolated and better able to cope with the challenges of caring.⁷

² (Australian Bureau of Statistics, 2022)

³ (Deloitte Access Economics, 2020)

⁴ (Government of Western Australia, 2018)

⁵ (Carers NSW, 2024)

⁶ (Carers NSW, 2024)

⁷ (SAGE Design and Advisory, 2025)

The WA results of the 2024 National Carer Survey found that carers with stronger social support and a greater sense of recognition reported higher wellbeing.⁸ Yet many carers do not feel recognised by the organisations and systems they interact with most often. This means carers can miss out on information, support and opportunities to be involved in decisions that affect them and the people they care for.

3.2.2 Consideration of carer needs

In the 2024 National Carer Survey, WA carers reported that they were not asked about their own needs. This was seen in more than half of WA carers across hospital, GP, mental health and NDIS services, and 37.5% of carers accessing aged care services. This translates into missed opportunities for carer support and early intervention.

3.2.3 Meaningful inclusion in discussions and service planning

While carers reported that they were more involved in the care of the person they support, this does not necessarily mean being listened to. Across all service types, only around half of carers felt their views made a difference. This was particularly low in hospitals, mental health services and the NDIS.

Carer recognition and inclusion is decreasing. Compared with WA National Carer Survey results from 2022, there was a decrease in the proportion of carers who said they were involved in decisions and in the proportions of carers asked about their own needs.

When carers are not recognised and included, they risk delaying or missing out on support, struggling to meet both their own needs and the needs of the people they care for. Carers bring valuable knowledge and experience, and when their voices are not heard, opportunities for better care and better outcomes can be lost.

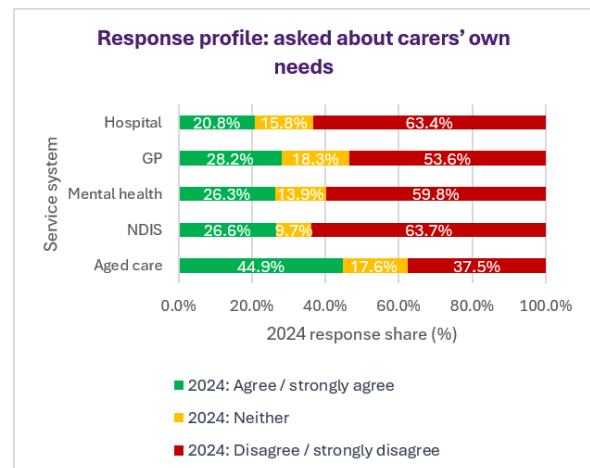


Figure 2 Proportions of WA carers asked about their needs by services (Carers NSW, 2024)

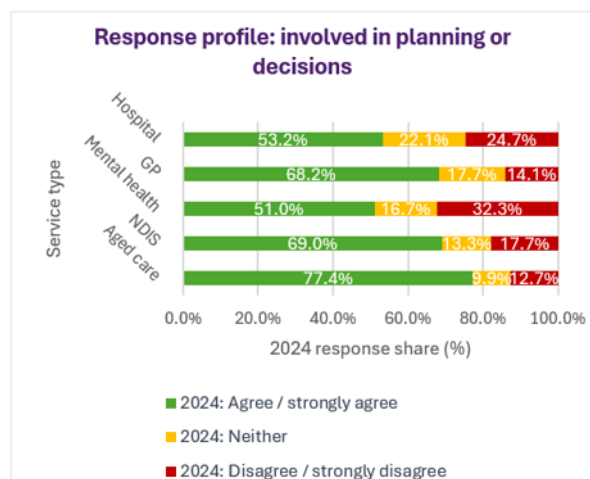


Figure 3 Proportion of WA carers involved in planning or

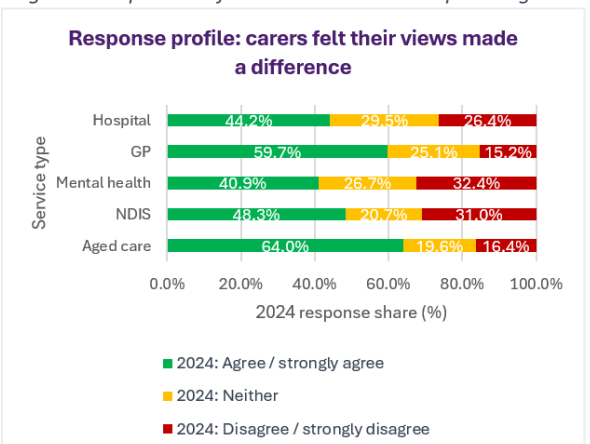


Figure 4 Proportion of WA carers who felt their views made a difference in different services (Carers NSW, 2024)

