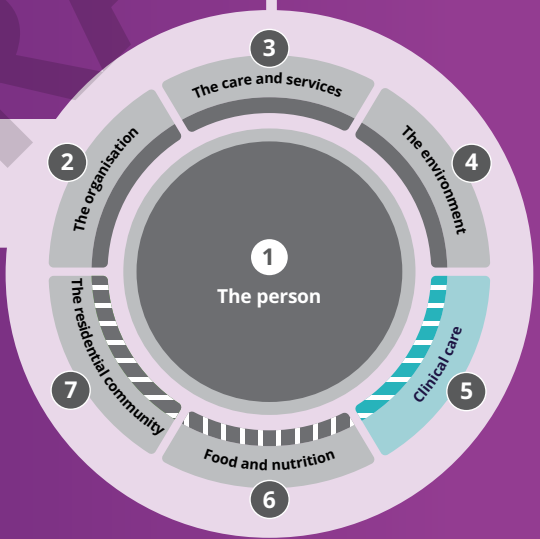
Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Draft
Standard 5 Clinical Care

Guidance material for the strengthened Aged Care Quality Standards for review and discussion



January 2024

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Contents

Please note the draft strengthened Quality Standards in this document are not yet in operation. This draft is intended for consultation purposes only.

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Purpose of the guidance

The Aged Care Quality and Safety Commission is committed to supporting the aged care sector to be ready for the implementation of the strengthened Aged Care Quality Standards.

This draft guidance material is intended to support providers to comply with the strengthened Quality Standards. It also aims to promote best practice in service provision.

Aged care services vary in size and structure and have different ways of meeting the Standards. The draft guidance shows how providers can demonstrate they meet each Standard outcome.

This material is not a prescriptive guide. When we assess provider conformance against the Aged Care Quality Standards we won't expect that every provider will necessarily be taking each of the described actions. The actions you take to deliver high quality safe care will depend on the circumstances of your service and the needs of the people in your care. The material in this document can be used as a guide to achieving quality care outcomes in your organisation.

Consultation

We are consulting on the draft guidance materials for providers that deliver government-funded aged care services. Your insights will help to make our guidance materials:

- fit for purpose across service types
- practical and easy to understand
- useful tools for continuous improvement

We invite you to consider the below questions when reading through this document:

- Have you read and understood the draft Guidance material for the strengthened Quality Standard?
- To what extent do you feel the draft Guidance is fit-for-purpose for the different service types you deliver?
- To what extent do you feel the draft Guidance easy to understand and interpret?
- Is the level of detail in the Guidance right for each Outcome or Action? Is there content missing in relation to any Outcome or Action? Please specify the Outcome and Action and tell us what you would like changed.

You can provide your feedback by filling in this feedback form or using the QR code on this page before midday (AEST) on 19 May 2024.

Questionnaire
https://survey.websurveycreator.com/s/ConsultationStrengthenedQualityStandardsMaterial

Structure of this document

The guidance material is intended to help support delivery or person centred quality care and outcomes. It presents the intent and outcomes of the strengthened Standard including key concepts.

The tables on the following pages outline how you can achieve these outcomes in practice, depending on your role within an organisation.

To help users easily find information that applies to their service role, there are separate tables for:

- Governing body
- Provider organisation
- Worker (when applicable)

Different colour bars at the top of the tables indicate who in your organisation the information is targeted for.

Each of the tables include suggested actions and activities that can help achieve the outcomes of the strengthened standards and support continuous improvement.

We are also developing examples and other key resources that can be used as a further guide to ensure best practice in person-centred care. These will be made available at a later stage.

You will notice when looking at the guidance products there is a difference to Standard 5. This document has been prepared by the Health Care Commission and has a slightly different approach to the other guidance documents. The three main areas of difference are:

- Information that is specific to Residential or Home Care has been separated in a blue box. The guidance for the other Standards has this information within the body of the text where applicable.
- There is an overarching governing body section which is to be taken into consideration for all outcome areas. The guidance for the other Standards has a governing body section for most of the outcome areas.
- There is guidance content against each of the actions, whereas the guidance for other standards has been aimed at the outcome level.

We are interested in your views on the different approaches, level of detail provided and usability of the guidance products and will be seeking your feedback in the consultation.

The Guidance material for Standard 5 was developed by the Australian Commission on Safety and Quality in Health Care, with valuable input from the Commission's aged care advisory committee and clinical expert working group and in partnership with the Aged Care Quality and Safety Commission.

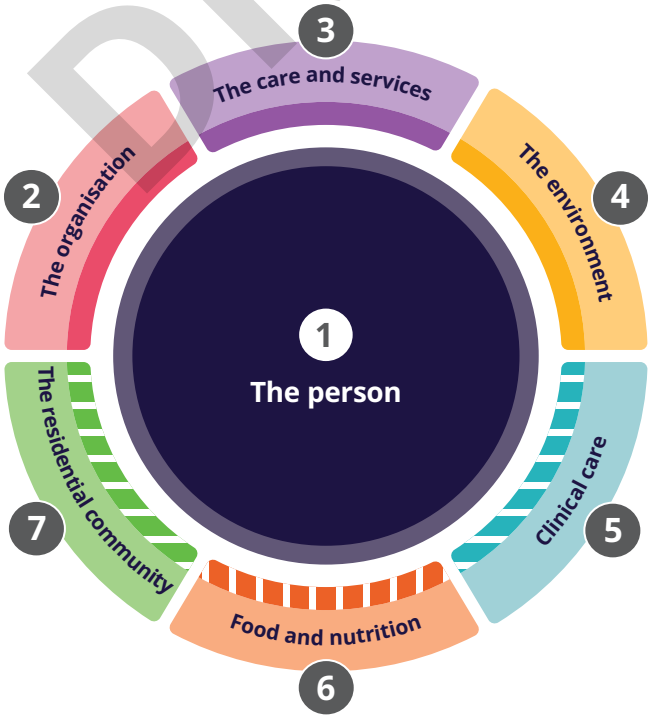
Guidance on Standard 5: Clinical Care

What is the intent?

Standard 5 aims to support providers to improve the quality and safety of clinical care delivered through Commonwealth subsidised aged care services. It provides a nationally consistent statement about the quality of clinical care older people can expect when receiving aged care services.

The health needs of people receiving aged care are, on average, greater and more complex than those of the general population. Complex needs require a coordinated, multidisciplinary response involving both the health and aged care systems.

Standard 5 describes the responsibilities of providers to deliver safe and quality clinical care to older people. The governing body has overall responsibility to ensure a clinical governance framework is implemented and to monitor its effectiveness. Providers operationalise the clinical governance framework and report on its performance.



Many older people who require clinical care have multiple chronic co-morbidities and complex care needs. These people may be experiencing sickness, frailty, disability, cognitive impairment or be nearing the end of their life. Access to a range of health professionals is crucial to address these complex needs. Good clinical care can optimise an older person's quality of life, reablement and maintenance of function. Improved health and wellbeing supports continued participation in activities that are enjoyable and give life meaning.

At all times, the clinical care provided should be person-centred. It should be planned and delivered in partnership with the older person, involving family, carers and others in line with the older person's needs and preferences. Delivering safe, quality clinical care requires a multidisciplinary approach with a skilled workforce with clear accountabilities that are supported to deliver contemporary, evidence-based care. Allied health professionals have distinct roles in reablement and maintenance of an older person's functional capabilities.

Effective implementation of Standard 5 is reliant on the systems and processes from Standards 1–7. Standard 5 does not seek to replicate the base expectation of understanding the person in Standard 1 or the base planning, assessment and delivery expectation of Standard 3 as an example. These systems and processes establish a baseline expectation which supports the delivery of person-centred and safe clinical care, ensuring that risks of harm to older people from clinical care are minimised and support continuous quality improvement.

Service context considerations

The Guidance for Standard 5 is designed to help providers understand and implement the Actions for each Outcome. Each Action represents a component of what the provider needs to do to achieve the Outcome. All Actions are relevant to all providers whether they deliver aged care services in residential or home care settings.

The Guidance also provides Associated Activities against each Action. Associated Activities describe elements of evidence-based good practice in aged care, including establishing systems and processes and monitoring and continuously improving these.

The Associated Activities are intended to support providers in effectively implementing each Action. They are not meant to be a 'tick-box' or exhaustive list of strategies to implement an Action.

Most Associated Activities can be applied in residential aged care (residential care) and home care contexts. However, there is sometimes a difference between how residential and home care providers need to (or are able to) approach the activities when implementing an Action.

These differences are highlighted in the third column within the 'Associated Activities' sections.

What will older people say if you are achieving the outcomes of this Standard?

I receive evidence based, safe, effective and person-centred clinical care by qualified health professionals and competent workers that meets my changing clinical needs and is in line with my goals and preferences.

What are the key concepts?

The following key concepts are covered by Standard 5: Clinical Care:

Key concepts for all of Standard 5	Outcome 5.1 Clinical governance	Outcome 5.2 Infection prevention and control	Outcome 5.3 Safe and quality use of medicines
Quality Improvement	Governing body	Antimicrobial resistance	Medication administration
Evidence-based	Routinely collected data	Antimicrobial stewardship	Medication management system
Quality care	Standard National Terminology	Aseptic technique	Quality use of medicines (QUM)
Facilitate access	Clinical governance framework	Infection Prevention and Control (IPC) Lead	Medication review
Allied Health	Conformant Software	Infection control	Polypharmacy
Shared decision making	Scope of practice	Infection prevention	Medicine side-effect
	Roles and responsibilities	Invasive devices	Medicine-related adverse event
	Clinical information system (CIS)		Psychotropic medicines
	External health Professionals		
	Healthcare Identifiers		
	Interoperability		
	My Health Record		
	Coordination of care		

Continued on the next page

* A full list of key terms and definitions about the strengthened Quality Standards can be found in the Glossary of Terms and Definitions.

Outcome 5.4 Comprehensive care	Outcome 5.5 Clinical safety	Outcome 5.6 Cognitive impairment	Outcome 5.7 Palliative care and end-of-life care
Comprehensive care	Sensory impairment	Cognitive impairment	Anticipatory medicines
Clinical frailty	Eating and drinking with acknowledged risk (EDAR)	Behaviour support plan	End-of-life
Comprehensive clinical assessment	Incontinence	Changes in behaviour	Recognising end-of-life
Reablement	Incontinence associated dermatitis	Restrictive practices	Advance care planning
Reassessment	Falls		End-of-life planning conversations
Telehealth	Functional decline		Bereavement support
ISBAR for structured clinical handover Introduction, Situation, Background, Assessment and Recommendation	Mental health		Last days of life
Multidisciplinary care	Mental illness		Spiritual care
Goals of care	Psychological safety		
Deterioration	Wellbeing		
	Oral health		
	Oral hygiene		
	Preventative		
	Pain management		
	Pain-related communication barriers		
	Sensory impairment		

* A full list of key terms and definitions about the strengthened Quality Standards can be found in the Glossary of Terms and Definitions.

Guidance for Outcome 5.1: Clinical Governance

What is the Outcome that needs to be achieved?

The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care.

The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.

Why is this Outcome important?

Clinical governance is important because it ensures that clinical care is consistently safe and of high quality through the development of a culture of quality improvement and the implementation of effective systems and processes. Effective clinical governance supports people to understand and enact the roles, relationships and responsibilities involved in an older person's care. Identifying and managing clinical risks, preventing harm, and improving the processes of clinical care leads to better clinical outcomes and improved wellbeing. Every person involved in clinical care has a role in clinical governance.

The governing body sets strategic direction and priorities for improving the quality of clinical care informed by older people, clinical experts and information and data on care and services. It has a responsibility to endorse the clinical governance framework and monitor the effectiveness of clinical governance systems through regular reporting from management on clinical indicators, outcomes, feedback from older people and workers and incidents.

The provider has processes to regularly collect and record data and feedback from all involved in an older person's care, including the older person, in a way that is safe, supported, and confidential. Priority areas for improvement are identified through feedback and analysis of qualitative and quantitative data on clinical care processes and outcomes. Priorities, findings and responses are shared with older people and staff in a way that is meaningful and useful.

All workers and health professionals employed or contracted by the provider to deliver clinical care, understand and enact their role, scope of clinical practice and accountabilities for person-centred, safe, effective and coordinated care. There are processes to agree on and record the respective roles and responsibilities of contracted, employed and external health professionals and the service in the provision of clinical care.

Effective use of clinical information can mitigate risk of harm to an older person when changing settings, health providers and when there is a change to their health or deterioration. Timely access to up-to-date clinical information informs clinical decision making and allows health professionals to understand an older person's clinical history at the point of care and allows providers to plan for appropriate clinical care on entry or return to their service.

Service context considerations

All providers have responsibilities for clinical governance as outlined in actions 5.1.1-5.1.5. While home care services do not have responsibility for all aspects of an older person's care, all the time, they should have systems and processes to address all the actions outlined in 5.1.

Clinical governance is implemented using a clinical governance framework that is appropriate to the complexity and context of the service. Where there are a number of different providers or health professionals involved in the care of an older person, the roles and responsibilities for care should be clearly identified and documented. The role of the older person, family and other support people, should also be discussed and identified.

How can you achieve Outcome 5.1 in practice?

Governing body	
Actions	**Associated activities**
5.1.1 The governing body: a) sets priorities and strategic directions for safe and quality clinical care and ensures that these are communicated to workers and older people b) endorses the clinical governance framework c) monitors the safety and quality of clinical systems and performance.	[Linked with Standard 2], the governing body sets and leads the governance structure and processes, culture and direction of the organisation and communicates priorities for improving the quality of clinical care to workers and older people. Good clinical governance is applied to all other outcomes in Standard 5. Governing for Reform in Aged Care: Governance and Leadership capability uplift program **Establish and maintain systems** to communicate the priorities and strategic directions for the organisation to older people and workers. • Endorse a clinical governance framework through publication and inclusion in strategic plans and the overall governance systems of the organisation • Include in the clinical governance framework systems that reflect the size and complexity of the organisation to: – set priorities for achieving person-centred, safe, coordinated, and effective care – outline roles and accountabilities for delivering and coordinating clinical care – partner with older people, family, carers, and workers to design care and services – keep records, analyse, and report on internal and external clinical safety and quality data including feed-back on experiences of older people and others involved in their care – ensure contemporary, evidence-based practice is used – identify and manage clinical risk – evaluate and continuously improve clinical care quality. *Continued on the next page*

Governing body (continued)	
Actions	**Associated activities**
Refer to Actions on the previous page	**Monitor, review and improve safety and quality** • Monitor the implementation and effectiveness of clinical governance systems described in the clinical governance framework through oversight of the providers service including through regular reporting on care and services from provider management. • Review clinical performance and outcomes and use these to monitor services and inform quality improvement activities. • Monitor the quality of the providers response to complaints and incidents. • Use the organisational self-assessment tool to collate information on clinical governance arrangements and identify gaps in the clinical governance framework for action. • Use data and reporting to identify the organisation's key priorities for improvement of their services clinical care. • Ensure the membership of the governing body includes the skills and knowledge to oversee, monitor and improve provision of safe and high-quality clinical care. • Confirm that the governing body members understand their role and responsibility for monitoring, reviewing and improving the delivery of person-centred, safe, co-ordinated and effective care. • Review the governance structure, role descriptions and contract templates of the board and associated committees, management, health professionals and other members of the workforce to ensure that responsibility for safety and quality is clearly defined at all levels. • The governing body membership receives training in clinical governance that equips it to enact its role and to oversee management's role. • Develop a skills matrix, which outlines the 'must have' skills, knowledge and behaviours required of individual members and the governing body as a collective against new requirements.

