Strengthened Quality Standards

Provider Guidance

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Australian Government
Aged Care Quality and Safety Commission

Engage
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Safeguard

Disclaimer

The Strengthened Standards guidance supports 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 The draft guidance shows how providers can demonstrate they meet each Standard outcome.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.

Please note that the information about the strengthened Quality Standards in this guidance should be considered draft until the standards are enacted in the Aged Care rules.

Contents

Standard 1: The person

What is the intent?

Quality Standard 1 is the basis for care and service delivery across all Standards. It applies to all registered providers.

Standard 1 underpins the way you and your staff should treat older people. It explains how important it is for you to understand that each older person is unique and has a different life story.

Standard 1 reflects important concepts about:

- dignity and respect
- older person individuality and diversity
- independence
- choice and control
- **culturally safe care***
- **dignity of risk***.

These are all important in fostering a sense of:

- safety
- autonomy
- inclusion
- **quality of life*** for older people.

Older people are valuable members of society, with rich and varied histories, characteristics, identities, interests and life experiences.

Older people can come from a diverse range of backgrounds and groups, including, but not limited to:

- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse (CALD) backgrounds
- people living in rural or remote areas
- people who are financially or socially disadvantaged
- people who are veterans
- people experiencing homelessness or at risk of becoming homeless
- people who are care leavers (a person who spent time in care as a child)

- parents separated from their children by forced adoption or removal
- people who are lesbian, gay, bisexual, transgender or intersex
- people of various religions
- people experiencing **mental health*** problems and **mental illness***
- people living with **cognitive impairment*** including **dementia***
- people living with disability.

A person's **diversity*** does not define who they are, but it is critical that providers recognise and embrace each person's **diversity*** and who they are holistically as a person, and that this drives how providers and workers engage with older people and deliver their care and services.

Outcome 1.1

What is the outcome you need to achieve?

The **provider*** understands that the safety, health, **wellbeing*** and **quality of life*** of older people is the primary consideration in the delivery of care and services.

The **provider*** understands and values the older person, including their:

- identity
- culture
- ability
- **diversity***
- beliefs
- life experiences.

Care and services are developed with, and tailored to, the older person, taking into account their **needs, goals and preferences***.

Why is this outcome important?

Outcome 1.1 explains providers' obligations to deliver **person-centred care*. Outcome 1.1** is relevant to, and supports, all other standards. To meet **Outcome 1.1**, providers and workers need to understand each older person so they can deliver **person-centred care***.

Person-centred care* makes sure the care older people receive is tailored to their individual **needs, goals, and preferences*** by placing them at the centre of all services and decisions made by **provider***s. **Person-centred care*** respects each older person as a unique individual. It makes them central to the planning and delivery of their care. Providers need to partner with older people and understand their needs to deliver **quality care*** and services.

Supporting older people's independence is incorporated in **Outcome 1.1.** It now means more than respecting older people's rights to make decisions about their own care. This outcome focuses on the provider making sure they have **systems*** and **processes*** that support older people, their families and carers to shape how their care and services are delivered. This involvement is essential for **person-centred care***.

Partnerships* and personal relationships are at the centre of **Outcome 1.1**. Partnering with older people means working closely with them to develop and review their **care and services plans***. This makes sure that you deliver care in a way that meets their individual **needs, goals and preferences***. Partnerships help build trust and make sure that care is **person centred***.

Providers need to have **processes*** to support **culturally safe care***. This acknowledges and respects the diverse backgrounds, identities and beliefs of older people. Care and services should be tailored to each older person's cultural, spiritual, religious and social needs. This will help to make sure the care they receive is respectful and meaningful to them. **Diversity*** is a key focus of **Outcome 1.1**. It highlights how important it is to recognise and support individual differences and needs.

A stronger focus on **trauma aware and healing informed*** care, recognises that many older people have experienced trauma at some point in their lives. This can significantly affect their **quality of life*** and **wellbeing***. Being aware of these experiences helps you to provide care that is **trauma aware and healing informed***. **Outcome 1.1** makes sure care and services meet the older person's physical needs and also supports their emotional and psychological wellbeing.

You need to give focus to:

- valuing the individual needs and preferences of older people
- supporting the safety and wellbeing of older people
- creating professional and trusting relationships with older people.