⁸ (SAGE Design and Advisory, 2025)

3.3 Consultation findings and themes

"The main issue hasn't been really tied into practical measures that carry the recognition into part of the consumers area." – feedback from a carer

This submission is informed by ongoing feedback from WA carers, as well as targeted consultation with 24 Western Australian carers through an online survey, and online and in-person consultation sessions. The consultations tested whether the draft Standards adequately recognise carers, explored the practical changes required to address gaps, and identified the outcomes and accountability measures that matter most to carers.

WA carers consulted broadly welcomed the review of the Standards and the increased visibility of carers across the draft. They supported the stronger focus on person-centred practice, cultural safety, shared decision-making, communication, coordinated care, safer transitions, digital information sharing and continuous improvement. However, participants consistently regarded these changes as a starting point. The dominant view was that references to carers remain largely aspirational unless they are translated into clear, mandatory and assessable obligations for health services.

3.3.1 Recognition, identification and legal status

"Carers should be treated as partners in care, not simply as family members or visitors." – Feedback from a carer

Recognition of carers emerged as the strongest and most consistent priority. Consultation participants raised that carers should be recognised as distinct partners in care and as individuals with their own rights, needs, wellbeing and outcomes, rather than being recognised principally through the support they provide to patients and consumers. Key points raised included that the Standards should clearly distinguish carers from consumers, family members, next of kin and other support people, recognise the diversity of caring relationships, and align the definition of a carer with relevant Commonwealth, state and territory carer recognition legislation. Participants emphasised that many people provide substantial unpaid care without describing themselves as carers, meaning that identification processes must not rely on self-identification alone.

Participants supported mandatory early identification and recording of carers from the beginning of a person's interaction with a health service, with this information reviewed during treatment, transfer and discharge. Carers raised that services should record the nature of the caring relationship, the support provided, the carer's knowledge and experience, relevant consent and information-sharing arrangements, and the carer's willingness, capacity and support needs. Consistent and actively used electronic records, patient or carer passports, and other continuity mechanisms were recommended as initiatives which could reduce the need for carers to repeatedly explain their role or retell difficult information.

3.3.2 Partnership, communication and use of carer expertise

"I don't see any recognition of actual living carers." – feedback from a carer

Participants raised that carers should be involved from the earliest point of contact and throughout assessment, treatment, transfer and discharge whenever decisions affect the caring role. Points were made including that carers often hold important knowledge about a person's baseline functioning, communication needs, behaviour, risks and likely response to treatment. Participants said that this knowledge should be actively sought, documented and incorporated into assessment, risk management and care planning. They also raised that carers should receive timely information in clear, accessible and culturally appropriate formats, both verbally and in writing, and services should check understanding rather than assume health literacy or familiarity with clinical processes.

Privacy and consent were recognised as important safeguards, but participants reported that privacy is sometimes applied in ways that unnecessarily exclude carers. Carers raised that the Standards should clarify the distinction between information that cannot be disclosed to a carer and information that can be received from a carer. It was recommended that health professionals have greater guidance and training to balance patient autonomy, confidentiality, clinical risk and appropriate carer involvement. Where decisions create or increase responsibilities for a carer, participants raised that the carer should be involved before those decisions are finalised.

3.3.3 Discharge, coordination and sustainable care

"Hospitals should never gaslight carers." – feedback from a carer

Discharge and transitions were identified by participants as critical safety points. It was raised that discharge planning should be undertaken with carers, not presented to carers as a completed decision. Carers recommended that before care responsibilities are transferred, health services should provide complete and understandable information, practical training, time to organise equipment and transport, confirmed referrals and follow-up, and a clear point of contact if circumstances change. Medication changes, rehabilitation requirements, home modifications, escalation pathways and formal support arrangements should be addressed before discharge occurs.