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.1.1 The governing body: – sets priorities and strategic directions for safe and quality clinical care and ensures that these are communicated to workers and older people – endorses the clinical governance framework – monitors the safety and quality of clinical systems and performance.	The decisions made by a governing body on the priorities for care, areas for improvement and the strategic direction of the organisation, including on resources, are informed by high-quality and accurate analysis of data and reporting from provider management. **Establish systems** to drive safety and quality improvement • The provider has systems in place to monitor and evaluate the clinical care provided in the service including to use the outcomes of monitoring and evaluation activity to improve care and services **Implement processes** to ensure the governing body has the information it needs to set priorities, strategic directions and monitor clinical outcomes and processes • Establish a schedule for reporting to the governing body on care quality [Link to Standard 2] • Use data collected on the performance of the service, to report to the governing body, including but not limited to: – feedback from older people, families, carers, workers and other stakeholders including but not limited to complaints – clinical incidents, other clinical measures used in reporting, trends and reporting on other similar services to understand provider performance against the sector – the effectiveness of clinical governance systems in supporting quality care and managing clinical risk – other data collected as a part of routine data collection including at commencement of care – identified risks, incidents (both serious, non-reportable, and near misses) and how they were managed and resolved • Ensure reports presented to the governing body are clear and use accurate data and quality analysis • Ensure workers and older people have been involved in the development of and informed about the provider's goals for the service.	**All residential and home care services** have a governing body and understand the priorities for care of the organisation.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.1.2	The provider implements the clinical governance framework as part of corporate governance, to drive safety and quality improvement.	**Implement processes as described in the clinical governance framework** A clinical governance framework describes the systems used in the organisation to support workforce, health professionals and committees to understand and enact their roles and accountabilities for providing person-centred, safe coordinated and effective care. • Implement the endorsed clinical governance framework by: – communicating a statement from the governing body about organisational culture, priorities, and commitment to the provision of quality clinical care to all older people and workers – outlining roles, responsibilities and organisational structure for the quality and safety of clinical care in the providers system – applying measures of success in clinical governance and clinical quality and safety and reporting on these – implementing processes for reviewing the clinical governance framework – ensuring plans, policies and procedures and other documents or systems that support the clinical governance framework and achievement of safe, quality clinical care are accessible, available and used by workers – establish processes for workers to monitor, evaluate and improve clinical care, including use of risk management systems – clearly describing roles and responsibilities for clinical governance and clinical quality and safety in position descriptions to ensure they are understood by everyone working in the service. *Continued on the next page*	**All residential and home care services** implement a clinical governance framework. To achieve this Outcome, effective clinical governance is implemented through the use of a clinical governance framework that reflects the complexity of the clinical care provided by the service.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, review and improve clinical care** The decisions made by a governing body on the priorities for care, areas for improvement and the strategic direction of the organisation, including resources, are informed by high-quality and accurate analysis of data and reporting from provider management. • Use internal and external data collected on the service, to report to the governing body, including but not limited to: – the effectiveness of clinical processes in supporting quality clinical care – care outcomes and performance – feedback from older people, others involved in their care and workers, including complaints – clinical incidents and other clinical indicators – the diversity or people who use their service including but not limited to cultural background or experience of disability. • Present the analysis of data to support understanding of the service to the governing body, managers workforce and older people in a way that is clear, understandable and useful. • Consider how the clinical governance framework is operationalised and reviewed to provide quality care (person-centred, safe, coordinated and effective) in this service. • Use information and reporting from monitoring activities outlined above to inform review and improvement of clinical care. • Consider the measures for success. These measures could include: – using comparison of complaints data to demonstrate improvements – positive feedback from older people – evidence the workforce is aware of key policies and procedures for clinical quality and safety and are observed operating within them – feedback from workers indicate they are satisfied – positive feedback from visitors to the service.	Refer to Service context considerations on the previous page

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.1.3	The provider implements processes to ensure workers providing clinical care are qualified, competent, and work within their defined scope of practice or role.	**Establish and maintain systems for employment and management of clinical staff employed by or contracted to the service** • Ensure these systems align with the processes outlined in Outcome 2.9: Human Resource Management. • Credentials, qualifications, prior training and registrations are verified and recorded. • Management and workers understand the defined scope of practice for clinical care staff and contractors **Implement processes for managing clinical staff** • Position descriptions and recruitment processes clearly identify the clinical skills, experience, knowledge and qualifications required for each role. • Ensure the provider has processes for: – describing and monitoring the scope of clinical practice – providing clinical education and training – monitoring and managing performance – oversight of health professional registration where required – orienting workers and health professionals to the providers' safety and quality systems and processes. • Clearly describe roles and responsibilities for clinical governance and clinical quality and safety and ensure they are understood by everyone working in the service. • Ensure that roles and responsibilities for clinical governance and clinical quality and safety are: – reflected in position descriptions – the terms of reference for relevant committees – described in policy and process documents. *Continued on the next page*	**All residential and home care services** have a responsibility to ensure they have processes in place to verify the qualifications, training and experience of their workers. Worker roles and scope of practice are understood by the provider and workers. There are processes to ensure workers perform their roles within their scope of practice.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, review and improve** • Regularly review the organisational structure, position descriptions and contracts to ensure that roles, responsibilities and accountabilities for clinical safety and quality are clearly defined and articulated at all levels of the organisation. • Ensure a committee or individual has the delegated responsibility for oversight of registration and scope of practice. • Seek feedback from older people on the care they receive from workers. • Ensure there are processes to address concerns raised by workers about expectations of their role. • When there are identified pressures for workers to perform beyond their scope of practice ensure there are processes to escalate, address and resource positions with appropriately qualified workers to ensure provision of appropriate care. • Review processes for monitoring, training and verifying competency (Outcome 2.9).	Refer to Service context considerations on the previous page

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.1.4	The provider and health professionals agree on their respective roles, responsibilities, and protocols for providing quality clinical care.	**Implement processes for agreement between health professionals and the provider** • Coordinated care for older people ensures older people have access to the clinical care that is right for them at the right time and in the right place. The provider has responsibilities for facilitating access to care for older people when the clinical need is beyond the provider's service capability or capacity. • These responsibilities could include: – preparing private spaces for visits if this is preferred by the older person – working with the older person to prepare for appointments – providing access to clinical information systems, and ensuring instructions, clinical information and notes are documented and securely stored – ensuring access to the older person's care plan and clinical information at the time of the visit – ensuring the health professional can access the older person's home or the aged care home at the time of their appointment. • An agreement between health professionals and a provider could include: – the expectations of the older person in relation to their goals of care – a description of responsibilities for clinical care – expected behaviours and responsibilities of both parties when providing clinical care to an older person – the processes for providing care as referred to in the clinical governance framework and/or as agreed between the provider organisation and the health professional – protocols for clinical information use including access, consent, sharing, and editing – a timeframe for review of agreements – processes for updating care and services plans and reporting of feedback and incidents *Continued on the next page*	For this action there are important distinctions between home and residential care services. The way this action is applied will vary according to the setting. **Home care services** Older people in their own home may have several services or health care requirements met by health professionals or others with no existing relationship with the provider. However, their actions may impact on the care required by the older person from the responsible provider. It is vital to: • communicate with others providing care where it is appropriate and with the older person's or person responsible consent • document the agreed arrangements, this may include the role of family and other support people • have an agreement between health professionals and providers that ensures all involved in an older person's care, know and understand the clinical care requirements of the older person and outlines processes to provide safe clinical care.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, respond and improve clinical care** • Elicit feedback from the older person to ensure they are satisfied with their care • Ensure care is provided using the agreed processes • Review agreements regularly to ensure they are fit for purpose and support the provider and health professional to provide high-quality clinical care to older people. • Use feedback from the older person on their experience of clinical care where there are agreements between the provider and health professionals and use this to improve the quality of care • Ensure workers are informed of changes to an older person's care needs as a result of treatment or assessment by health professionals, as appropriate, and with consent from the older person or their representatives • Ensure that the clinical workforce and external health professionals have access to information about the services and level of care that is supported by the provider and referral pathways to specialist expertise when required.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.1.5 The provider works towards implementing a digital clinical information system that: a) integrates clinical information into nationally agreed digital health and aged care records b) supports interoperability using established national Healthcare Identifiers, terminology and digital health standards c) has processes for workers and others to access information in compliance with legislative requirements.	Link with Outcome 2.7 to ensure information is secure, accuracy is maintained and is used with the appropriate consent. "Working towards", means where a clinical information system (CIS) is not in place, the provider has looked at available systems, considered their requirements and have detailed a plan for a staged implementation of a conformant system. Effective clinical information systems can support an older person's clinical safety by improving communication and ensuring continuity and coordination of care between settings and between health professionals and providers. Use of standard national terminology ensures that information captured in a local CIS are interoperable with other CIS, such as primary health provider systems when available, and can be used for de-identified data analysis. It also ensures that clinical information captured in local systems can be readily understood and used by other health professionals accessing this information and correct information is associated with the correct older person at the point of care. **Establish a system for safe use of clinical information** • Incorporate clinical information into care and services plans and use in planning for care and when transitions between settings occur. • Consider the overall architecture of the information collected and used and how it can be used securely, with the older person's consent and in line with legislation. • Clinical information is managed through the use of a digital CIS that uses conformant software and complies with relevant digital health standards. • Where possible, aged care providers that provide clinical care, should consider how to ensure there is the least duplication of entry of information including by working towards systems that are integrated. This reduces errors and makes it easier for health professionals to know where to find the most up to date information. *Continued on the next page*	These activities are useful strategies for all services to use when working towards an integrated clinical information system. Consider these in your service context. For **Residential Care** services there are resources to support use of standard national terminology and Healthcare Identifiers (HI), when entering clinical information and My Health Record. For **both service contexts** There is no expectation that providers have a role in ensuring external systems are compatible. Rather the provider should be working towards a system that has the potential to link with other systems where and when this is possible.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Implement processes to manage clinical information.** • To safely manage clinical information, providers implement processes for: – external health professionals to access the CIS when required and with consent to document outcomes of assessment or other relevant information. Consider how health professionals can access provider clinical information systems when off-site or during telehealth appointments. – internal health professionals such as RNs, to enter clinical information in the CIS using standard national terminology and health identifiers where possible – workers to access the information relevant to their role and in line with the consent of the older person or their representative – all health professionals have appropriate access to clinical information in line with the older person's wishes and relevant legislation – older people to access and review their clinical information, including consideration of on-screen display or printable information, if and when they request to do so – all health professionals, with the older person's consent, to view, review and update clinical information – seek consent and record the outcome for sharing and accessing clinical information – assign and communicate roles and responsibilities for documentation and the use of clinical information. • Eligible workers have health professional identifiers (HP-Is) and use these and the older person's Individual health identifier (IHI) when accessing or entering information in an older person's My Health Record or other agreed health record system. Use of Healthcare Identifiers supports interoperability with nationally agreed health records and other CIS, such as primary health provider systems where available. • Develop and implement a security and access policy to ensure workers keep older people's clinical information safe. • Monitor, review and improve processes for clinical information accuracy and use • Evaluate existing software systems to understand how clinical information is currently managed and shared. *Continued on the next page*	Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	• Identify gaps and areas for improvement such as unnecessary duplication of entry of the same or similar information or manual entries that do not use standard agreed terminology or follow the provider processes for entry of clinical information. • Where there is not a system in place access the digital health agency's register of conformity and information to identify conformant systems that meet the needs of the service. • Consider using the resources available to ensure relevant clinical information is integrated with other systems using conformant software. If the provider does not have a CIS in place, they have developed a plan to obtain a conformant software system. • When there are identified issues with the accuracy of information or the security of information review processes and access requirements. • Ensure protocols for offline clinical information management are understood by workers and health professionals.	Refer to Service context considerations on the previous page

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.1:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.2: Preventing and controlling infections in clinical care

What is the Outcome that needs to be achieved?

Older people, workers and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

Infection risks are minimised and, if they occur, are managed effectively.

Why is this Outcome important?

Infection prevention and control (IPC) is an important part of providing safe aged care. Everyone providing care to older people in any aged care context, and everyone entering a residential aged care home, has a role and responsibility in preventing and controlling infection. This includes aged care workers, health professionals, families, visitors, contractors, and carers.

Older people are more vulnerable to contracting infectious diseases due to factors including age-related physiological changes, reduced immunity, co-morbidities, communal living and use of invasive devices in their care. These factors also meant that infections can be more challenging to treat in older people, often requiring more complex treatment or hospitalisation.

Outcome 5.2 is closely related to Outcome 4.2 (Standard 4), in which general infection prevention and control (IPC) measures are required for all aged care service environments. Outcome 5.2 more specifically covers IPC in the context of clinical care and introduces the requirement for Antimicrobial Stewardship (AMS). The actions in Outcome 5.2 support providers to implement systems and processes to prevent infections acquired from clinical care procedures and invasive devices, reduce exposure to and spread of transmissible infections, and limit resistance to antimicrobial medicines.

Providers can minimise infection risk by applying evidence-based IPC strategies and following endorsed national and jurisdictional IPC guidelines. Clinically trained and qualified workers and health professionals should use aseptic technique to prevent infections associated with clinical interventions such as inserting, maintaining and removing invasive devices.