Key tasks:

Put in place strategies that support tailored care for each older person.

Partner with older people when developing and reviewing their **care and service plan*** (**Outcome 3.1**). Include in the plan how your care and services are going to be tailored and safe for the older person. This includes identifying, documenting and accommodating each older person's:

- background
- gender identity, such as gender diverse or transgender
- sexual orientation
- culture and beliefs
- language and communication needs and preferences
- life experiences. It's important to try and understand each older person's life experiences and how this can affect them. A life experience can be a single event at a particular time or a long period in an older person's life. Life experiences can include family, friends, career, meaningful activities and trauma.

Keep in mind an older person's **diversity*** when considering daily activities like food preferences (**Outcome 6.2**) and community-based activities (**Outcome 7.1**). If the older person identifies as Aboriginal and Torres Strait Islander, you need to record this information with their consent (**Outcome 2.7**). If an older person has a diverse background, tailor their **care and services plan*** to make sure that their care and services are respectful and safe:

- spiritually
- socially
- emotionally
- culturally
- physically.

It's important to make sure you respect older people's privacy through this **process*** (**Outcome 1.2**).

Identify if the older person is vulnerable. For example, an older person may be more at risk if they:

- live on their own
- live in rural or remote areas without many service options
- are socially isolated or don't have close relationships
- have few or no family or friends who 'check in' on them
- have **cognitive impairment*** and might have difficulty problem solving or advocating for themselves
- have difficulty communicating or expressing themselves
- are not very mobile
- show **clinical frailty***
- are dependent on their **carer*** or only have one **carer***.

Make sure their **care and services plan*** explains how you will address these circumstances and needs. Do this in partnership with the older person, their family, carers and others involved in their care and services with their permission.

Make sure older people receive **quality care*** and services based on their **care and services plan***. This includes any **clinical care***, **palliative care*** and **end-of-life care*** (**Outcomes 3.2, 5.4** and **5.7**).

Deliver care and services that:

- meet older people's **needs, goals and preferences***. For example, for older people living in a residential care home, make sure food, drinks and the **dining experience*** meet their needs and preferences (**Outcomes 6.2, 6.3** and **6.4**).
- improve people's **quality of life***
- help people to do what they want to do. For example, if an older person wants to go for a daily walk but is finding this difficult because of their health, look at how care and support can help them achieve their goals and move safely. This could include allocating a worker to assist or supervise the older person, providing mobility aids such as a four-wheel walker, or offering a wheelchair for part or all of the walk.
- help older people to get maintain and improve their physical, mental and cognitive function by encouraging them to use their skills and strengths. In some cases where older people have experienced a loss or reduced function, getting function back may not be possible. If this is the case, care and services should help them to maintain their current function. The guidance for **Outcomes 3.1**, **3.2** and **5.4** has more information on how you can support older people's **reablement*** and maintenance of function.
    - meet older people's cultural needs and preferences, are **culturally safe***, responsive and suitable for older people with diverse backgrounds (**Outcome 3.2**)
    - are **trauma aware and healing informed*.** Make sure that workers understand different types of trauma and how this can affect older people. Older people may have past experiences of trauma that aren't included in the **care and services plan*** or that the older person doesn't want to share. The older person may show signs that they have past experiences of trauma. Workers should be aware of these signs and deliver **trauma aware and healing informed care***. Make sure **trauma aware and healing informed care*** is part of your **systems*** and **processes***.
- recognise the rights and autonomy of older people. This includes their right to intimacy, sexual and gender expression.
- are informed by **contemporary, evidence-based practices***
- help older people to develop relationships and social connections. Older people who identify as Aboriginal and Torres Strait Islander may need extra support to stay connected with community, culture and Country. For residential care home providers, the guidance for **Outcome 7.1** has more information on how you can help support older people with their daily living.
- match what you have agreed to with the older person during assessment and planning. They also need to be included in their **care and services plan*** (**Outcome 3.1**).