Participants strongly supported formal assessment of each carer's willingness and capacity before care responsibilities are transferred. Assessment was recommended to consider the carer's physical and mental health, disability, confidence, knowledge and training, fatigue, other caring and family responsibilities, employment and education commitments, financial circumstances, transport and housing, and available formal and informal support. Participants raised that a history of providing care should not be treated as evidence of continuing capacity. Where a carer cannot safely undertake the proposed responsibilities, it was raised that this should trigger alternative planning rather than pressure for the carer to accept additional care.

Participants also highlighted gaps between hospitals, primary care, mental health services, aged care, disability services, the NDIS and community supports. A person's needs may increase following hospitalisation without a corresponding adjustment to formal supports, leaving carers to absorb the difference. Participants considered that discharge should not proceed where unmet support needs would create safety risks or impose an unsustainable responsibility on carers.

3.3.4 Carer wellbeing, distress and practical support

"The Standards recognise carers as partners in the patient's care, but give less attention to carers' own wellbeing, capacity and support needs." – feedback from a carer

Carers WA's consultation results emphasised that carer wellbeing is an outcome in its own right. Caring can affect physical and mental health, sleep, employment, education, finances, relationships and social participation. Participants called for these impacts to be recognised throughout the care journey and for assessments to lead to practical responses, including altered discharge arrangements, referrals, respite, peer support, mental health support, community nursing, allied health and connections to carer organisations. Particular consideration was raised as being required for young carers, older carers, carers with disability, carers from culturally and linguistically diverse communities, carers in regional and remote areas, and arrangements where care is shared across family or community members.

Participants also called for health services to respond appropriately to carer distress. It was raised that carers experiencing stress during hospitalisation, crisis or complex advocacy should be treated with dignity and offered support and de-escalation, rather than being dismissed, stigmatised or excluded. Dedicated carer support roles, including carer champions, peer workers, lived-experience workers and navigators, were identified as valuable mechanisms for helping carers understand their rights, navigate services and access appropriate support.

3.3.5 Governance, measurement and accountability

"The scenario of combining carer, consumer and family all into one entity hasn't been looked at and separated out." – feedback from a carer

Participants strongly supported dedicated carer involvement in governance, co-design and quality improvement. Carers raised that consumer representatives should not be assumed to represent the distinct experiences and interests of carers. It was recommended that carers be involved from the outset of policy and service development, supported and resourced to participate, and able to demonstrate how their contributions influenced decisions. Meaningful participation meant reviewing complaints, compliments, adverse events, hospital-acquired complications, policies, audits and evaluations.

Carers WA's consultation identified carer identification and recognition, together with assessment of carer willingness and capacity, as the highest-priority measures. Other important indicators include whether carers were involved in decisions affecting their role, received clear and accessible information, knew whom to contact for support, were connected with appropriate services, were treated with dignity and respect, and saw feedback translated into action. Participants also supported measurement of the broader effects of caring on health, wellbeing, employment, education and finances. It was raised that health services should publicly report what carers said, what action was taken and what outcomes were achieved.

3.3.6 Preferred structural reform

"If there is nothing specific there, then administrators and governance teams have no requirement to comply and it'll be missed." – feedback from a carer

The clearest structural reform supported by carers through Carers WA's consultation was a dedicated Partnering with Carers, Families and Consumers Standard. Participants considered that a dedicated Standard would reduce fragmentation, clarify the distinction between carers and consumers, and establish a visible accountability framework for identification, involvement, capacity assessment, governance, outcomes, auditing and reporting. If a dedicated Standard is not adopted, participants considered that equivalent explicit, mandatory and measurable carer requirements should be embedded across all three proposed Standards and supported by consolidated implementation guidance.

Consultation participants recommended that the Standards establish clear duties, practical implementation mechanisms and measurable outcomes to demonstrate whether carers are consistently identified, listened to, involved, prepared and supported as an integral component of safe, person-centred healthcare.