AMS programs aim to promote appropriate antimicrobial usage, improve care outcomes and reduce adverse consequences of antimicrobial use (including antimicrobial resistance, toxicity, and unnecessary costs).

Service context considerations

Providers of both residential and home care services are expected to establish and maintain systems and processes for infection prevention and control and antimicrobial stewardship. Provider focus may differ according to the type of clinical services offered and where these services are delivered.

In all service contexts, clinical procedures should only be carried out by appropriately qualified and trained workers or health professionals within their scope of practice.

How can you achieve Outcome 5.2 in practice?

Provider organisation			
Actions		**Associated activities**	**Service context considerations**
5.2.1	The provider implements an antimicrobial stewardship system that complies with contemporary, evidence-based practice and is relevant to the service context.	**Establish and maintain a system for AMS** • Document the components of the organisation's AMS system. Components include: – policies and procedures to promote the appropriate use of antimicrobials for older people – roles and responsibilities for AMS within the organisation – processes for regular clinical reviews and specialist referrals, including microbiological testing where required – processes outlining how the service or organisation will access external expertise related to AMS if it is required – AMS education and training systems for workers and health professionals employed by or contracted to the provider – processes for monitoring and reporting the effectiveness of the AMS system – quality improvement processes for identified antimicrobial issues. • In developing the AMS system, consider relevant aspects of evidence-based best practice covered by Chapter 16 of the Antimicrobial Stewardship Book – Antimicrobial stewardship in community and residential aged care and evidence from surveillance reports healthsuch as the Aged Care National Antimicrobial Prescribing Survey (NAPS), the Australian Report on Antimicrobial Use and Resistance in Human Health (AURA), and reports on analysis of Pharmaceutical Benefits Scheme data. **Implement processes for effective AMS** • Ensure workers and health professionals who are responsible for supplying, administering and monitoring the use of antimicrobial medicines: – have the required training and qualifications to fulfil their role – understand their role in promoting appropriate use of antimicrobials and reducing antimicrobial resistance *Continued on the next page*	**For all residential care providers** Implement an effective system and processes for AMS. All associated activities outlined in this section can support these providers to do this. **For home care providers offering clinical care involving the prescription, supply, or administration of antimicrobial medicines:** implement an effective system and processes for AMS. All associated activities for 5.2.1 can support these providers to do this. **For home care providers which do not prescribe, supply or administer antimicrobial medicines:** implement an effective system and processes for AMS. *Continued on the next page*

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	– understand how to monitor older people who have been prescribed antimicrobials for effectiveness, side-effects, and adverse events – know how to recognise and escalate inappropriate use of antimicrobials, including to prescribers – have easy access to clinical guidelines and resources (such as Therapeutic Guidelines: Antibiotics, and the Australian Medicines Handbook). • Consider how to support older people to participate in informed decisions about using antimicrobials. This may include offering information to older people, their family and carers about the risks, benefits, and alternatives to antimicrobials for their condition. **Monitor, review and improve AMS processes** • As relevant to the service's level of involvement in antimicrobial supply, administration and monitoring, consider how to: – monitor the frequency and clinical reasons for use of antimicrobials among older people using the service – analyse trends in the use of antimicrobials (this may include linking with pharmacies to gather data) – conduct regular surveillance to monitor prevalence of infections and use of antimicrobials – for residential care services, this may include participating in the Aged Care National Antimicrobial Prescribing Survey (AC-NAPS) – analyse and report the data collected during monitoring to relevant stakeholders, including the governing body, prescribers and to older people and families, to support improvement in the effectiveness of AMS systems and processes. • Note that some of the associated activities in 5.3.6 on monitoring and evaluation of medication management systems will be helpful to monitor use of antimicrobials and trends in adverse medicines-related events and side-effects.	Given the lower level of involvement with antimicrobials in these services, the focus of AMS systems and processes may be on associated activities which support: • education of home care workers and health professionals about appropriate use of antimicrobials and raising concerns about inappropriate use • provision of information to the older person about antimicrobial risks and benefits to support them in making informed decisions with their prescriber.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.2.2 The provider implements processes to minimise and manage infection when providing clinical care that include but are not limited to: a) performing clean procedures and aseptic techniques b) using, managing and reviewing invasive devices including urinary catheters c) minimising the transmission of infections and complications from infections.	**Establish and maintain an infection prevention and control system** • Document the components of the organisation's IPC system, including: – policies and procedures to guide IPC in the context of the clinical care provided – roles and responsibilities for IPC, including senior leadership accountabilities and specification (where relevant) of the IPC Lead role – a list of clinical procedures used by the provider organisation for which aseptic technique is required, and protocols for using aseptic technique and clean procedures – a list of invasive devices used by the provider organisation, and protocols for their insertion, monitoring and removal – training systems to support workers and health professionals to fulfil their IPC responsibilities including education for care workers to reduce the risk of contracting or spreading infection. • In developing the IPC system, ensure it aligns with: – endorsed national and state/territory guidelines, legislation and regulations – evidence-based best practice in line with the IPC Guidance for Aged Care, A supplementary resource of the Australian Guidelines for the Prevention and Control of Infection in Healthcare. *Continued on the next page*	**In all service contexts**, clinical processes and procedures should only be carried out by appropriately qualified and trained workers or health professionals within their scope of practice. **For all residential care providers:** implement an effective system and processes for infection prevention and control (IPC). All associated activities for 5.2.2 can support providers to do this. **For all home care providers:** implement an effective system and processes for IPC. In the home care context, IPC is complicated by a reduced ability to control the environment in which clinical procedures are carried out. *Continued on the next page*

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Implement IPC processes for clinical care** • Ensure that processes support a risk-based approach to IPC for the service context, considering the risk of infection presented by the environment of care delivery, types of services offered, and the scope of practice of workers and health professionals delivering the services. • Ensure that workers and health professionals are supported to fulfil their IPC roles and responsibilities, including: – easy access to the organisation's IPC policies, procedures and protocols – adequate training and time for those responsible for IPC (such as the IPC Lead to carry out IPC-related activities • adequate training and education for those who conduct aseptic procedures and manage invasive devices • appropriate equipment to perform aseptic procedures and manage invasive devices safely. **Monitor, review and improve IPC processes and outcomes** • As relevant to the service's context and level of involvement in clinical procedures and use of invasive devices, consider how to: – Monitor compliance with processes and protocols regarding use of aseptic technique and management of invasive devices. – Assess and monitor infection risks and the effectiveness of mitigation strategies. – Use the data collected during monitoring to identify areas of improvement to reduce exposure to and transmission of infection during clinical care.	This may affect how clinical care is provided and surveillance activities are conducted. Home care providers should design an IPC system and processes using a risk-based approach to ensure that contextual factors are considered. Associated activities for 5.2.2 can support providers to do this.

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.2:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.3: Safe and quality use of medicines

What is the Outcome that needs to be achieved?

Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm.

Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person.

Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement.

Why is this Outcome important?

Safe and effective use of medicines benefits the health and quality of life of the older person, whereas unsafe use has potential to cause significant harm. Medication management is a frequent subject of complaints about aged care services, and medication errors are among the most common clinical incidents experienced by older people using aged care.

The aged care provider organisation is responsible for creating the conditions (structures, systems, processes and working practices) for consistently safe and appropriate use of medicines within its services. This means setting up strong medication governance and management systems and implementing processes to support those involved in an older person's care to use medicines safely and to monitor and respond to changing clinical needs. It also means putting older people at the centre of informed decision-making about their medicines if they want this.

Actions under Outcome 5.3 are consistent with the principles and guidance published by the national Quality Use of Medicines program for aged care, including residential care, home care and at transitions of care. Outcome 5.3 is closely linked to Outcomes 5.2 and 5.6, which cover the appropriate use of antimicrobial medicines and psychotropic medicines respectively.

Service context considerations

Providers of both residential and home care services involved in any aspect of medication management are expected to establish and maintain systems and processes for the safe and quality use of medicines. Medication management activities include prescribing, supplying, storing, administering, and monitoring the effect of medicines, as well as providing information about medicines.

In all care settings, medication management activities are strictly regulated and should only be carried out by appropriately qualified and trained health professionals within their scope of practice and in line with national and state/territory legislation.

How can you achieve Outcome 5.3 in practice?

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.3.1 The provider implements a system for the safe and quality use of medicines, including processes to ensure: a) access to medicines-related information for older people, workers and health professionals b) access for health professionals and others caring for the person to the up-to-date medicines list and other supporting information at transitions of care c) safe administration of medicines by qualified health professionals including assessment of the older person's swallowing ability, determining suitability of crushing and providing alternative safe formulations when required d) minimal interruptions to the administration of prescribed medicines including supporting access to medicines when an older person is prescribed a new medicine or an urgent change to their medicine e) documentation of a current, accurate and reliable record of all medicines including pro re nata (PRN) medicines, including clinical reasons for treatment f) support for remote access for prescribing.	**Establish and maintain a medication management system** • Consult the good practice principles from the National Quality Use of Medicines publications for residential and community (home care) settings and for transitions of care, as relevant to the service context. • Document the components of the medication management system. Components include: – a governance mechanism for oversight and monitoring of the medication management system, in the form of an expert multidisciplinary group. In residential care services, this group is called a Medication Advisory Committee (MAC) – policies and procedures for procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines, as relevant to the service context – guidelines, tools and standard processes that support workers and health professionals in the safe and quality use of medicines – adverse event and incident monitoring and reporting system and processes. • Specify roles and responsibilities for medication management, in line with national and state/territory legislation, regulations and professional standards. *Continued on the next page*	**In all service contexts,** medication management activities are strictly regulated and should only be carried out by appropriately qualified and trained health professionals or their delegates within their scope of practice and in line with national and state/territory legislation. **All residential care providers** Implement an effective system and processes for medication management. All associated activities for 5.3.1 can support providers to do this. **Home care providers** offering clinical services involving any aspect of medication management. Implement an effective system and processes for medication management. All associated activities for 5.3.1 can support providers to do this. *Continued on the next page*

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Implement processes for medication management** • Processes should be in place to ensure safe administration of medicines including making sure that: – health professionals and workers understand their roles and responsibilities in medication administration under governing legislation, regulations and professional standards – the older person's swallowing capacity and tolerance to different drug formulations are reviewed when required, and recommendations are documented and followed (link to 5.5.2) – older people who have capacity to self-administer medicines are supported to do this safely. • Consider how to support older people, carers and substitute decision-makers to participate in informed decision-making about their medicines, when this is what they want. This can include: – providing access to an up-to-date, comprehensive, and accurate medicines list – providing information about all non-pharmacological and pharmacological treatment options – providing information about medicines' risks and benefits to allow for informed consent, and to support adherence to medicine-related treatment plans – involving the older person, carers and substitute decision-makers in regular medication reviews. • Implement processes for timely and uninterrupted access to prescribed medicines, especially at transitions of care, when urgent clinical needs arise, and where there are changes to prescribed medicines. This includes processes supporting remote access for prescribing. • Implement standardised documentation processes to ensure that a current, accurate and reliable record of all medicines is available to the older person and those involved in their care. Records should include clinical reasons for treatment, prescribed medicines and administered medicines. These processes can be implemented using electronic systems such as the National Residential Medication Chart (eNRMC) or similar, as appropriate to the care setting.	**Home care providers** offering clinical services that do not involve medication management Associated activities for 5.3.1 should be considered and applied as relevant to the home care provider's context where there is not direct involvement in medication management. Associated activities for these providers should at a minimum be aimed at ensuring that workers know how to document and escalate any observations or concerns about an older person's medicines to a relevant health professional, so that these can be communicated to the prescriber where appropriate.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.3.2 The provider has processes to ensure medication reviews are conducted including: a) at the commencement of care, at transitions of care and annually when care is ongoing b) when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell c) when there is polypharmacy and the potential to deprescribe d) when a new medicine is commenced, or a change is made to an existing medicine or to the medication management plan e) when there is an adverse event potentially related to medicines.	**Implement processes for regular and as-needed medication reviews** Within the medication management system described in Action 5.3.1, the regular review of each older person's medicines by a qualified health professional is a key strategy for ensuring the safe and quality use of medicines. Reviews help to identify opportunities for more optimal therapies, identify side-effects and interactions, promote adherence, ensure optimal administration, and identify opportunities for deprescribing and for reducing the risk of harm from unnecessary polypharmacy. The following activities outline good practice in medication reviews for providers with services involving medication management. • Implement processes to support regular (at least annual) medication review for each older person. Where the health professional qualified to complete this review is not employed by or contracted to the provider, the provider should put processes in place to communicate the need for a review and to encourage sharing of documentation about the outcomes of the review and inclusion of the findings and any associated changes are incorporated into the care and services plan. • Implement processes for monitoring, documentation and communication of the effects and side-effects of prescribed medicines to the prescriber. • Support workers and health professionals to identify triggers for medication review. *Continued on the next page*	**All residential care providers** **And** **Home care providers** offering clinical services involving any aspect of medication management All associated activities for 5.3.2 are relevant, including where the health professional conducting a medication review may be a general practitioner (GP) or credentialled pharmacist who is not directly employed by or contracted to the provider. In these cases, the provider may not have control over whether a review is carried out and how often, but systems and processes should still ensure that: • the need for a regular review is communicated to the relevant health professional and followed up where necessary • review outcomes are documented, and changes made to care and services plan *Continued on the next page*