Partner with older people to deliver **quality care*** and services (**Outcome 2.1**). Make sure they:

- receive **critical information*** about their care and services (**Outcome 3.3**). Find out the older person's language and how they need and prefer to be communicated with. Provide them with information in their language and that meets their communication needs and preferences. Include **critical information*** in care statements.
- receive planned and **coordinated care*** and services (**Outcome 3.4**). This includes where there are multiple health and aged care providers, family and **carers*** involved in delivering care and services, such as during **transitions of care***. This may include hospital-in-the-home arrangements where an older person receives acute care in either their home or residential aged care environment. During **transitions of care***, you are responsible for making sure there is effective communication processes, and the older person receives continuity of care. For residential care home providers, the guidance for **Outcome 7.2** has more information on how you support older people with transitions.

There may be situations where an assessment of an older person's care needs are beyond what you are required to deliver to them under your legislative obligations and registration conditions. You are at all times expected to partner with the older person and health care professionals to support them to access the care and services they need. You should be clear in your communication about what can and cannot be provided as part of your agreement to provide care in line with your legislative obligations.

Make sure workers have the time, support, resources and skills to plan for and deliver safe, quality and person-centred care*.

Provide your workers with guidance and training on how to deliver safe, quality and **person-centred care*** for each older person (**Outcome 2.9**). This needs to be in line with:

- the workers' abilities and qualifications
- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- the workers' **roles and responsibilities***.

Make sure workers understand how to:

- create professional and trusting ongoing relationships with older people
- tailor care and services to each older person's **needs, goals and preferences***
- deliver care that is **culturally safe***, **trauma aware and healing informed***.

The guidance for **Outcome 2.8** and **Outcome 2.9** has more information on workforce planning and worker training.

Monitor how you plan for and deliver care and services to make sure older people's needs, goals and preferences are at the centre all services and decisions you make*.

To check if you're providing tailored care for each older person, you can review:

- each older person's care and service documents. For example, **care and services plan***s and progress notes (**Outcome 3.1**).
- **complaint***s and **feedback*** you've received (**Outcome 2.6**)
- information about **incidents*** and **near misses*** in connection with the delivery of care and services (**Outcome 2.5**).

Look for situations where:

- older people have not felt safe, welcome, included or understood
- you haven't met an older person's communication needs and preferences
- you have delivered care and services in a way that isn't **culturally safe***, **trauma aware or healing informed***
- you or your workers haven't respected or recognised an older person's rights or autonomy.

Also, talk with older people, their families and **carers*** about the care and services they receive. Ask them if there are any services that they're not currently receiving that they would like to. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure***. This means being open about what has gone wrong. Share what went wrong with older people, their family and **carers***.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*** and **open disclosure***.

Outcome 1.2

What is the outcome you need to achieve?

The **provider*** delivers care and services in a way that:

- is free from all forms of discrimination, abuse and neglect
- treats older people with dignity and respect
- respects the personal privacy of older people.

The **provider*** demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld.

Why is this outcome important?

Outcome 1.2 explains providers' obligations to make dignity, respect, and privacy a key part of their care and services. Providers need to make sure they include these values in all aspects of how they deliver care. It's important providers understand the rights of older people, as outlined in the Statement of Rights. **Outcome 1.2** is relevant to, and supports, all other standards. To meet **Outcome 1.2**, providers and workers need to understand each older person so they can deliver **person-centred care***.

Outcome 1.2 focuses on the rights of older people to:

- not be discriminated against, abused or neglected
- maintain their dignity
- protect their privacy.

Supporting these principles makes sure older people are empowered to decide how they receive care. This helps to create a sense of autonomy and control over their lives. Providers need **systems*** and **processes*** that help older people to make informed choices about how their care and services are delivered. These choices respect their preferences, support their wellbeing and protect them from discrimination.

Personal privacy is a key part of **Outcome 1.2**. Care needs to be delivered in a way that respects an older person's privacy and dignity. To help strengthen trust and maintain older people's privacy and dignity, make sure that:

- intimate care is done privately
- you protect older people's personal spaces and belongings.

Making these values a key part of how you deliver care shows that it's important to treat older people as individuals with the right to a private, respectful and dignified life.

Providers need **systems*** and **processes*** that recognise, prevent and respond to discrimination, neglect and abuse. This helps protect older people's rights. Through respectful and **person-centred care***, providers make sure older people are treated with compassion and respect while also protecting their personal privacy.

You need to give focus to:

- recognising and respecting the relationship between older people, their family and carers
- making sure older people have a choice about when and how they receive physical care or treatment
- carrying out intimate care in private.