In its submission to the first consultation on the NSQHS Standards (third edition) in September 2025, Carers WA recommended that either an additional standard for carers be developed, or that the 'Partnering with Consumers' standard in the second edition be expanded to more explicitly include carers. The additional standard for carers has successfully been implemented within the National Standards for Mental Health Services 2010, Standard 7. This was also raised by carers during Carers WA's consultations for this submission. Further, the dedicated standard for 'Partnering with Consumers' has also been raised by carers and by broader stakeholders as having an impact on consumer and carer recognition and inclusion. Carers WA would like further clarity as to why a specific standard for carers and consumers has been removed from the draft third edition of the Standards.

Carers WA recommends:

1. A dedicated Partnering with Carers, Families and Consumers Standard be added to the final Standards.
2. The final Standards establish enforceable clear duties, practical implementation mechanisms and measurable outcomes to demonstrate whether carers are consistently identified, listened to, involved, prepared and supported.
3. The final Standards use mandatory and enforceable language for all core carer-related obligations, supported by clearly defined responsibilities, standardised implementation tools, auditable indicators and carer-specific experience and outcome measures.

4.0 Consultation questions

4.1 Do the draft Standards reflect key safety and quality priorities?

*"Listen to us. We know the patients best. If we say something isn't right, something isn't right." –
Feedback from a carer*

Carers WA believes that the draft Standards broadly reflect important safety and quality priorities, including person-centred care, cultural safety, shared decision-making, accessible communication, coordinated care, safer transitions, digital information sharing, and continuous learning and improvement. Carers consulted welcomed the increased visibility of these aspects across the draft and the greater recognition of feedback from carers as a source of service improvement. These changes provide a stronger foundation for safe, high-quality and integrated care.

However, the draft does not yet adequately reflect a key safety and quality priority: the systematic recognition, involvement and support of carers as distinct partners in care. References to carers are distributed across the framework, but the draft does not establish sufficiently clear and enforceable requirements for health services to identify carers, assess their willingness and capacity to care, involve them in decisions affecting their caring responsibilities, or measure carer experiences and outcomes. Consultation participants consistently reflected that recognising the word “carer” is not the same as recognising carers in practice.

This is a safety issue as well as a recognition issue. Carers often hold important knowledge about a person’s baseline functioning, communication needs, behaviour, risks and likely response to treatment. Failure to identify carers, listen to the information they provide, or assess whether proposed arrangements are realistic can undermine care planning, risk management, discharge safety and continuity of care.

The Standards should therefore recognise carers as individuals with their own rights, wellbeing, capacity, responsibilities and outcomes, rather than principally through the support they provide to patients. This recognition should be accompanied by practical service requirements and measurable accountability.

Carers WA recommends:

4. The final Standards recognise the systematic identification, involvement and support of carers as a core safety and quality priority.
5. The Standards recognise carers as distinct partners in care and as individuals with their own rights, wellbeing, capacity and outcomes, supported by mandatory service requirements and measurable accountability.

4.2 How could the draft Standards be strengthened to support the delivery of high quality care and improved health outcomes?

"The capacity and wellbeing of the carer should also be considered, rather than assuming they can provide whatever care is required." – feedback from a carer

Carers consulted raised that the most significant improvement would be the establishment of a dedicated Partnering with Carers, Families and Consumers Standard. Carers participating in the consultation were concerned that distributing carer-related requirements across the framework may fragment responsibility and weaken accountability. A dedicated Standard would provide a clear structure for separating the roles and interests of carers and consumers while ensuring that both groups are meaningfully involved.

At a minimum, the Standards should require health services to identify and record carers at the earliest point of contact and review that information during treatment, transfer and discharge. Services should recognise people who provide substantial unpaid support even where they do not identify themselves as carers, and should record the nature of the caring relationship, relevant consent arrangements, the care provided, and the carer's knowledge, circumstances and support needs. Services should assess and regularly review each carer's willingness, wellbeing and capacity before proposing or transferring care responsibilities. Carers should be involved in decisions affecting their caring role, receive clear and accessible information and practical training, be represented in governance and quality-improvement structures, and be included in carer-specific experience and outcome reporting.