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	• Implement processes to ensure or encourage the use of standardised processes for medication reviews, to include documentation of available information about current (existing and newly prescribed) medicines; the history of medicine-related orders including oral and parenteral, multiple- and single-dose medicines; any anaesthetic and operative records; and ceased medicine orders. Reviews consider: – Is there a documented reason or evidence base for use of the medicine? – Does the older person still need the medicine? – Is the medicine still working? – What risks are associated with the medicine, and what monitoring is needed? – What risks are associated with stopping a medicine where polypharmacy is identified?	• workers and employed/ contracted health professionals know how to identify situations in which a review may be needed. **Home care providers not involved in any aspect of medication management:** Associated activities for 5.3.2 should be considered and applied as relevant to the home care provider's context where there is not direct involvement in medication management. Associated activities for these providers should at a minimum be aimed at ensuring that workers know how to escalate and document and escalate any observations or concerns about an older person's medicines to a relevant health professional, so that these can be communicated to the prescriber where appropriate.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.3.3	The provider documents existing or known allergies or side effects to medicines, vaccines or other substances at the commencement of care and monitors and updates documentation when new allergies or side effects occur.	Within the medication management system described in Action 5.3.1, the documentation and communication of each older person's allergies and previous reactions to medicines is an important component of the safe and quality use of medicines. **Implement processes to document allergies and adverse reactions** • Implement a process to ensure that workers and health professionals involved in the older person's care document known medicine allergies and any adverse medicines-related events (noting that these will often be self-reported by the older person), and that this information is kept up to date. • Ensure information about medicine allergies and adverse reactions is accessible to all health professionals who prescribe, dispense or administer medicines. • Ensure workers know how to observe and document the older person's reactions to any newly prescribed or over-the-counter medicines (including new allergies or side effects) and how to escalate observations and concerns to relevant health professionals.	**All residential care providers** **And** **All home care providers** All associated activities for 5.3.3 are relevant.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.3.4	The provider implements processes to identify, monitor and mitigate risks to older people associated with the use of high-risk medicines, including reducing the inappropriate use of psychotropic medicines.	As part of the medication management system (see Action 5.3.1), specific attention is required to establish clear policies, procedures and processes for the use of high-risk medicines in accordance with relevant legislation and guidelines. High risk medicines include opioids, anticoagulants, insulin and psychotropic medicines. These pose a higher risk to older people and are associated with adverse drug events, hospitalisation, poor health-related quality of life, and death. **Implement processes for safe use of high-risk medicines** • Implement processes for identifying, documenting, monitoring and reviewing the high-risk medicines prescribed to older people in the service. • Implement processes to support the safe use of high-risk medicines for each older person for whom they are prescribed, including: – clear, ongoing, documented communication between those involved in the older person's care, including external health professionals such as GPs and credentialled pharmacists, to monitor those taking high-risk medicines – documentation of the level of risk of harm from using a medicine and any mitigation strategies to ensure use is appropriate and their benefit outweighs risk. – regular medication reviews to monitor efficacy, identify adverse effects and interactions with other medications or disease states, and to identify any opportunities to reduce the dose or to deprescribe (see Action 5.3.2) – consideration of alternatives to high-risk medicines if appropriate (including non-pharmacological strategies).	**All residential care providers** **And** **Home care providers offering clinical services involving any aspect of medication management** All associated activities for 5.3.4 are relevant. Home care providers offering clinical services that do not involve medication management Associated activities for 5.3.4 should be considered and applied as relevant to the home care provider's context where there is not direct involvement in medication management. Associated activities for these providers should at a minimum be aimed at ensuring that workers know how to escalate and document any observations or concerns about an older person's medicines to a relevant health professional, so that these can be communicated to the prescriber where appropriate.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.3.5	The provider has processes to report adverse medicine and vaccine events to the Therapeutic Goods Administration.	Adverse medicines-related events are unintended and sometimes harmful occurrences associated with the use of a medicine, vaccine or medical device (collectively known as therapeutic goods). The Therapeutic Goods Administration (TGA) regulates and investigates the safety, efficacy and supply of medicines. Providers have a responsibility to report medicines-related adverse events to the TGA. **Implement processes for reporting to the TGA** • Implement reporting processes for all new adverse medicines-related events experienced by older people, and train workers and health professionals in their use. Ensure that workers and health professionals are aware of what an adverse medicines-related event is, and what their roles and responsibilities are. For workers, this means reporting observations and concerns to a health professional or service manager.	**All residential care providers** **And** **Home care providers** offering clinical services involving any aspect of medication management All associated activities for 5.3.5 are relevant.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.3.6	The provider regularly reviews and improves the effectiveness of the system for the safe and quality use of medicines.	Action 5.3.6 is relevant to the monitoring, evaluation and improvement of the medication management systems and processes described in Actions 5.3.1. – 5.3.5. **Establish systems to monitor and evaluate safe and quality use of medicines** • Develop policies, procedures and guidelines for the systematic monitoring and evaluation of medication management processes and outcomes and have these endorsed by the organisation's medicines governance group (such as the Medication Advisory Committee (MAC) in residential aged care). **Implement processes to monitor, review and improve medication management** • Consider how to monitor for updates to relevant legislation and guidelines, implement changes, and evaluate compliance. • Consider how to assess whether the medication management system is successful in embedding safe and quality use of medicines into the everyday care of older people. • Consider how to monitor whether medication review processes are being conducted regularly and when clinically indicated, and that recommendations are communicated and acted upon. This may include: – auditing regularity of routine medication reviews for each older person – reviewing records to assess how often outcomes of reviews and plans of action are documented – reviewing records to assess how often follow-up actions are taken after medication reviews. • Strategies for monitoring and measuring implementation of processes could include, for example: – auditing compliance with documentation requirements on commencement of care and at transitions of care – asking older people and their substitute decision-makers whether they feel informed and involved as much as they want to be in decisions about their medicines, including in medication reviews. *Continued on the next page*	**All residential care providers** **And** **Home care providers** offering clinical services involving any aspect of medication management All associated activities for 5.3.6 are relevant.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	• Strategies for assessing the safety and appropriateness of the use of medicines may include: – monitoring trends in the occurrence, type, and impact of medicines-related adverse events (such as those related to falls and those leading to hospital admission) – analysing incident reports and auditing clinical records to identify unreported or under-reported medicines safety issues – collecting and reporting data against quality use of medicines indicators, which can include but may not be limited to those in the National Mandatory Quality Indicator Program. • Based on the outcomes of monitoring, identify and implement quality improvement strategies for medication management. Report the outcomes of quality improvement activities to the governing body, the workforce, older people and other relevant organisations according to the service context.	Refer to Service context considerations on the previous page

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.3:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.4: Comprehensive care

What is the Outcome that needs to be achieved?

Older people receive comprehensive, safe and quality clinical care that is evidence based, person-centred and delivered by qualified health professionals.

Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function.

The provider has systems and processes that support coordinated, multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences.

The provider supports early identification of and response to changing clinical needs.

Why is this Outcome important?

Comprehensive care is an overarching approach to the planning and delivery of all aspects of clinical care that an older person requires or requests. The principles and practices of comprehensive care underpin all other clinical care outcomes and actions in Standard 5. A comprehensive care approach considers the impact of clinical conditions on the older person's quality of life and wellbeing and helps to ensure that risks of harm during clinical care are prevented and managed.

Providers need to build on principles of person-centred care (Standard 1) and reablement (Outcome 3.1), the assessment and planning system (Standard 3) and evidence-based practice (Outcome 2.3) to implement comprehensive care effectively.

The intent of Outcome 5.4 is to ensure that clinical care is driven by understanding and addressing the older person's clinical needs, their individual preferences and is aligned with their goals of care.

Comprehensive clinical assessment provides the foundation for safe and high-quality clinical care. Providers establish systems and processes to partner with the older person in their own care, involving family, carers, substitute decision-makers and others in line with the older person's preferences. Information about options is provided in a way that the older person can understand to enable them to make informed decisions and provide informed consent when required. Older people's choices and decisions are respected, and they are supported to exercise dignity of risk to achieve their goals and maximise their independence and quality of life.

The provider's assessment and planning processes involve the GP, nurse practitioner (NP), registered nurses (RN) and health professionals to jointly identify and plan for clinical risks. Continuity of care is supported and older people are provided with choice to maintain relationships with health professionals.

The provider's processes establish their role in coordinating the delivery of care, encouraging and enabling multidisciplinary collaboration and communication between health professionals and services required to meet the older person's clinical needs.

Service context considerations

Residential care services have 24-hour responsibility for planning and managing the clinical needs and risks of the older person. All of the actions and activities are applicable to the residential care setting.

Home care providers have systems in place to manage risks to older people that is proportionate to the complexity of the older person's needs, the service type and the context where care is delivered. They work with the older person and others involved to understand and agree arrangements for care provided by others.

How can you achieve Outcome 5.4 in practice?

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.4.1 The provider implements an assessment and planning system that supports partnering with the older person, family, carers and others to set goals of care and support decision-making.	**Establish and maintain systems for partnering in assessment and planning** • Comprehensive clinical care systems are designed to ensure that clinical care assessment and planning is driven by the needs, goals and preferences of the older person. Building on systems for person-centred care (Standard 1) and assessment and planning systems (Standard 3), providers establish systems and processes for: – supporting older people to partner in all aspects of their care and decision-making – identifying the older person's preferences for involving substitute decision-makers, family and carers in their care – supporting workers and health professionals understand their roles and responsibilities for partnering with older people. **Implement processes for partnering in assessment and planning** • Partner with older people in setting goals of care through discussions about what is important to them, their needs, values and aspirations for their health and wellbeing. Involve substitute decision-makers, carers and family (in line with the older person's preferences). • Document and integrate goals of care into clinical assessment and the care and services plan. Regularly assess and evaluate progress towards achievement of goals of care. • Provide the workforce with access to training on the principles of person-centred care, supported decision-making and informed consent **Monitor, review and improve systems for partnering with older people** • Analyse feedback from older people, workers and health professionals about the quality of supporting goal setting and decision-making. • Audit clinical records to evaluate the integration of goals of care in clinical assessments and care planning. • Use the information collected during monitoring to improve the safety and quality of systems and processes for partnering with older people. Report the results of quality improvement efforts to the governing body, older people and the workforce.	In **both residential and home care services**, the provider implements systems and processes for partnering with the older person and others, in line with their preferences.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.4.2 The provider conducts a comprehensive clinical assessment on commencement of care, at regular intervals and when needs change, that includes: a) facilitating access to a comprehensive medical assessment with a general practitioner b) identifying, documenting and planning for clinical risks, acute conditions and exacerbations of chronic conditions c) identifying an older person's level of clinical frailty and communication barriers and planning clinical care to optimise the older person's quality of life, independence, reablement and maintenance of function d) identifying and providing access to the equipment, aids, devices and products required by the older person	**Implement processes for comprehensive clinical assessment** • Building on the systems for person-centred care (Outcome 1.1) assessment and planning system (Outcome 3.1) and reablement (Outcome 3.1), implement evidenced-based clinical assessment processes that: – identify and address the complexity of the older person's acute conditions and exacerbation of chronic conditions, issues and risks. Include strategies to prevent, mitigate and escalate risk of harm in the care and services plan. – Provide opportunities for older people to maintain or regain function or skills to maximise their independence and quality of life. – ensure that reassessment includes evaluation of whether clinical care is effective and optimises the older person's quality of life, while respecting their choices and dignity of risk. – facilitate access to the older person's preferred GP, NP and other appropriate health professionals to conduct clinical assessment and support continuity of care. Use telehealth where appropriate for the older person and when the provider can support a telehealth appointment in line with best practice. • Ensure health professionals have the required knowledge, training and skills to: – conduct comprehensive clinical assessment – document the outcomes of clinical assessment and any identified risks in the care and services plan – communicate these outcomes to those involved in the older person's care (Outcome 3.4). **Monitor, review and improve assessment and care planning** • Analyse clinical data and feedback about comprehensive clinical assessment such as the quality and frequency of comprehensive clinical assessments, involvement of the older person's preferred GP and relevant health professionals and how assessments are incorporated into care planning. • Based on outcomes of monitoring, identify and implement quality improvement strategies for comprehensive clinical assessment. Report on the outcomes of quality improvement activities to the governing body, the workforce, older people and other relevant organisations according to the care setting.	In **both residential and home care services**, the provider implements systems and processes for comprehensive clinical assessment. Specific considerations for home care services in conducting clinical assessment may include the complexity of the older person's clinical needs, the service type and the context where care and services are delivered. The frequency of clinical assessment in all care settings is, at a minimum, on commencement of care, at regular intervals and when there is change or deterioration.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.4.3	The provider refers and facilitates access to relevant health professionals and medical, rehabilitation, allied health, oral health, specialist nursing and behavioural advisory services to address the older person's clinical needs.	• Building on the systems for person-centred care (Outcome 1.1) and the assessment, planning and delivery of care (Standard 3), implement processes for referring and facilitating access to health professionals. • Develop referral pathways that facilitate access to a range of health professionals and health services. This may include GPs, NPs and other primary health care professionals, registered nurses, pharmacists, and allied health professionals (who have distinct roles in supporting reablement and maintenance of function). Pathways include geriatricians and other specialist doctors, dentists and oral health practitioners, specialist nursing, behavioural advisory services and multidisciplinary specialist teams. Services that provide emergency and out-of-hours clinical care such as medical and dental services are identified and accessed when required. • Support the older person's preferences regarding referral to health professionals and services. Identify and document their existing relationships and private health insurance status (if they have this) to support choice and continuity of care. • Ensure that workers and health professionals have the knowledge and skill to identify when access to health professionals may be required. This includes assessments on commencement of care, in response to change or deterioration in the older person's condition or functional capacity, and when the older person's needs cannot be met by the provider. • Based on the older person's clinical needs and preferences, facilitate access to relevant health professionals and specialist services (when required). • Implement processes to agree the roles, responsibilities and accountability for health professionals involved in the clinical care of the older person (Outcome 5.1). Document the health professional with overall accountability for the older person's care (such as the GP or NP) and ensure up-to-date contact details are documented in the providers system • Workers and health professionals use standardised clinical communication tools such as ISBAR to support communication for safety and facilitate structured information exchange with health professionals and use standard national terminology (Outcome 3.4). *Continued on the next page*	In **both residential and home care services**, the provider implements processes for facilitating access to relevant health professionals to address the older person's needs. The extent of the activities expected of the provider in facilitating access will be proportionate to the composition of its workforce (including the scope of practice of health professionals), service type, the context where services are delivered and any legislative or other provider obligations.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, review and improve** • Collect, analyse and report data on referrals to health professionals and health services, including access barriers and waiting times. • Foster effective partnerships with health professionals and services to address access barriers.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.4.4 The provider implements processes to: a) deliver coordinated, multidisciplinary and holistic comprehensive care in line with the care and services plan b) communicate and collaborate with others involved in the older person's care, in line with the older person's needs and preferences c) facilitate access to after-hours and urgent clinical care d) provide timely notification to the older person's General Practitioner, family, carers and health professionals involved in the older person's care when clinical incidents or changes occur.	**Implement processes to deliver multidisciplinary care** • Implement processes for delivering person-centred, holistic, comprehensive care in partnership with the older person that addresses their goals of care, needs and preferences (Outcome 1.1 and 3.2). Carers, family and substitute decision-makers are involved in line with the older person's wishes. • Building on the processes in Outcomes 5.4.3 and 5.1 collaborate with the multidisciplinary team to: – establish roles and responsibilities of members of the multidisciplinary team – review clinical needs and goals of care with the multidisciplinary team – share relevant clinical information with the multidisciplinary team, with the older person's consent – support workers to develop and use skills in effective multidisciplinary teamwork and communication. • Establish and implement processes for access to after-hours and urgent clinical care when clinical deterioration is identified and escalation is required, aligned to the older person's goal of care. • Implement communication processes and protocols for timely notification of clinical incidents or changes to the GP, substitute decision-maker, carers and health professionals. Examples may include notification of a fall, transition of care, medication incident or changes to medicines. **Monitor review and improve processes for multidisciplinary care** • Consider strategies for monitoring and measuring implementation of processes for the delivery of comprehensive care. • Monitor and improve the quality of communication and multidisciplinary teamwork. • Consider incidents and indicator data to improve comprehensive care delivery and processes for access to after hours and urgent care.	In **both residential and home care services**, the provider implements processes for delivering comprehensive care. The extent to which the provider undertakes these activities is proportionate to the complexity of the older person's clinical needs, the provider's agreed role in care coordination, the service type and the context where care and services are delivered. Specific considerations for home care services may include carer assessment to identify their role and capacitie in supporting the older person. This information may inform care and services planning.