Key tasks:

Put in place a system* to recognise, respond to and stop abuse and discrimination from happening. This also applies to violence, racism, neglect and exploitation.

Integrate this **system*** with your **systems*** for:

- providing safe and **quality care*** and services (**Outcome 2.3**)
- managing **incidents*** (**Outcome 2.5**)
- managing **feedback*** and **complaints*** (**Outcome 2.6**)
- worker training (**Outcome 2.9**).

Be clear about how your organisation:

- uses **systems*** and **processes*** to stop abuse and discrimination from happening
- identifies cases of abuse, discrimination and neglect
- investigates and addresses these issues, to reduce the risk of them happening again
- monitors and evaluates how effective steps to respond to cases of neglect are
- encourages older people to provide **feedback*** and **complaints*** following your **feedback*** and **complaints*** management **system*** (**Outcome 2.6**).

Make sure workers follow the Code of Conduct for Aged Care. This will help your organisation and workers to:

- support an older person's right to personal choice, dignity and respect
- promote kind, honest and respectful behaviour
- protect older people from harm.

Report any serious matters or situations where older people have been harmed or were at risk of harm by following the Serious Incident Response Scheme (SIRS) process.

Make sure workers get **informed consent*** from the older person or their **substitute decision-maker*** when responding to situations that involve abuse or discrimination (**Outcome 1.3**).

Older people may experience complex family dynamics that workers may become aware of. If complex situations put the older person's safety and **wellbeing*** at risk, they need to:

- escalate these concerns
- follow the organisation's risk, incident and **information management systems*** (**Outcomes 2.4, 2.5** and **2.7**).

Put in place strategies that maintain the personal privacy of older people.

Make sure these strategies:

- meet the older person's **needs, goals and preferences*** (**Outcome 1.1**)
- are part of the organisation's **information management system*** and **clinical information system*** (**Outcomes 2.7** and **5.1**).

Have a **process*** for providing intimate personal care or treatment, such as help showering. During your assessment and planning (**Outcome 3.1**), work out when and how an older person receives intimate personal care or treatment. This needs to be:

- based on the older person's needs and preferences
- done in private and in a sensitive way
- done in a **trauma aware and healing informed*** way (**Outcomes 1.1** and **3.2**)

Where an older person's needs or preferences are different to the organisation's usual approach, document this in the older person's **care and services plan*** (**Outcome 3.1**). For example, if the older person prefers to shower only when a family member is there to help them and this isn't on a regular day. Make sure you follow the older person's **care and services plan*** when delivering care and services (**Outcome 3.2**). This will help to make sure their care is consistent.

Personal privacy also includes the older person's personal space and the things they own.

Make sure workers have the time, support, resources and skills to treat older people with dignity, respect and privacy.

Give workers guidance and training on how to deliver care and services that respect older people's dignity and privacy (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- treat older people with kindness, dignity and respect
- recognise and respect the relationship between older people, their family and **carers***
- respect the privacy of older people. This includes their home and the things they own. It also includes their information and the things they discuss with you during care.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how you plan for and deliver care and services to make sure older people are treated with dignity, respect and privacy.

To check if your organisation and workers are treating older people with dignity, respect and privacy, you can review:

- older people's care and services (**Outcome 3.1**). For example, **care and services plans*** and progress notes.
- **complaint***s and **feedback*** (**Outcome 2.6**)
- information about **incidents*** and **near misses*** (**Outcome 2.5**).

Look for situations where:

- older people haven't been treated with kindness, dignity or respect
- the relationships between older people, their family, and **carers*** haven't been recognised or respected
- the personal privacy of older people hasn't been respected.

Also, talk with older people, their families and **carers*** about the care and services they receive (**Outcome 2.1**). Ask them how workers treat them and their family. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure***. This means being open about what has gone wrong. Share what went wrong with older people, their family and **carers***.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*** and **open disclosure***.

Outcome 1.3

What is the outcome you need to achieve?

Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided **timely***, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise **dignity of risk*** to achieve their goals and maintain independence and **quality of life***.

Why is this outcome important?

Outcome 1.3 explains providers' obligations to support older people in exercising their choices, independence and **quality of life***. **Outcome 1.3** is relevant to, and supports, all other standards. To meet **Outcome 1.3**, providers and workers need to understand each older person so they can deliver **person-centred care***.