Carer identification must be more than a one-off administrative exercise. Identification should lead to meaningful involvement, an assessment of the carer's circumstances, and practical support. Electronic records, patient and carer passports, or other interoperable systems could reduce the need for carers to repeatedly establish their role and retell difficult information, provided that records are accurate, current and actively used by staff.

The Standards should also require health services to recognise carers' lived expertise. Carer observations should be actively sought, documented and incorporated into assessment, risk management and care planning. Clearer guidance is required on how services can receive important information from carers even where privacy requirements restrict what can be disclosed in return.

Finally, the Standards should use mandatory language such as "must" rather than relying on discretionary or aspirational wording. Requirements should be supported by implementation guidance, workforce training, measurable indicators, auditing and carer outcome reporting.

Carers WA recommends:

6. The dedicated Partnering with Carers, Families and Consumers Standard mandate early identification and recording of carers, assessment of willingness and capacity, meaningful involvement in decisions and governance, accessible information and practical preparation, and carer-specific experience, outcome, auditing and reporting requirements.

4.3 Do the draft Standards adequately support care delivery and coordination across services, settings and providers - does this area require strengthening?

"I would encourage the Commission to consider the carer as part of the healthcare system, not simply as an extension of the patient." – feedback from a carer

Carers WA welcomes the draft Standard's increased emphasis on coordinated care, multidisciplinary practice, transitions and digital systems that support information sharing. However, this area requires substantial strengthening to ensure that coordination requirements translate into safe and sustainable arrangements for carers and patients. Feedback from carers identified variable coordination between services, gaps in communication and handovers, and insufficient planning at discharge.

Carers should be involved early in care and discharge planning, rather than being informed after decisions have been made. Before discharge, there should be a jointly developed plan that considers the patient's ongoing needs, the carer's willingness and capacity to care, and whether the proposed arrangements are realistic and sustainable. Carers should have a clear pathway to raise concerns where they believe a discharge plan is unsafe.

Before care responsibilities are transferred, health services should be required to confirm that the carer has been consulted and is willing to undertake the proposed responsibilities; that the carer's physical and mental health, skills, confidence, other responsibilities and support network have been considered; and that the carer has received a written discharge summary, a verbal explanation and an opportunity to ask questions. Services should also confirm that medication changes, equipment, rehabilitation, transport, home modifications and follow-up appointments have been addressed, that any required training has been provided and understood, that referrals and formal supports are operational, and that the carer knows who to contact if circumstances change.

A previous history of providing care must not be treated as evidence that a carer remains willing or able to provide the same or a greater level of care. If a carer cannot safely undertake the proposed responsibilities, the service should develop an alternative plan rather than transferring unsupported risk to the carer.

The Standards should also include clearer requirements for coordination between hospitals, primary care, mental health services, aged care, disability services, the NDIS and community-based supports. Consultation participants described circumstances in which a person's care needs increased following hospitalisation, but formal supports had not adjusted, leaving carers to address the gap. Discharge should not proceed where unmet support needs would create safety risks or impose an unsustainable burden on carers.

Carers WA recommends:

7. Strengthened coordination and discharge requirements so that carers are involved from the outset, their willingness and capacity to care are formally assessed, and care responsibilities are not transferred until information, training, equipment, referrals, follow-up and formal supports are in place. Where the proposed care arrangement is unsafe or unsustainable, an alternative plan should be developed.

4.4 Are the draft Standards easy to understand and free from duplication? Where could they be clearer or simpler?

"The Standards could be simplified by reducing repetition and using clearer plain language, particularly where the same principles about communication, person-centred care, carer involvement and care coordination appear across different Standards." – feedback from a carer

Carers consulted raised that although generally understandable, the draft Standards remain lengthy, technical and repetitive. Similar concepts relating to person-centred care, communication, shared decision-making, carer involvement and care coordination appear across multiple parts of the framework. This can obscure what health services are specifically required to do and make it difficult for carers and consumers to understand what good practice should look like.