Provider organisation (continued)			
Actions		**Associated activities**	**Service context considerations**
5.4.5	The provider implements processes to monitor clinical conditions and reassess when there is a change in diagnosis or deterioration in behaviour, cognition, mental, physical or oral health, and at transitions of care.	**Implement processes for clinical monitoring and reassessment** • Building on systems from person-centred care (Outcome 1.1), care planning and delivery (Outcomes 3.2 and 3.3), implement processes to support timely monitoring and reassessment of clinical conditions that: – recognise and respond to signs and symptoms of clinical deterioration in an older person's behaviour, cognition, mental, physical or oral health, and at transitions of care – establish and use escalation pathways for older people at high risk of harm – provide mechanisms for older people, substitute decisions-makers, carers and family to escalate concerns about changes or deterioration in an older person's condition – review and evaluate comprehensive care routinely and in response to a transition of care, clinical deterioration or change in needs. This is conducted in collaboration with the older person, multidisciplinary team and substitute decisions-makers, carers and family. • Workers and health professionals are trained and supported (relative to their scope of practice or role) to effectively identify and monitor changes or clinical deterioration and to be responsive to changes in the older person's clinical needs. **Monitor, review and improve processes for clinical monitoring and reassessment** • Review feedback about the timeliness and appropriateness of the response to change or deterioration by workers and health professionals. • Analyse the effectiveness of documenting and tracking agreed observations to detect clinical deterioration. • Use outcomes of this review to improve the response to clinical deterioration.	In **both residential and home care services**, the provider implements processes to monitor and respond to clinical deterioration. The level of monitoring is proportionate to the complexity of the older person's condition, the service type and the context where care is delivered. In **residential care services** providers are expected to deliver 24-hour care, including monitoring, management and escalation of change or deterioration to health professionals (when required). In **home care services** where providers do not deliver 24-hour care, providers ensure that workers at all levels and health professionals use processes to identify and provide timely escalation change or deterioration when identified.

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.4:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.5: Clinical Safety

What is the Outcome that needs to be achieved?

Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people.

Why is this Outcome important?

It is important for older people to receive high-quality, safe, person-centred, evidence-based and coordinated clinical care to optimise function and minimise harm. Prioritised clinical areas of risk, as identified by the Royal Commission into Aged Care Quality and Safety, are choking and swallowing, continence, falls and mobility, nutrition and hydration, mental health, oral health, pain, pressure injury and wounds and sensory impairment.

Reducing risk of preventable deterioration requires providers to use proactive interventions that consider the impact of co-morbidity, interaction of one or more clinical risk areas, psychological factors such as previous experience of trauma or abuse and the older person's preferences for care.

Evidence-based clinical care maintains and aims to improve the older person's physical and psychological function and responds to clinical change or acute deterioration. The provider has processes for identifying, monitoring and responding to changes in clinical care needs and facilitating access to specialist care when required. Data is collected on outcomes of care and incidents and is used for mandatory reporting and to inform strategies for improvement.

The provider facilitates clinical assessment, both when care begins and for its duration as outlined in 5.4 Comprehensive Care. Processes for assessment, or referral to a GP or relevant health professional for assessment, are detailed in the provider's policies, procedures and protocols.

Assessment processes may identify clinical risks additional to those described in 5.5.2 – 5.5.10 that also require management and monitoring.

Outcomes of assessments are recorded in the CIS and coordinated care from relevant primary, specialist and allied health professionals is delivered when indicated. Provider clinical staff, RNs, GPs and other specialist doctors and nurses, NPs, oral and allied health professionals, pharmacists and Aboriginal health practitioners, deliver clinical care when required, in line with the older person's preferences, and have access to an older person's clinical information at the point of care with their consent.

Using the processes from Outcome 3.2, plans to minimise risk of harm from prioritised clinical areas of risk, including those highlighted in Actions 5.5.2-5.5.10, are documented and communicated to older people, workers and others involved in their care.

As with all components of clinical care, improving clinical safety is within the context of shared decision making and respecting a person's choice to make decisions that may involve risk to their health.

Service context considerations

Home care providers have systems in place to identify, manage and escalate risks to older people that is proportionate to their service input [link to Outcome 2.4]. They work with the older person and others involved to understand arrangements for care provided by others.

Residential care providers have 24-hour responsibility for the clinical care needs of older people.

How can you achieve Outcome 5.5 in practice?

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.5.1 The provider implements a system that supports the identification, monitoring and management of high impact and high prevalence clinical care risks, including but not limited to Actions **5.5.2** to **5.5.10**.	Identifying, monitoring and managing clinical risks should be carried out in accordance with the principles of care planning, clinical governance and comprehensive care outlined in Outcomes 3.1, 5.1 and 5.4, so that older people can access appropriately skilled health professionals with a scope of clinical practice and skill to manage and treat identified clinical needs. Meeting clinical needs includes providing older people with the information they need to make decisions about their care and ensuring that the person's goals and preferences guide decisions, including allowing for dignity of risk. Health professionals may include GPs, geriatricians and other specialist doctors and nurses, Nurse Practitioners, RNs, EENs, and other primary health care, pharmacists, allied health professionals, oral health practitioners and multidisciplinary specialist teams. Older people have access to the information they need to make decisions about their care. **Establish systems to promote clinical safety, particularly for identified high impact and high prevalence areas of risk** • Using evidence and input from qualified health professionals, establish systems that include processes to identify, monitor and respond to clinical risks, escalate care, ensure workers roles and responsibilities for clinical care are clearly defined and for documenting outcomes of assessment and clinical needs in an older person's clinical information in the providers system. *Continued on the next page*	**Both residential and home care services** should have systems and processes in place to manage older peoples' clinical care needs, to mitigate risk and ensure older people are safe. The activities below outline common risks that often cause harm to older people when they are not managed appropriately.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Implement processes for clinical safety that enable workers to:** • identify clinical needs on commencement of care, regularly and when there is a change or deterioration in an older person's health using validated assessments or referral to a qualified health professional as agreed with the older person • record outcomes of assessment and the treatment options agreed with the older person in the CIS • monitor outcomes of assessment and care to prevent and identify deterioration • respond to changes in an older person's health using evidence-based approaches • manage high impact and high prevalence risks using multidisciplinary team approaches to ensure holistic clinical care • ensure health professionals have the specific skills and competencies to manage and respond to the clinical care needs of older people including identified areas of risk such 5.5.2-5.5.10 and other high prevalence areas of risk such as diabetes, enteral feeding and invasive devices management. **Monitor and review the impact of clinical safety risks and improve the safety of clinical care** • Where there are identified unnecessary hospital transfers consider the effectiveness of clinical decision making, processes for escalation and interventions used in the service and use this information to improve care • Providers should use data to monitor clinical safety in their service	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Choking and swallowing **5.5.2** The provider implements processes to support safe chewing and swallowing when the older person is eating, drinking, taking oral medicines and during oral care.	**In line with the principles of care planning and comprehensive care described in Outcomes 3.1 and 5.4**. It is important that an older person's eating, drinking or swallowing impairment is identified, assessed and safely managed in line with the person's needs and preferences. This is to reduce the risk of choking and other adverse outcomes. **Implement processes to support safe eating, drinking and swallowing that:** • Ensure the processes developed to support safe eating, drinking and swallowing are evidence-based and have input from, and review by, qualified health professionals such as speech pathologists and dietitians. • Support workers (including through access to training and resources) to understand their roles and responsibilities related to eating, drinking and swallowing impairment, including: – identifying risks to older people when providing food, fluids, oral care and medicines – ensuring safe provision of food and fluids providing supervision or assistance when required, and understanding best practice preparation and provision of modified food and fluids – accessing and using documented information about the older person's safe eating, drinking and swallowing strategies, needs and preferences – using the incident management system to record, investigate, manage, and respond to choking and swallowing incidents – escalating care to supervisors and qualified health professionals when required. • Implement processes to facilitate partnership with the older person and/or their representative in decision making to agree strategies for managing risks around eating, drinking and swallowing and to obtain their consent for the proposed approach. • Ensure that swallowing assessments are carried out by a qualified speech pathologist when risks are identified. Healthcare professionals such as trained RN or GP can screen at the commencement of care and on a regular basis for eating, drinking or swallowing impairments and can manage risks until a full speech pathologist assessment is completed in a timely manner. *Continued on the next page*	For **residential care services** 24/7 onsite first aid capabilities should be in place and clinical staff should be able to access and use suction devices to remove food and liquid from the mouth and throat if required.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Choking and swallowing (continued) Refer to Actions on the previous page	• Ensure the outcomes of speech pathology assessment are documented in a report with recommended management strategies to minimise risks during eating, drinking, swallowing of oral medicines, and during cleaning of teeth and gums. Ensure that dietitians are aware of outcomes of assessments, such as the need for a nutrition and hydration review. • If the older person declines the recommendations of the speech pathologist, ensure appropriate guidance is in place such as an eating and drinking with acknowledged risk (EDAR) management plan. • Record the strategies agreed with the older person in their care and services and mealtime support plans, and • Ensure necessary care changes are implemented when recommended by a qualified speech pathologist, as agreed with the older person, including texture modified foods and thickened fluids. **Monitor review and improve processes to support safe eating, drinking and swallowing** • Ensure ongoing review of formal policies for safe eating, drinking and swallowing. • Ensure the older person is satisfied with and has input into the strategies in place to manage risk including decisions about their food service. • Documented incidents and outcomes of care are used improve processes that support safe eating, drinking and swallowing and contribute to continuous improvement plans. • Documented outcomes of care and reported incidents should be reviewed and used to inform continuous improvement plans (including ongoing staff education) to support safe eating, drinking and swallowing thereby minimising future risk/s.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Continence **5.5.3** The provider implements processes for continence care by: a) optimising the older person's dignity, comfort, function and mobility b) ensuring safe and responsive assistance with toileting c) managing incontinence d) protecting the older person's skin integrity and minimising incontinence associated dermatitis.	Good continence care is vitally important to the health, quality of life and wellbeing of older people. The prevalence of bladder and bowel symptoms is high in older people, particularly those with complex clinical needs. Continence care is responsive to individual needs and preferences, protective of dignity, and optimises functional ability. **Implement processes for continence care** Implement processes to ensure that continence care is person-centred, evidence-based and clinically informed, through assessment. • Provide person-centred care by eliciting, documenting and communicating with the older person about their choice, values, goals and preferences for continence care (Outcome 1.1 and 5.4). Involve carers as partners in care planning, aligned with the older person's preferences. • Support the older person to maintain and improve their mobility and functional skills. This includes optimising the physical environment to support the maintenance of continence and independence. • Identify the need for a comprehensive, evidence-based continence assessment to identify risks and treat factors that can cause or contribute to incontinence and bladder or bowel dysfunction. • Assessment includes review of current medicines when bladder symptoms are identified, such as urinary incontinence, nocturia and overactive bladder. Providers support the use of tools for assessment and monitoring of bowel and bladder symptoms. Use the assessment to inform continence planning, care and evaluation. • Consider a multi-strategy approach when incontinence or other bladder or bowel symptoms are identified. Lifestyle interventions may be considered as a first line therapy. • Facilitate access to relevant health professionals to support continence care when required (Outcome 5.4). This may include assessment by a continence clinical nurse consultant. *Continued on the next page*	All **residential and home care services** should have systems and processes in place to support continence care for older people, relative to the service context. For **residential care services**, additional activities should include reporting data on incontinence and IAD as required by the National Aged Care Mandatory Quality Indicator Program.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Continence (continued) Refer to Actions on the previous page	• Identify, assess, monitor and respond to decline in skin integrity and incontinence-associated dermatitis (IAD). This includes implementation of a skincare program for the prevention and management of IAD when required. • Prevent, identify and manage constipation. This may include assessment by a dietician, GP or NP. • Ensure the use of continence aids and continence products is responsive to the older person's clinical needs and preferences Ensure that workers and health professionals have the required knowledge and skills to meet continence care needs. Workers understand and communicate changes in an older person's continence needs or signs of IAD and implement strategies to minimise risk. **Monitor, review and improve processes for continence care** • Review incidents and feedback from the older person, family, carers and workers about continence care and whether toileting assistance is timely, meeting the older person's needs and is aligned with their preferences. • Consider how the workforce delivers continence care to preserve the older person's dignity, comfort, functional capacities and mobility. • Routine monitoring to ensure that adequate supplies of continence products are available and provided.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Falls and mobility **5.5.4** The provider implements processes to minimise falls and harm from falls by: a) maximising mobility to prevent functional decline b) delivering effective and timely post falls care c) monitoring falls and injuries and review the reason for and consequences from falls.	Falls are a significant cause of harm to older people. Many falls can be prevented by a combination of interventions tailored to the risks and needs of each older person. Fall prevention interventions are planned and delivered in line with the older person's goals and preferences, respecting their dignity of risk. Engaging multidisciplinary teams, older people and family and carers is crucial to fall prevention. **Implement processes to minimise falls and fall-related harm:** • Implement person-centred, evidence-based, best practice guidelines for fall prevention in residential care services and/or community care. The expectations of providers is proportionate to the type of services provided and the context where care is delivered. • When a fall occurs, deliver post-fall assessment, monitoring and escalation for review by an appropriate health professional. Update the care and services plan with assessment outcomes (Outcome 3.1). • Facilitate access to health professionals when required, in consultation with the older person. This includes GPs, NPs, RNs and allied health professionals such as physiotherapists, occupational therapists, exercise physiologists and podiatrists to conduct assessments, treatment, ongoing evaluation and monitoring of fall prevention strategies. • Ensure workers and health professionals are provided with training in fall prevention and preventing decline in an older person's mobility or functional capacities (Outcome 3.1-3.2). *Continued on the next page*	Best practice guidelines for minimising falls and harms from falls differ between **residential services (where 24-hour care is provided) and home care services**. Expectations of providers are proportionate to the type of services provided. **For residential care services** • Routinely provide all older people with tailored multifactorial fall prevention interventions. This includes regularly reviewing personal and environmental risk factors and engaging with workers to develop targeted and individualised fall prevention plans for the older person based on the findings of fall risk assessments. • Provide tailored, supervised and ongoing exercise for older people who are willing and able to participate. • Plan and provide for the dietary needs of older people (Outcome 6.2). Ensure that menus are assessed by dietitian and include adequate provision of dairy foods, including at least three serves of dairy foods daily to meet calcium and protein nutritional requirements • Facilitate access to the older person's GP to consider Vitamin D supplements (for all older people) and bone protective treatments (for older people with osteoporosis or a history of low-trauma fractures). • Discuss evidence-based options for reducing the risk of fall-related fractures, such as hip protectors and support the older person's choice (Outcome 1.3). • Providers collect and analyse data on falls and major injury as part of the National Aged Care Mandatory Quality Indicator Program *Continued on the next page*