Supporting older people's right to make informed choices and decisions about their care and services is key to **Outcome 1.3**. It also helps empower older people to maintain their independence and **quality of life***. Providers should provide information in ways that meet the older person's needs. This can be through:

- accessible formats
- translation services
- extra time to process information.

Providers need to understand each older person's language and communication needs and preferences.

Effective communication supports **dignity of risk*** and helps people to give their **informed consent***. **Outcome 1.3** makes sure providers support older people to take part in activities that improve their independence and **quality of life***.

Dignity of risk* acknowledges that older people have the right to make informed choices and decisions, including decisions involving some risks to achieve their personal goals and maintain their **wellbeing***. This can help providers create a **person-centred*** environment that respects the older person's **needs, goals and preferences***, independence and choices. This in turn improves the older person's **quality of life***. Using **supported decision-making*** helps older people make

complex choices. It makes sure their voices are heard, even when a supported decision maker or **substitute decision-maker*** is involved. **Outcome 1.3** supports older people to make informed decisions and use **substitute decision-makers*** only after all options to support an older person to make decisions are exhausted.

Respecting **informed consent*** helps make sure older people have accurate and relevant information about their care. Before any changes are made to an older person's care, providers need to give older people information about the change. Providers also need to give people time to think about, consult and make a decision based on their needs and preferences. This makes sure older people can be involved in their care and services and supports their dignity and right to personal choice. **Outcome 1.3** shows that it's important to support older people to use advocates and involve family and carers in making decisions, if they want to. Older people's choices should always be considered. This encourages a balanced approach to risk, safety and independence.

You need to give focus to:

- **informed consent***
- supporting older people to make informed choices and decisions about their care and services
- identifying older people who need **supported decision-making***
- using **substitute decision-makers*** only after all options to support an older person to make decisions are exhausted
- making sure older people have access to advocates.

Key tasks:

Put in place a system* to provide information to older people.

Integrate this **system*** with your organisation's:

- **information management system*** and **clinical information system*** (**Outcomes 2.7** and **5.1**)
- communication **system*** (**Outcome 3.3**)
- risk management **system*** (**Outcome 2.4**).

Make sure the **system*** for providing information to older people includes information about how you support them to make informed choices. This includes information about **dignity of risk*** and positive risk-taking. Risks are considered 'positive' if they encourage an older person's independence and improve their **quality of life***.

Make sure the information you give to older people is current and accurate. Make sure you share information in a **timely*** way with older people and others involved in their care and services, including:

- family
- **carers***
- workers
- **health professionals***.

You need to share information in a way that meets each older person's language and communication needs and preferences (**Outcome 1.1**). This may include using:

- simple, plain language and avoiding medical jargon
- inclusive formats to give older people information if they have **communication barriers***, such as using large text or images
- language services. For example, interpreters and translators for older people:
  - from culturally and linguistically diverse (CALD) backgrounds
  - from Aboriginal and Torres Strait Islander backgrounds
  - who are deaf, hard of hearing or deafblind.

Make sure older people understand the information you give them. Give them time to think about the information if they need it. This will help older people, their family and **carers*** to make informed decisions about their care and services.

Put in place a system* to get informed consent* from older people.

You need a **system*** that clearly explains:

- situations where you need to get **informed consent***. You need to get **informed consent*** before an older person receives a **clinical care*** treatment, procedure or other intervention. This includes changes to their care and services. For example, when:
  - there are changes to fees and charges they have agreed to in the past (**Outcome 1.4**)
  - you need to collect use, store, or share older people's information (**Outcomes 2.7, 3.1, 3.3**, **3.4 and 7.2**)
  - you're considering clinical interventions such as **restrictive practices*** or escalating an older person to medical or emergency services (**Outcome 3.2**).
- how to find out if an older person needs help to make decisions. This **system*** needs to explain how the older person can be supported if they need it. This includes access to advocates they want.
- how you support older people to make informed choices and take positive risks
- how you support older people with **dignity of risk*** (**Outcomes 3.2** and **5.4**). This includes risks that may be harmful to them, such as smoking.
- how you explain **dignity of risk*** and how it's understood by the older person, their family and **carers***.
- where older people haven't given you **informed consent***. You need to explain the steps workers should take to understand why and if the organisation can provide more support to help the older person make a decision. Depending on the conversation, document this in your **information management system*** (**Outcome 2.7**).