Recommendations from Carers WA's consultations for improved clarity in the draft Standards included:

- Including a clear definition of a carer, consistent with and with reference to the definition in the Carers Recognition Act 2010, with recognition that carers may be relatives, partners, friends or other people providing unpaid care and may not self-identify as carers.
- Include clear definitions of 'consumer representative' and 'carer representative', with separate governance arrangements, requirements and outcomes for each.
- Explicitly distinguishing carers from consumers, family members, next of kin and other support people
- Use of shorter sentences and consistent terminology, consolidate duplicated requirements, provide practical implementation examples, and clearly distinguish mandatory requirements from supporting guidance and examples of good practice.

Consolidating carer-related requirements within a dedicated Standard would reduce duplication while also making responsibilities easier to locate, understand, implement and assess. If carer requirements remain distributed across the three Standards, the framework should include a consolidated carer implementation guide or cross-reference table showing where each obligation appears and how the requirements operate together.

Carers WA recommends:

8. A clear definition of *carer* be included within the NSQHS Standards, aligned with and referencing the *Carers Recognition Act 2010*, and recognising that carers may be relatives, partners, friends or other individuals providing unpaid care who may not self-identify as carers.

9. Inclusion of separate definitions of *consumer representative* and *carer representative*, supported by distinct governance requirements, participation mechanisms and expected organisational outcomes to ensure the unique perspectives and contributions of carers are appropriately recognised.
10. The final Standards explicitly distinguish carers from consumers, family members, next of kin and other support persons throughout the framework to provide clarity regarding rights, responsibilities, engagement processes and service obligations.
11. The draft Standards be revised to improve readability and implementation by reducing duplication, using consistent terminology, simplifying technical language, incorporating practical implementation examples, and clearly differentiating mandatory requirements from supporting guidance and examples of good practice.
12. Carer-related requirements be consolidated within a dedicated NSQHS Standard focused on partnerships with carers, to improve visibility, strengthen accountability, reduce duplication, and facilitate consistent implementation and assessment across health services.
13. If carer-related requirements remain distributed across multiple Standards, the Australian Commission on Safety and Quality in Health Care should develop a consolidated implementation guide or cross-reference framework that clearly identifies all carer-related obligations and demonstrates how requirements across the Standards operate together to support carer engagement and partnership.

4.5 Do the draft Standards help health services learn, reflect and improve over time? Does this area require strengthening?

"Collecting feedback does not, by itself, demonstrate learning or improvement." – feedback from a carer

Carers WA supports the draft's focus on continuous learning and the recognition of complaints, incidents, experiences and feedback as sources of quality improvement. However, this area requires strengthening because collecting feedback does not, by itself, demonstrate learning or improvement. Carers consulted also raised concerns about limited reporting back to them on complaint outcomes, and on reporting back on outcomes from feedback given as part of carer and consumer representative positions.

Consultation respondents expressed limited confidence that health services consistently listen to carers or use their feedback to improve care. Carers wanted services to actively seek their views following significant care events and transitions, identify recurring issues, and demonstrate how feedback has influenced policies, services and frontline practice.

The Standards should require health services to collect carer-specific experience and outcome data and use accessible approaches to seek feedback from carers who may face barriers to participation. Carers should be involved in reviewing complaints, compliments, adverse events and hospital-acquired complications, and should participate from the outset in service design, implementation, audit and evaluation. Health services should identify and report recurring themes in carer feedback, publish what carers said and what action was taken, and evaluate whether resulting improvements produced meaningful changes in carer and patient experiences.

Priority measures should include whether carers were identified and recognised, appropriately involved in relevant decisions, provided with clear information, assessed for willingness and capacity, connected with appropriate support, and informed about whom to contact for assistance. Services should also measure whether feedback resulted in action and whether carers were treated with dignity and respect.

Learning should occur during the care journey as well as after an incident. Health services should have mechanisms for carers to raise emerging concerns and trigger review of a plan before preventable harm occurs. Carer involvement in governance and quality improvement should be appropriately supported and resourced, with dedicated carer representation rather than an assumption that general consumer representatives can speak for carers.

Carers WA recommends

14. The final Standards require health services to collect and report carer-specific experience and outcome data, involve carers in governance and quality improvement, and demonstrate what changed in response to carer feedback. Learning mechanisms should enable concerns to trigger timely review during the care journey, rather than operating only after an incident has occurred.