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Falls and mobility (continued) Refer to Actions on the previous page	**Monitor, review and improve processes minimising falls and harm from falls** • Use the incident management system to analyse data on falls and harm from falls to review processes and outcomes of care. • Monitor the timeliness of access to health professionals, equipment and devices and address access barriers. • Consider feedback from older people, workers and others about fall prevention strategies, including any dignity of risk considerations.	**Home Care Services** • Support older people to undertake exercise on an ongoing basis. Exercise programs target balance and mobility and may include strength training. Exercise programs are designed and delivered by a health professional or appropriately trained instructor. • For older people with increased risks, facilitate access to health professionals such as a physiotherapist or exercise physiologist for individualised programs, and an occupational therapist for home safety interventions and education. • Consider interventions to address specific fall risk factors, such as podiatry interventions for older people with foot problems or pain.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Nutrition and hydration **5.5.5** The provider implements processes to maintain an older person's nutrition and hydration by: a) conducting regular malnutrition screening using a tool validated in aged care b) minimising the impact of chronic conditions c) responding to the risk of malnutrition and when an older person is malnourished or has unplanned weight loss or gain	Prevention of, and timely response to malnutrition and dehydration is important as these conditions carry high risk of rapid clinical deterioration. **Implement processes for maintaining nutrition and hydration** • Ensure policies, procedures and processes are aligned with evidence-based practice guidelines for the prevention, early identification and management of dehydration and malnutrition. • Ensure the older person's needs and preferences for preventing and managing malnutrition and dehydration are asked about, documented and communicated to workers and health professionals caring for the person. This includes consideration of how to assess and manage needs in ways that are safe for a person with lived experience of trauma and are culturally safe [Link to Outcome 1.1] • Embed prevention of malnutrition and dehydration into the delivery of care and services, including (as relevant to the service context): – ensuring availability of appropriate, varied and nutritionally adequate foods and fluids that provide the opportunity to meet nutrition and hydration needs – effective management of chronic conditions – consideration of impact of medicines on risk for weight loss or gain and for malnutrition or dehydration – access to dietitians, speech pathologists, pharmacists, GPs, psychologists and other specialists and allied health when clinically indicated. • Define workers' roles and responsibilities for preventing malnutrition and hydration and for early escalation of concerns. Identify tools and document processes for use by workers, qualified and working within their scope of practice or role description, to monitor nutrition and hydration status. • Define processes for early identification and subsequent assessment and management of dehydration and malnutrition, including: – regular screening assessment of nutritional and hydration status, using a tool validated in aged care, and documentation of findings, including any weight loss or gain *Continued on the next page*	Under Activities to monitor, review and improve processes, the requirement for reporting differs by care setting. **Residential care services** report on unplanned weight loss, as a requirement of the National Aged Care Mandatory Quality Indicator Program **Home care services** should still use data to monitor outcomes and improve care. This could include: Feedback from older people and workers, incidents, outcomes of complaints and hospital admissions.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Nutrition and hydration (continued) Refer to Actions on the previous page	– clinical assessment, review and multidisciplinary management by qualified health professionals, including a dietitian, when malnutrition, dehydration and unexplained weight loss are identified or suspected – referral for specialist clinical assessment and advice where required. – implementation of recommended management strategies arising from health professionals' assessments, and documentation of these in the care and services plan. Strategies may include texture modified foods and thickened fluids, in line with the older person's preferences. **Monitor, review and improve processes for nutrition and hydration** • Ensure the older person is satisfied with the strategies in place to manage risk through feedback from older people. • Documented outcomes of care (including weight and malnutrition screening) and reported incidents should be reviewed and used to inform continuous improvement plans (including ongoing staff education) • Analyse data collected on incidents, unplanned weight loss and use of relevant health professionals or hospital transfers and use findings to improve care.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Mental health **5.5.6** The provider implements processes to optimise mental health by: a) actively promoting an older person's mental health and wellbeing b) responding to signs of deterioration in an older person's mental health c) responding supportively to distress and symptoms of mental illness including self-harm and suicidal thoughts, minimising risks to the psychological and physical safety of each older person.	Mental health is a state of overall wellbeing that can be supported or improved for all older people. Mental ill-health is not an inevitable part of ageing. When there are changes in the mental health of an older person, it is important that these are recognised early and responded to in a timely way, with specialist assessment and input where required. **Implement processes to optimise mental health and respond to mental illness** • Implement processes to ensure each older person is supported to maintain or improve their sense of mental health and wellbeing. This means processes which: – embed the promotion of positive mental health for all older people into working practices – incorporate evidence-based strategies to actively promote mental wellbeing, such as creating environments and supports that enable social connection, meaningful activity, and a sense of coping with stressors – define workers' roles and responsibilities for older people's mental health and wellbeing – proactively create psychological, physical and sexual safety for older people in supportive, non-restrictive ways. • Implement processes to support recognition and response to deterioration in mental health, to: – prioritise engagement with each older person, their family and carers, to the extent the older person wants, to learn from their experience and knowledge about their own mental health. This can include knowledge about what change or deterioration looks like for them, and strategies that have helped them maintain their mental health or cope with distress in the past. – ensure that this knowledge and experience is integrated into both the assessment of mental health needs at the commencement of care and planning of response to any deterioration – identify signs of deteriorating mental health early – escalate worker observations and concerns appropriately to qualified health professionals *Continued on the next page*	**All residential and home care services** have a role to play in promoting positive mental health. The associated activities related to optimising older people's mental health are therefore relevant in all care settings. All **residential care services, and home care services** engaged in care or support for older people at risk of or experiencing mental illness, are also expected to ensure timely recognition and supportive response to existing or emerging signs of distress or deterioration in mental state. This includes providing or facilitating access to evidence-based treatment and care for existing or emerging mental illness.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Mental health (continued) Refer to Actions on the previous page	– ensure supportive and person-centred responses to older people who are distressed or who have symptoms of mental ill-health (including thoughts of harm or suicide) – monitor and document any changes in mental health, interventions and strategies used to respond to changes, and observations of the effectiveness of interventions and strategies – refer to a GP or nurse practitioner in case of deteriorating mental health, for further assessment and possible referral to a mental health specialist such as a psychogeriatrician, psychiatrist, psychologist, or social worker – record in the care and services plan (including in the behaviour support plan where indicated) the outcomes of any assessment/s, recommended interventions and support strategies, and responsibilities for implementing these and for reviewing progress. **Monitor, review and improve processes to optimise mental health and respond to mental illness** The following activities can be used to support continuous quality improvement. • Consider how to monitor the safety and quality of the organisation's processes to optimise mental health and respond to mental illness. Monitoring mechanisms could include: – analysis of trends in the organisation's data against the National Mandatory Quality Indicator Program for restrictive practices and use of psychotropic medicines (residential care) – themes from incident reports related to mental health and trends in incident numbers and types – feedback from workers about their knowledge of and confidence in promoting mental health and responding supportively to mental illness – feedback from older people, their families and other supporters. • Consider how to use the information collected during monitoring to identify areas for quality improvement • Report the results of quality improvement efforts to the governing body, older people and the workforce.	Refer to Service context considerations on the previous page

Provider organisation (continued)

Actions	Associated activities	Service context considerations
Oral health **5.5.7** The provider implements processes to maintain oral health and prevent decline by: a) facilitating access to a dentist or other oral health practitioner for oral health assessments at the commencement of care, regularly and when required b) monitoring and responding to deterioration in oral health c) assisting with daily oral hygiene needs.	Oral health is integral to overall health, wellbeing and quality of life. In older people, poor oral health is linked to malnutrition, swallowing difficulties, pneumonia, frailty, systemic inflammation, diabetes, cardiovascular disease, bone and joint health, depression, delirium, Alzheimer's disease and dementia, cancer and hearing impairment. Oral cancers are mostly diagnosed in older people. Oral pain may affect an older person's ability to eat, drink, swallow and speak, sleep and their mood and behaviour. Older people with cognitive impairment may find it difficult to self-report pain and discomfort. Oral health interventions are person-centred and are planned and delivered in line with the older person's goals and preferences, respecting their dignity of risk. **Implement processes to support the older person to maintain their oral health** • Implement person-centred processes (Standard 1) that support the older person's independence and functional capacities with oral health care. • Encourage and assist (as required) older people with natural teeth to brush their teeth, gums and tongue twice daily using a fluoride toothpaste. • For older people with dentures, encourage and assist twice daily (as required), to brush and clean dentures. Dentures are removed overnight and stored in a dry, denture container labelled with the older person's name. • Facilitate access to and use oral health products, aids and equipment. *Continued on the next page*	**Both residential and home care services** are expected to have processes to support older people to maintain their oral health and prevent decline. The expectation of the provider is proportionate to the complexity of the older person's needs, service type and the context where care is delivered. In **residential care**, where 24-hour care is provided, providers are expected to support oral hygiene twice daily, in line with the older person's preferences. **Home care providers** are expected to implement processes to ensure that the oral hygiene needs of older people are supported through care planning, in collaboration with carers and others (as required).