The guidance for **Outcomes 3.2** and **5.4** has more information on **dignity of risk*** and decision-making.

The guidance for **Outcomes 6.1** and **6.2** has more information on **dignity of risk*** for eating and drinking. This includes **eating and drinking with acknowledged risk (EDAR)***.

Make sure that your systems* for planning and delivering care and services include the right people. This means making sure that you think about all people who the older person wants to be involved in the decision-making process.

When doing assessment and planning, including **comprehensive care*** planning and **advance care planning*** (**Outcome 5.4**), use the **systems*** for planning and delivering care and services to:

- find out if an older person needs support to make decisions. Document this information. Help the older person get the support they need to make, share and take part in decisions that affect their lives. If the older person wants an advocate to support them, help the older person find an advocate.
- identify which family and **carers*** the older person wants to be involved in making decisions. Make sure:
  - all relevant people are involved in future decisions
  - **substitute decision-makers*** are only asked to make health, medical and residential decisions for an older person if they lose their decision-making capacity
  - you keep records.

- find out the older person's **needs, goals and preferences***, so they can take positive risks. This supports the older person's independence and **quality of life***. Make sure that **dignity of risk*** is clearly shared with and understood by older people and those making decisions.
- monitor changes to the older person's **quality of life***. Take steps to manage and resolve any issues. Document this information in the older person's **care and services plan*** and progress notes.

Older people in residential care homes need different processes for assessing, monitoring and supporting their **quality of life*** to people receiving home care. For residential care home providers, the guidance for **Outcome 7.1** has more information on how you can support an older person's independence and **quality of life***.

Systems* for planning and delivering care and services need to be clear on what an organisation defines as a decision. This will depend on the type of care and services you deliver. This helps workers, older people, their family and **carers*** understand when to follow your **process*** for making decisions. For example, when the organisation or workers need to have formal conversations with older people or their **substitute decision-maker*** or both.

The guidance for **Outcomes 3.1** and **5.4** has more information on assessment and planning.

Make sure workers have the time, support, resources and skills to help older people to make decisions about their care and services.

Give workers guidance and training on how to support older people to make decisions about their care and services (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- use the organisation's **systems*** to share information with older people
- get **informed consent*** from the older person
- involve the right people in making decisions
- correctly document each of these steps.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how you deliver care and services to make sure workers help older people to make decisions about their care and services.

Make sure your workers are following your:

- **information management system*** (**Outcome 2.7**)
- **clinical information system*** (**Outcome 5.1**)
- communication **system*** (**Outcome 3.3**).

To check if workers are helping older people to understand their **dignity of risk*** and make decisions, you can review:

- older people's care and services (**Outcome 3.1**). For example, **care and services plan***s and progress notes.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- information about **incidents*** and **near misses*** (**Outcome 2.5**).

Look for situations where workers haven't:

- supported the older person to make informed choices or decisions
- supported the older person with **dignity of risk***
- provided information in a way the older person can view or understand.

Also, talk with older people, their families and **carers*** about the care and services they receive (**Outcome 2.1**). Ask them about how workers have supported them to make choices. Ask them if the information workers have given them has been in a way they can view and understand. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure***. This means being open about what has gone wrong. Share what went wrong with older people, their family and **carers***.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 1.4

What is the outcome you need to achieve?

Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions.

Why is this outcome important?

Outcome 1.4 explains providers' obligations for agreements, charges and invoices. Providers must make sure the information they give older people, their families and carers is clear and easy to understand. This helps them to make informed decisions and maintain their autonomy. Older people have the right to make decisions about their care and services. This includes understanding the fees for these services and any changes a provider makes to an older person's agreements.

Outcome 1.4 makes it clear that providers must get **informed consent*** from older people before making any changes to services, fees or charges. It's important providers give older people enough time to:

- explore their options
- get advice
- understand the consequences of their decisions.

This supports older people's autonomy and can also help them to feel more in control of their care and financial choices.

You need to give focus to**:**

- making sure older people have time to think about their options and get advice before signing an agreement
- getting **informed consent*** from older people before you make any changes to agreed fees and charges
- supporting older people to understand agreements, fees and invoices and make informed decisions.