4.6 Do the draft Standards reduce compliance burden while maintaining safety and quality? What changes could further support this objective

"Health services should publicly report what carers said, what action was taken and what outcomes were achieved." – feedback from a carer

Carers WA supports a streamlined and outcomes-focused framework, provided that reducing compliance burden does not weaken accountability or remove protections for carers and patients. Consolidating eight Standards into three may reduce duplication, but distributing carer-related obligations across the new framework creates a risk that responsibility will become fragmented and requirements will be inconsistently interpreted or implemented. Consultation participants cautioned that unclear wording and weak accountability could result in minimal practical change.

Compliance could be simplified without compromising safety by establishing a dedicated Partnering with Carers, Families and Consumers Standard, adopting a single national definition of a carer, and consolidating mandatory carer requirements and indicators. Standardised processes should be used to record carer identity, consent arrangements, willingness and capacity. Reusable assessment and discharge-planning tools, interoperable digital records, concise implementation guidance and closer alignment between accreditation evidence, audit indicators and carer outcome reporting would reduce duplication and inconsistent interpretation.

These measures would provide clearer expectations for health services while reducing local duplication and inconsistent interpretation. A dedicated Standard may also reduce the need for organisations to locate and reconcile dispersed requirements across the framework.

Compliance should focus on demonstrated outcomes rather than documentation alone. Evidence that a form was completed or that a carer was recorded should not be sufficient if the carer was not meaningfully involved, adequately prepared or supported. The framework should assess whether requirements changed practice and improved experiences, rather than encouraging another “tick box” process.

Carers WA recommends:

15. The final Standards include a consolidated set of mandatory carer requirements, standardised tools and aligned accreditation indicators.

4.7 Do the draft Standards contain any requirements that may present challenges in terms of feasibility, applicability or assessability?

"I think it [the Standards] has a high element of being aspirational ... I'm not convinced yet that it describes how it's going to achieve an audit and how it's going to demonstrate an improvement for carers."

Based on carer feedback, Carers WA believes the principal challenge is not that the draft imposes excessive carer-related requirements, but that many relevant expectations are not sufficiently specific to be consistently implemented or assessed. Aspirational wording about partnership, communication and person-centred care may be interpreted differently across organisations unless accompanied by clear actions, indicators and evidence requirements.

Potential implementation challenges include identifying people who do not describe themselves as carers, assessing changing willingness and capacity, involving carers appropriately where consent or privacy issues arise, coordinating across different service systems, and providing dedicated carer support in settings facing workforce constraints. These challenges are real but should not be used to justify excluding carers or transferring unmanaged risk to them.

The Commission should support feasible and consistent implementation by providing standardised identification and assessment tools, guidance on receiving information from carers while observing privacy and confidentiality obligations, and guidance on involving carers who are not the patient's next of kin. Implementation support should also include workforce education on carer recognition, communication and de-escalation; culturally responsive and accessible communication resources; examples covering different services and caring relationships; clear escalation arrangements where carers identify unsafe caring arrangements; staged implementation and baseline data collection; and carer-specific indicators that can be reliably audited.

Assessability should include both process and outcome measures. Relevant process measures include whether a carer was identified, whether willingness and capacity to care were assessed, and whether discharge information and training were provided. Outcome measures should examine whether carers felt recognised, appropriately involved, prepared and supported, and whether their feedback resulted in visible change.

Particular attention will also be required for young carers, older carers, carers with disability, carers from culturally and linguistically diverse communities, carers in regional and remote areas, and caring arrangements involving several family or community members. The Standards should be sufficiently

flexible to accommodate diversity while retaining clear minimum obligations.

Carers WA recommends:

16. The Commission support implementation of the final Standards through standardised identification and capacity-assessment tools, privacy and consent guidance, workforce training, culturally responsive resources, clear escalation pathways and auditable carer-specific indicators. Minimum obligations should remain clear while allowing application across diverse services, cohorts and caring arrangements.

4.0 Conclusion

Should any further information be required regarding the comments included within this submission, or assistance from the perspective of WA carers, Carers WA would be delighted to assist. Please contact the Carers WA Policy Team at policy@carerswa.asn.au.

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