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Oral health (continued) Refer to Actions on the previous page	**Implement processes to support oral health assessment and management** • Visual clinical inspections of the older person's oral health using a validated Oral Health Assessment Tool is completed by a health professional such as an RN on commencement of care, regularly and when changes or deterioration are identified. • Facilitate access to oral health assessment by a dentist or oral health practitioner regularly, including on commencement of care to identify pre-existing oral health concerns and preventative and management strategies. Dentists or oral health practitioners provide regular review and reassessment when change or deterioration is identified (Outcome 5.4). If public dental services are required, facilitate timely referral. • Recognise and respond to changes in an older person's oral health or capacities to self-manage due to physical frailty or cognitive impairment. Escalate oral health concerns to oral and dental health practitioners. Facilitate access to other health professionals such as doctors, pharmacists and speech pathologists as required such as when dry mouth (xerostomia) is identified or when there is polypharmacy. • Ensure that workers have knowledge and skills in delivering oral hygiene (including assisted brushing) and supporting older people with complex needs or behaviours to maintain their oral health and prevent decline. • Identify, prioritise and deliver regular and appropriate oral care to older people with higher oral health care needs. This may include older people with cognitive impairment, who are at the end of their life, experience eating, drinking and swallowing impairment, • dry mouth (xerostomia), altered salivation (reduced or excessive), and those who are nil by mouth (Outcomes 5.6 and 5.7) • Consider the linkage between oral health and diet and encourage nutritious food and non-sugary foods and drinks, while supporting the older person's choice (Outcome 1.3). *Continued on the next page*	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Oral health (continued) Refer to Actions on the previous page	**Monitor, review and improve processes to maintain oral health and prevent decline** • Analyse clinical records to identify where poor oral health may be impacting on the systemic health of the older person and use this to improve care. • Audit clinical records regarding the frequency of oral health assessments. Ensure that care and services plans include oral health and incorporate the outcomes of regular oral health assessments. Include the older person's capacity to manage their own oral health and required products, aids and equipment. • Use feedback from older people and workers on oral health processes to improve the quality of oral health care.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Pain **5.5.8** The provider implements processes to manage pain by: a) assessing the older person's pain including where the older person experiences challenges in communicating their pain b) planning for, monitoring and responding to the older person's need for pain relief c) ensuring pain management is available 24-hours a day	Effective pain management is a key contributor to quality of life for older people. However, pain is sometimes difficult to identify and can be missed, especially if an older person cannot communicate their pain. This means that evidence-based assessment processes are crucial to safe and quality care for pain. Pharmacological treatment is not the only strategy used to treat pain. Context-specific, non-pharmacological strategies are the first consideration in pain management. A range of pain relief strategies are available that can be tailored to the assessed needs of the older person. **Implement processes to optimise pain management** • When establishing and reviewing the organisation's policies, protocols and procedures for pain management: – ensure alignment with evidence-based clinical guidance, and ensure review by qualified health professionals – ensure 24-hour availability of pain management – incorporate non-pharmacological options into decision-making on pain management – define the roles and responsibilities of workers and health professionals in the assessment, identification, management and monitoring of pain. • Implement processes to support assessment and management of pain incorporating: – validated assessment tools, including tools to assess pain in non-verbal older people and older people experiencing delirium, dementia, cognitive impairment or sensory impairment – evidence-based strategies for pain management, tailored to the needs and preferences of the older person, such as those described in the Pain Management Guide Toolkit for Aged Care – review by a qualified health professional such as a GP, pain specialist or pain clinic for persistent uncontrolled pain. *Continued on the next page*	Service settings affect how pain management actions are applied. For **residential care services**, all associated activities described below are relevant to providing safe and quality pain management. For **home care services** providing clinical care that involves pain management, all associated activities are relevant All aged care services, regardless of level of engagement in pain management, should implement systems and processes that support workers and health professionals to identify and escalate any pain-related concerns.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Pain (continued) Refer to Actions on the previous page	• Implement processes to support health professionals and workers to know their roles and responsibilities relating to pain assessment, identification and management, including: – for qualified health professionals, to plan and provide pain relief (both non-pharmacological and pharmacological) according to the type of pain experienced and the preferences of the older person, and to evaluate the efficacy of interventions – for workers, to recognise potential pain (including where the older person cannot express the severity or location of their pain or where their behaviour has changed) and to escalate concerns – updating the care and services plan, implementing any care changes required and informing family and others. • Consider context-specific, non-pharmacological strategies in pain management. A range of pain relief strategies are available that can be tailored to the assessed needs of the older person. • Consider the impact of sensory deficits from health conditions such as diabetes and peripheral vascular disease, on identification and experience of pain **Monitor, review and improve processes to manage pain** The following activities can be used to support continuous quality improvement. • Consider how to monitor the safety and quality of the organisation's processes to optimise pain management. Monitoring mechanisms could include: – for residential care, analysis of trends in residents' responses to Q2 of the QOL-ACC quality of life tool (this is used for the Quality of Life indicator under the National Mandatory Quality Indicator Program; the question relates to the resident's perception of how often their pain is well managed) – themes from complaints reports and other feedback from older people, their families and carers – feedback from workers about their knowledge of and confidence in recognising pain, including in people who have challenges communicating their pain. *Continued on the next page*	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Pain (continued) Refer to Actions on the previous page	• Consider how to use the information collected during monitoring to identify areas for quality improvement. Tools from the Pain Management Guide Toolkit for Aged Care such as the Pain Management Audit Checklist and the Pain Action Plan can be helpful for residential care services. • Report the results of quality improvement efforts to the governing body, older people and the workforce. • Monitor efficacy and safety of pain management processes, including escalation of care of pain, to qualified health professionals.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Pressure injury and wounds **5.5.9** The provider implements processes to prevent and manage pressure injuries and wounds by: a) conducting routine comprehensive skin inspections b) monitoring and responding to pressure injuries and wounds when they occur.	Older people's skin is vulnerable to deterioration and associated breaks from pressure or other injury. Strategies to prevent wounds from occurring include routine skin inspections and management of other interacting clinical risks such as those described in actions 5.1.3 – 5.1.10. **Implement processes for prevention and management of pressure injuries and wounds that include:** – structured pressure injury risk assessments, including but not limited to, assessment of a person's skin and tissues, mobility, existing pressure injuries or breaks in skin, and impact of conditions such as diabetes, incontinence and malnutrition are conducted by an RN or other appropriately qualified health professional – individualised, evidence-based risk-based pressure injury prevention plans – defined workers' roles and responsibilities for managing skin integrity and breaks in skin integrity – wound management plans for managing acute and chronic wounds – documentation, frequent monitoring and reporting – the use of validated assessment tools to diagnose wounds and monitor healing – referral pathways when treatment of pressure injuries and wounds are beyond the scope of practice of workers. • Consider the dignity and cultural safety of the older person when conducting routine skin inspections • Refer to qualified health professionals, including allied health professionals, to prevent wounds occurring and to support wound healing *Continued on the next page*	**Residential care services** report on pressure injuries as a requirement of the National Aged Care Mandatory Quality Indicator Program **Home care services** should still use data to monitor outcomes and improve care. This could include feedback from older people and workers, service trends, incidents and hospital admissions.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Pressure injury and wounds (continued) Refer to Actions on the previous page	**Monitor, review and improve processes to prevent and manage pressure injuries and wounds** • Consider regular reviews of processes used to monitor and respond to pressure injuries and wounds. • Consider what effective, holistic and multidisciplinary pressure injury and wound prevention looks like in your service. • Consider how to ensure clinical interventions follow an evidence-based pathway for care of wounds and workers know what these are. • Consider how aids, such as specialist mattresses, if recommended by an OT, may be used to minimise risk of pressure injuries. • Consider the use of data collected in the service such as on incidents, quality indicator data, hospital admissions, trends in data related to pressure injuries and wounds, and feedback from older people on the management and prevention of wounds • Use analysis to inform development of plans for continuous improvement	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Sensory Impairment **5.5.10** The provider implements processes to minimise and manage sensory impairment from hearing loss, vision loss and balance disorders by providing access to and supporting the use of assistive devices and aids to maximise the older person's independence, function and quality of life.	**Implement processes to optimise support for people with sensory impairment** • When establishing and reviewing the organisation's policies, protocols and procedures for optimal care of people with sensory impairment: – ensure alignment with evidence-based guidelines for supporting people with vision and/or hearing loss and for people with balance disorders – support timely identification of sensory loss and development of individualised care strategies – define the roles and responsibilities of workers and health professionals in identifying and supporting an older person with sensory impairment – consider how the care environment and access to assistive devices can maximise the older person's independence, function and quality of life – document requirements for assistive devices in the clinical information system. • Implement processes to facilitate: – timely identification of decline in sensory function – ongoing monitoring of the older person's hearing, vision and balance to identify changes in sensory function and to ensure ongoing appropriateness of aids and devices – referral to specialist health professionals for management including diagnosis, treatment and management of devices and aids – access to assistive devices and aids such as hearing aids, walking aids and glasses and ongoing monitoring of their use – optimisation of the care environment using strategies such as noise management, lighting, colour contrast, signage, textures and design.	Care settings effect how sensory impairment risks and needs are identified and managed. **For residential care services**, all associated activities described below are relevant to providing safe and quality care for sensory impairment. **For home care services** directly engaged in providing advice, care, support or equipment for sensory impairment, the associated activities are relevant. All aged care services, regardless of direct involvement in support for sensory impairment, should implement systems and processes that support workers and health professionals to identify and escalate any concerns about sensory impairment.

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.5:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.6: Cognitive Impairment

What is the Outcome that needs to be achieved?

Older people who experience cognitive impairment, whether acute, chronic, or transitory, receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences. Situations and events that may lead to changes in behaviours are identified and understood.

Why is this Outcome important?

Evidence-based clinical care is essential to optimise the quality of life and safety of older people living with cognitive impairment. Symptoms of cognitive impairment can be short-term or persistent and can often become more severe over time. A specific diagnosis can assist with a better understanding of symptoms and more effective, individualised care for a person experiencing behavioural changes.

Experiencing cognitive impairment can be frightening for the older person and those close to them. Providers who adopt a proactive approach to identifying, using and monitoring individualised, non-medication strategies can avoid inappropriate use of restrictive practices and reduce escalating distress.

The intent of this Outcome is to ensure person-centred, safe and high-quality clinical care for the older person who experiences acute changes in cognition such as delirium, or progressive decline in cognition as a result of a neurodegenerative disorder such as dementia. The principles of partnership with the older person (see Outcome 2.1), a comprehensive care approach (see Outcome 5.4), and non-restrictive care practices (see Outcome 3.2) underpins clinical care provision for people with any form of cognitive impairment.

Actions in Outcome 5.6 show how providers implement systems and processes so that an understanding of each older person's needs and preferences drives clinical care. This means that workers and health professionals routinely partner with the older person to understand:

- the impact of cognitive impairment on the complexity of each person's care needs
- contributing factors to a person's changes in behaviour
- the person's preferences for support strategies
- observed and reported effectiveness of specific support strategies for each older person.

Clinical guidelines outline safe, high-quality clinical care for cognitive impairment and highlight the need for a multidisciplinary team approach. The provider is expected to create the conditions where workers and health professionals can consistently follow these guidelines, as appropriate to their qualifications and scope of practice. It is important that people involved in an older person's care can recognise changes that may indicate cognitive deterioration and are aware of how to refer for or conduct comprehensive assessment of reasons for this.

Service context considerations

Providers of both residential and home care services are expected to establish and maintain systems and processes for the safe and quality clinical care of people living with cognitive impairment.

All providers including those not providing clinical care need to establish systems and processes to ensure workers and health professionals know how to identify and respond to signs of cognitive impairment or behaviour change (see action 3.2.6).

How can you achieve Outcome 5.6 in practice?

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.6.1 The provider identifies and responds to the complex clinical care needs of people with delirium, dementia and other forms of cognitive impairment by: a) identifying and mitigating clinical risks b) delivering increased care requirements c) being alert to deterioration and underlying contributing clinical factors.	**Implement processes to identify and respond to complex needs** • Establish policies and procedures to ensure that the older person's rights to dignity, autonomy and choice are embedded in processes for identifying, monitoring and providing care for cognitive impairment. • Consider how policies, procedures and processes for the clinical care of people with cognitive impairment can support workers and health professionals to: – understand the range of possible physical, social, psychological and behavioural needs associated with cognitive impairment – understand the importance of learning about the person – their history, personality, roles in life, values, beliefs and so on – to better identify unmet needs – understand their roles and responsibilities for monitoring and mitigating clinical risks for the older person with cognitive impairment, including increasing risk of falls, pressure injuries, medication errors and delirium – understand the range of potential contributing factors to cognitive and behaviour changes, including clinical, environmental and medication-related factors, and that some of these may be modifiable or reversible. • Establish policies and procedures which specify how to identify signs of cognitive deterioration and what to do when these are identified, including processes for: – identifying older people with symptoms of cognitive impairment, including recording information about a person's specific diagnosis or considering referral for specialist medical diagnosis – identifying and addressing any clinical, psychosocial or environmental factors contributing to cognitive symptoms – escalating observations or concerns about cognitive change to health professionals – screening and clinical assessment that is sensitively conducted in line with the older person's needs and preferences, when cognitive impairment is first identified and when there is any change in cognitive status, including delirium – identifying changing and intersecting physical, social, psychological and behavioural needs associated with cognitive impairment so that these are comprehensively assessed, monitored and supported *Continued on the next page*	For providers of **both residential and home care services**, all associated activities under this action are relevant and will support delivery of evidence-based care for people living with cognitive impairment.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	– assessing and monitoring clinical risks including recent and/or reoccurring falls, pressure injuries, medication errors, poor oral intake – documenting risks, needs and management strategies (including mealtime support, memory support, safe mobility, falls management and prevention) for each person with cognitive impairment in the care and services plan – identifying any modifiable factors exacerbating cognitive or behavioural symptoms as outlined in 5.6.3. • Implement processes for ongoing monitoring and response to: – changing clinical care requirements which could include changes to medication regimes – changing daily care needs such as personal hygiene and dietary requirements – need for additional care minutes from health professionals and workers. **Monitor, review and improve processes to identify and respond to complex needs** • Consider how to monitor the safety and quality of the organisation's processes to identify and respond to complex needs. Monitoring mechanisms could include: – analysis of trends in National Mandatory Quality Improvement Program data against indicators for clinical risks such as falls and pressure injuries – analysis of trends against relevant indicators from the Psychotropic Medicine in Cognitive Disability or Impairment Clinical Care Standard – themes from incident reports related to clinical risks such as falls, medication errors and pressure injuries – feedback from workers about their knowledge of and confidence in identifying and responding to complex needs – feedback from older people with cognitive impairment, their families and other supporters about whether they feel that their full range of needs are understood. • Consider how to use the information collected during monitoring to identify areas for quality improvement. • Consider how to identify quality has improved. • Report the results of quality improvement efforts to the governing body, older people and the workforce.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.6.2 The provider collaborates with older people with cognitive impairment, family, carers and others to understand the person and to optimise clinical care outcomes.	**Implement processes to partner with older people with cognitive impairment** • Develop and maintain policies and procedures that support collaboration, effective communication and shared decision-making between workers, health professionals and the older person, their family and carers (link to 3.2 6, 3.2.9). This can include: – Developing or identifying easy-to-understand information on care for people with cognitive impairment and make this information available to the older person and their support people in multiple formats. – Providing the workforce with access to training on methods for communicating with the older person, their family and other support people to understand the person and their preferences, interests and goals, and preferred support strategies (as part of training activities specified in action 2.9.6). – Documenting the older person's preferences and goals of care in their care and services plan and, when required, in their behaviour support plan (see action 5.6.3). **Monitor, review and improve processes to partner with older people with cognitive impairment** • Consider how to monitor the quality of your organisation's partnerships with older people with cognitive impairment. Potential mechanisms to achieve this could include: – Feedback from workers about their confidence in meaningfully partnering with older people, their families and other supporters – Feedback from older people with cognitive impairment, their families and other supporters about: — whether they are involved as much as they can or want to be in decisions about their care — whether they feel that their needs and preferences drive the strategies used to prevent and manage distress arising from changes in behaviour. • Use the information to consider where there are opportunities for improvement of quality in partnering with older people with cognitive impairment. • To close the feedback loop, monitor the impact of any quality improvement activities and report these to the governing body, older people and the workforce.	— For providers of **both residential and home care services**, all associated activities under this action are relevant and will support delivery of person-centred care for people with cognitive impairment.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.6.3 The provider implements processes to: a) identify and minimise situations that may precipitate changes in behaviour b) identify and respond to clinical and other identified causes of changes in behaviour.	**Implement processes to prevent and manage behaviour change** • Consider how to ensure that care is informed by an understanding of any clinical, situational, psychosocial and environmental factors, which may cause changes in behaviour for an older person. • Identify and mitigate stressors in the care environment and the day-to-day routines and processes of care that can increase the risk of acute changed behaviours occurring. • Proactively implement individual non-medication strategies known to be effective and acceptable to the older person as identified in 5.6.2, such as access to outdoor spaces, engagement in meaningful activities and pursuit of interests, to minimise occurrence of and distress from behaviour changes and to minimise use of restrictive practices (see Action 3.2.7). • Establish and implement assessment processes to respond to changes in behaviour that include: – ensuring the immediate safety of the older person and of others – identifying potential medical and mental health-related factors that could underlie changes, including delirium, pain and medication changes – identifying each older person's psychosocial and support needs – involving carers and family or others who know the person – referral to behavioural support specialists when required (in residential care, link to action 7.2.3). • Ensure person-centred, accessible and effective behaviour support plans are in place (within the care and services plan) for the older person with changed behaviours. *Continued on the next page*	For providers of **both residential and home care services** engaged in support related to people with cognitive impairment, all associated activities under this action are relevant and will support delivery of person-centred care for people with cognitive impairment. Behaviour Support Plans are required in the residential care context for people with changed behaviours, and it is also evidence-based practice to use these in the home care context. Some activities do rely on the service provider having control over the environment of care; these activities are more relevant to residential care settings but should still be considered for relevance by home care services.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, review and improve** • Consider how to monitor the safety and quality of the organisation's processes to prevent and manage behaviour change. Monitoring mechanisms could include: – trends in Mandatory Quality Improvement Program data against indicators for restrictive practices and use of psychotropic medicines (residential care) – trends against relevant indicators from the Psychotropic Medicine in Cognitive Disability or Impairment Clinical Care Standard – themes from incident reports related to changes in behaviour and trends in incident numbers and types – feedback from workers about their knowledge of and confidence in prevention and management strategies for behaviour change – feedback from older people with cognitive impairment, their families and other supporters about whether they feel that their needs and preferences drive the strategies used to prevent and manage distress arising from changes in behaviour. • Consider how to use the information collected during monitoring to identify areas for quality improvement. • Consider how to tell that quality has improved. • Report the results of quality improvement efforts to the governing body, older people and the workforce.	Refer to Service context considerations on the previous page

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.6:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

Guidance for Outcome 5.7: Palliative and End-of-life care

What is the Outcome that needs to be achieved?