Key tasks:

Use your communication system* to help older people understand the agreements they are entering into, including the fees and charges for care and services (Outcome 3.3).

Give information about agreements to older people before they enter into any agreements. It can also be before they start receiving care, whichever happens first. For example, give them information about:

- any agreements they will have to sign before receiving care or services
- any situations where a change needs to be made to a current agreement
- the terms and conditions about their rights and responsibilities
- the care and services you will provide
- fees and other charges they need to pay.

Include information about fees and other charges in agreements and invoices.

This information should help the older person make an informed decision about whether to enter into an agreement (**Outcome 1.3**).

Give older people, their family and **carers*** time to understand the information you have given them (**Outcome 1.3**) before they enter into any agreements or start receiving care. In particular:

- make sure workers give older people enough time to consider their options when entering into a new agreement. They also need to do this when the organisation makes changes to the prices, fees and payments.
- give older people time and support to ask for external advice if needed.

Help the older person, their family and **carers*** understand the information you have given them (**Outcome 1.3**). Consider each older person's language and communication needs and preferences (**Outcome 1.1**). For example, use plain language, large text, images, or have a conversation with them directly. Check to see if you need to use interpreters or translators.

Make sure workers check that the older person, their family or **carers*** understand the information they have given them.

The guidance for **Outcome 3.3** has more information on using the communication **system*.**

Put in place a system* to manage prices, fees, invoices and payments.

This **system*** needs to include **processes*** to make sure that:

- the prices, fees and chargeable items specified in agreements and shown on invoices are accurate and transparent. This means invoices need to show the care and services given to the older person. For example, invoices need to be itemised so the older person knows exactly what you're charging them for. Make sure charges follow the older person's agreement.
- you give invoices to older people, or people responsible for paying them, in a **timely*** way
- you give invoices to older people in a format that they can understand clearly. Consider older people's language and communication needs and preferences (**Outcome 1.1**). Make

sure that if they need any other support to understand this information, that you document this in their assessment and planning (**Outcome 3.1**).
- you tell older people and those involved in their care when issues in invoices are found. Make sure you address these in a **timely*** way and where needed, give refunds to older people (**Outcome 3.3**).
- you investigate any issues. Resolve any **system*** issues to stop any overcharging or undercharging from happening again.

Do regular checks to make sure invoices are accurate and any issues with agreements can be found and resolved in a **timely*** way.

Give older people or people responsible for paying invoices ways to give **feedback*** or make **complaints*** if they have been given incorrect charges (**Outcome 2.6**). Don't rely on older people to make **complaints*** about incorrect charges. Instead, have strong **systems*** in place to make sure billing is accurate at all times. These **systems*** should also allow you to monitor **complaints*** and record how you managed them.

Make sure that your system* for getting informed consent* from older people includes situations where fees and charges have changed (Outcome 1.3).

Use the **system*** for getting **informed consent*** when there are changes to:

- an older person's care and services
- fees and charges they have agreed to in the past.

Get **informed consent*** from the older person before making any changes. This is so you can encourage them to choose freely and with **dignity of risk*** (**Outcome 2.1**). This makes sure that you record changes about the older person when making decisions about their care and services. This means you will be able to find records of care or financial changes that may affect the ability of older people or their family to pay the agreed fees.

The guidance for **Outcome 1.3** has more information on **informed consent*** and decision-making**.**

Make sure workers have the time, support, resources and skills to use the systems* for agreements, invoicing and payments.

Give workers guidance and training on how to prepare invoices and agreements that are clear and easy for the older person to understand (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- give older people prices, fees and payments:
  - that are sufficient, accurate and transparent
  - in a **timely*** way
  - in a way they can view and understand.
- give older people enough time to think about their options before making decisions
- let older people know about any changes to fees and charges they have agreed to in the past
- get **informed consent*** from the older person before you make any changes to fees and charges.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor the use of your systems* for agreements, invoicing and payments and how well they work.

Check if your workers are following your **systems*** for agreements, invoicing and payments (**Outcome 2.9**).

To check if workers are supporting older people to understand their agreements, invoicing and payments, you can review:

- older people's care and services (**Outcome 3.1**). For example, **care and services plan***s and progress notes.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- information about **incidents*** (**Outcome 2.5**).