The older person's needs, goals and preferences for palliative care are recognised and addressed and their dignity is preserved. The older person's pain and symptoms are actively managed with access to specialist palliative care when required, and their family and carers are informed and supported, including during the last days of life.

Why is this Outcome important?

The clinical care that an older person receives in the last years, months and weeks of their life can reduce the distress and grief associated with death and dying. Safe and high-quality care at the end of life is comprehensive care delivered in a coordinated way (Outcome 5.4). All older people have the right to dignity, comfort and privacy and to be cared for respectfully and with compassion. The prevention and relief of suffering is the highest priority. Like dementia care, palliative care and end-of-life care is core business for providers.

Care at the end of life is evidence-based, clinically appropriate and timely. Using a person-centred approach, the older person is supported to identify their needs and goals, understand information, and make choices and decisions about their care. Workers and health professionals recognise and respect older person's values, needs and wishes and provide care that is responsive and aligned with their preferences. Substitute decision-makers, family members and carers are involved in decision making in accordance with the older person's wishes, and state or territory legislative frameworks (Outcomes 1.1-1.3).

An important component of Outcome 5.7 involves recognising when an older person has a condition that is life limiting and/or they are approaching the end of life and may benefit from a palliative care focus. Conversations about death and dying requires knowledge, sensitivity and skill by health professionals. The older person is supported to continue end-of-life care conversations to the extent that they choose, and their choices are respected. Processes support the review of advance care planning documents to ensure they align with the older person's needs, goals and preferences.

Effective communication, collaboration and teamwork is essential to supporting continuity of care and coordination between teams, settings and at transitions of care. While not all older people will require specialist palliative care, processes are in place to identify when an older person may benefit from this and to facilitate timely access.

The timely recognition of palliative care needs (at any point in a person's life-limiting illness) and the older person's transition to the last days of life is critical. Providers have processes in place to monitor, manage and escalate rapidly changing needs and unresolved symptoms. Palliative medicines to manage pain and symptoms, including anticipatory prescribing are identified and accessible 24-hours per day.

Voluntary assisted dying legislation in each Australian state and territory provides legal frameworks for eligible people with a terminal illness to choose the manner and timing of their death, with the assistance of a medical practitioner. Providers have responsibilities under State voluntary assisted dying legislation and are expected to familiarise themselves with legislation in their own jurisdiction and respect an older person's choice to access voluntary assisted dying services. An older person's decision to access voluntary assisted dying does not change their right nor should it affect their access to high-quality palliative and end-of-life care.

Note: Outcome 5.7 incorporates principles from the National Palliative Care Strategy, National Consensus Statement: Essential elements for safe and high-quality end-of-life care and the National Palliative Care Standards for All Health Professionals and Aged Care Services.

Service context considerations

Residential care services have 24-hour responsibility for the clinical care needs of the older person. All of the actions and activities are applicable to the residential care setting.

Home care providers have systems in place to manage risks to older people that is proportionate to the complexity of the older person's needs, the service type and the context where care is delivered. They work with the older person, carers, health professionals, specialist palliative care and others to understand and agree arrangements for care provided by others.

How can you achieve Outcome 5.7 in practice?

Provider organisation		
Actions	**Associated activities**	**Service context considerations**
5.7.1 The provider has processes to recognise when the older person requires palliative care or is approaching the end of their life, supports them to prepare for the end of life and responds to their changing needs and preferences.	**Implement processes for recognising and preparing for the end-of-life** • Implement person-centred processes (Standard 1) to recognise older people who are approaching the end of their life and who could benefit from a palliative approach. These may include: – supporting workers and health professionals to use risk prediction tools, simple trigger tools and questions including 'would you be surprised if the older person died in the next 12 months?' and 'would you be surprised if the older person died in the next days or weeks?'. – engaging with the older person, carers and family to identify signs that the older person may be approaching the end of their life. – identifying and managing episodes of acute deterioration that may be reversible. – involving the older person's GP or NP in discussions about diagnosis and prognosis as the older person approaches end of life. • Facilitate access to medication review and rationalisation by a health professional to consider deprescribing or discontinuing and safe administration routes, in discussion with the older person and in alignment with their goals of care. • Plan for anticipatory medicines and implement process for safe use and administration (when required). • Plan and facilitate access to equipment, aids and devices for older people and ensure that workers, health professionals and carers are trained and confident with their use. • Ensure that workers and health professionals have the required knowledge, skills and confidence in recognising older people approaching the end of their life and to perform in their role relative to their scope of clinical care and the setting where care is delivered. **Monitor, review and continuously improve recognition of the end of life** • Collect and analyse data from evaluation, audit and feedback to improve the recognition and response to care at the end of life. • Consider feedback about the experiences of older people, substitute decision-makers, carers and family about how they were supported to prepare for the end-of-life.	**All residential and home care services** build on the systems and processes for person-centred care (Outcome 1.1), assessment and planning (Outcome 3.1) and Comprehensive Care (Outcome 5.4) to recognise and prepare for the end-of-life. In **home care services** the role of the provider is proportionate to the type and complexity of services delivered and the service setting. The needs and capacity of carers and family in supporting the older person approaching the end of life may will need particular consideration.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.7.2 The provider supports the older person, their family, carers and substitute decision maker, to: a) continue end-of-life planning conversations b) discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions c) review advance care planning documents to align with their current needs, goals and preferences.	**Implement processes for end-of-life planning:** • Building on the systems and processes for person-centred care (Outcome 1.1), choice independence and quality of life (Outcome 1.3), assessment and planning (Outcome 3.1) and comprehensive care (Outcome 5.4), providers implement processes for end-of-life planning and decision-making that: – Support the older person to have ongoing, end-of-life planning conversations with workers, health professionals and others aligned with the older person's preferences e.g., substitute-decision maker, carers and family. This may include reviewing or completing advance care planning documents and appointing one or more substitute decision-makers. – Workers and health professionals are trained and supported in engaging in end-of-life conversations that are person-centred. – End of life conversations should elicit the older person's expressed wishes regarding the circumstances, environment and place where they wish to die. – Involve the older person's GP or NP in discussions about diagnosis, prognosis and options to develop a coordinated approach to planning and delivery of end-of-life care. – Provide supported decision-making when an older person has fluctuating capacity. – Engage with the substitute decision-maker when an older person lacks capacity to participate in decision-making. • Policies and processes for advance care planning documents and substitute decision-making align with state or territory legislative requirements and are understood by workers and health professionals. • Identify, store and manage advance care planning documents (including an appointment of a substitute decision maker) to ensure they are readily accessible, while maintaining privacy. • Share current advance care planning documents with relevant parties, particularly at transitions of care, in transfer summaries and with paramedics on transfer to hospital, with the older person's consent. • Support older people to understand the option of uploading advance care planning documents to My Health Record. *Continued on the next page*	Providers in **both residential and home care services** implements person-centred processes and activities for end-of-life planning that are proportionate to the type and complexity of services delivered.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	**Monitor, review and improve process to support older people at the end-of-life** • Monitor performance in implementing a whole-of-organisation approach to incorporating advance care planning into routine practice. This includes advance care planning audits on the receipt, storage and management of advance care planning documents, as well as assessment of how advance care planning documents are reviewed, enacted and shared with health professionals, in line with the older person's preferences. • Analyse feedback data from older people about the quality of end-of-life planning conversations. • Consider the effectiveness of processes for supported decision-making when an older person has limited capacity to make decisions about their own care.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.7.3 The provider uses its processes from comprehensive care, to plan and deliver palliative care that: a) prioritises the comfort and dignity of the older person b) supports the older person's spiritual, cultural, and psychosocial needs c) identifies and manages changes in pain and symptoms d) provides timely access to specialist equipment and medicines for pain and symptom management e) communicates information about the older person's preferences for palliative care and the place where they wish to receive this care to workers, their carers, family and others f) facilitates access to specialist palliative care and end-of-life health professionals when required g) provides a suitable environment for palliative care h) provides information about the process when a person is dying and about loss and bereavement to family and carers.	**Implement systems and processes for comprehensive palliative and end-of-life care** • Provide person-centred, culturally safe, trauma-aware, healing-informed care that aligns with an older person's expressed goals, preferences and wishes (Outcome 1.1) • Provide holistic, comprehensive assessment that prioritises comfort, dignity and effective pain and symptom to prevent and relieve suffering (Outcome 3.1 and 5.4). Comprehensive care at the end-of-life is responsive and adaptable care to fluctuations in clinical needs with periods of deterioration, stabilisation and sometimes improvement. • Revisit the older person's preferences about the people they want to be involved in their care and how they would like them to in involved e.g. substitute decision makers, carers, family and others (Outcome 1.1). • Support early identification of the older person's cultural, spiritual and psychosocial needs which may be as important to them as their physical needs (Outcome 1.1). This may include considerations such as beliefs and practices around the end of an older person's life and dying. • Identify the older person's preferred place to receive palliative care, and their preferred place of death. Strategies and interventions support the older person to remain at home, or their preferred place at the end-of-life. • For Aboriginal and Torres Strait Islander people who wish to die on country, collaborate with community members on these decisions, in line with the person's wishes. • Provide information to family and carers about the dying process, grief, loss and bereavement. • Ensure that workers and health professionals understand their role in providing comprehensive care for older people with palliative care needs and at the end-of-life care and have the knowledge, attitudes and skills to deliver provide high-quality care. • Establish and maintain relationships and referral pathways with the older person's GP and other specialist doctors and nurses, NPs, specialist palliative care services and allied health professionals. Identify and document the health professional that will coordinate end-of-life care for the older person (Outcome 3.3). *Continued on the next page*	Providers in **both residential and home care services** implement processes and activities for comprehensive end-of-life care that are proportionate to the type and complexity of services delivered. Setting specific considerations include: For **residential care services**, processes support equitable access to community and inpatient-based services (that are available to older people living in their own homes), including specialist palliative care services when required. For **home care services**, providers consider a carer assessment (if there is a carer) including their needs, capacities and the sustainability of their role in supporting to the older person.

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
Refer to Actions on the previous page	• Ensure timely identification, monitoring and escalation of a change or deterioration in an older person's health status. • Ensure timely communication with workers, health professionals, substitute-decision makers, carers and family as appropriate and aligned with the older person's preferences. • Facilitate timely access to specialist palliative care and other services when required. • Facilitate timely access to medicines. Medicine reviews include a focus on anticipatory prescribing and deprescribing to optimise symptom control (Outcome 5.3). • Facilitate timely access to specialist equipment for the older person with palliative care needs and at the end-of-life. **Monitor, review and improve** • Analyse clinical data on the effectiveness of the treatment of symptoms, including the use of pain relief. • Review feedback from older people, substitute decision-makers, family, carers and health professionals to improve the effectiveness of processes for comprehensive care at the end-of-life. • Monitor escalation pathways for specialist palliative care and health professionals and improve access barriers.	Refer to Service context considerations on the previous page

Provider organisation (continued)		
Actions	**Associated activities**	**Service context considerations**
5.7.4 The provider implements processes in the last days of life to: a) recognise that the older person is in the last days of life and respond to rapidly changing needs b) ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day c) provide pressure care, oral care, eye care and bowel and bladder care d) recognise and respond to delirium e) minimise unnecessary transfer to hospital, where this is in line with the older person's preferences	**Implement processes for the last days of life** • Building on systems for person-centred, comprehensive end-of-life care (Outcomes 1.1, 5.4 and 5.7) implement processes to: – identify older people who are in the last days of life. This may include using comprehensive assessment triggers and assessment tools. – support person-centred care and shared decision making with the older person for care in the last days of life. This may include decisions about transfer to hospital, stopping interventions that are not beneficial and avoiding futile interventions such as CPR (Outcome 1.1). – focus on maintaining comfort and dignity. Distress, discomfort and the possibility of severe symptoms are anticipated, planned for and managed. – ensure that mechanisms are in place for timely communication with older people, carers, family, substitute decision-makers and escalation health professionals in the last days of life (Outcome 3.4). – monitor, manage and escalate rapidly changing needs and unresolved symptoms for medical review which may involve a specialist palliative care service – address the increased risk of delirium, pressure injury and the requirements for increased oral care, eye care and bowel and bladder care, pressure area care and secretion management – ensure that anticipatory medicines to manage pain and symptoms are available, appropriately prescribed, administered, monitored, reviewed and available 24-hours per day (Outcome 5.3). • Ensure that workers and health professionals are trained, skilled and supported to identify when an older person is in the last days of their life and to provide comprehensive end-of-life care. This includes assessing and responding to symptoms that may have a reversible cause such as delirium. **Monitor, review and improve** • Analyse feedback from substitute decision makers, family and carers of people who received care in the last days of life and use this information to improve systems and processes. • Analyse audit data such as investigations, interventions and transfers of care in the last days of life.	Providers in **both residential and home care services** implement processes and activities for care in the last days of life that are proportionate to the type and complexity of services delivered. For **home care services**, specific considerations include ensuring that an individualised plan for the safe use of medicines to manage pain and symptoms, including anticipatory medicines is in place. The roles and responsibilities of the provider, carer, family, substitute decision-maker and health professionals is documented and understood by those involved. Ensure that a health professional or specialist team with overall accountability for the older person's care is appointed and escalation processes are available 24-hours per day.

What are the key resources that can be referred to?

The following key resources relate to Outcome 5.7:

- [TO BE COMPLETED]

Key legislation relevant to this outcome includes:

- [TO BE COMPLETED]

Other provider obligations include:

- [TO BE COMPLETED]

The content for this page is still under development and will be included in the final versions of the Guidance material.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

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