Look for situations where older people have had issues with differences in their:

- agreements
- the care and services they receive
- fees.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if workers have given them information about their agreements and fees in a **timely*** way and in a way they can view and understand. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find issues or ways you can improve though your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure***. This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Standard 2: The organisation

What is the intent?

The intent of Standard 2 is to set out the expectations of the **governing body*** to meet the requirements of the Quality Standards and deliver **quality care*** and services.

The **governing body*** sets the strategic priorities for the organisation and promotes a culture of safety and quality. The **governing body*** is also responsible for driving and monitoring improvements to care and services, informed by engagement with older people, family, carers and workers, and data and information on care quality.

A provider's **governance*** **systems*** and **workforce*** are critical to the delivery of safe, quality, effective and **person-centred care*** for every older person, and continuous care and services improvement. Workers are empowered to do their jobs well.

Outcome 2.1

What is the outcome you need to achieve?

Meaningful and active partnerships with older people inform organisational priorities and **continuous improvement*.**

Why is this outcome important?

Outcome 2.1 explains providers' obligations to make sure their activities are based on their understanding of and meet the needs, preferences and perspectives of older people. This helps tailor care and services to better meet each person's needs.

Outcome 2.1 highlights the active role older people can take in shaping the care and services they receive. In strategic planning activities, you should engage and partner with older people to make use of their strengths and insights. You can do this by encouraging the older person to actively take part in **governance*** and decision-making **processes***. For example, providing opportunities for older people to take part in Consumer Advisory Bodies or other advisory committees can help make sure their voices guide you as you design, plan, deliver and evaluate services. This can help support a culture of partnership and shared responsibility.

Partnering with older people from diverse backgrounds informs organisational priorities and supports **continuous improvement***. This can also help make sure care and services:

- are accessible
- are inclusive
- are **culturally safe***
- meet older people's changing needs.

Outcome 2.1 highlights how important it is to have **systems*** that support **continuous improvement***. They also need to support you to deliver **contemporary, evidence-based practice***. Learning from older people's feedback and bringing their ideas together with strategic and operational decisions can change your care and services to meet the diverse needs of older people. This improves how you deliver care in line with **contemporary, evidence-based practices***.

You need to give focus to:

- partnering directly with a diverse range of older people who use your services, including:
  - Aboriginal and Torres Strait Islander people
  - people from a diverse range of backgrounds
- supporting older people to partner with you on **governance*** and delivering services
- understanding the **diversity*** of older people who use your services. This includes people at higher risk of harm.
- focusing on **continuous improvement***.

Key tasks:

Partner with older people in the governance*, design, evaluation and improvement of quality care* and services.

Partner with a diverse range of older people to understand their needs and preferences. This includes older people who:

- use, or can use, the service
- identify as Aboriginal and Torres Strait Islander
- are culturally and linguistically diverse
- are living with **dementia***
- are living with disability or mental illness
- are veterans or war widows
- are financially or socially disadvantaged
- are homeless or at risk of becoming homeless
- are parents and children who are separated by forced adoption or removal
- are adult survivors of institutional child sexual abuse
- are care leavers, including Forgotten Australians and former child migrants placed in out-of-home care
- are lesbian, gay, bisexual, trans, transgender, intersex or other sexual orientations or are gender diverse or bodily diverse
- are neurodivergent

- are deaf, deafblind, vision impaired or hard of hearing
- live in regional, remote or very remote areas
- are represented by the Consumers and Families Panel (**Outcome 1.1**).

You can do this by:

- talking with older people, their families and carers about their **needs, goals and preferences***
- providing opportunities for older people to take part in your Consumer Advisory Body or other similar committees
- holding forums or **feedback*** sessions
- using surveys
- promoting the use of your complaints and feedback system.

Use the feedback from older people to:

- tailor information to older people's needs and preferences (**Outcome 3.3**). Consider the language and communication needs and preferences of older people (**Outcome 1.1**).
- design and improve the **quality and safety culture*** and quality **system*** (**Outcomes 2.2** and **2.3**)
- design care and services to make sure they:
  - centre around the needs and preferences of older people (**Outcomes 1.1 and 3.1**)
  - are accessible, appropriate and culturally safe for people from diverse backgrounds, including Aboriginal and Torres Strait Islander peoples
  - meet all relevant cultural needs (**Outcome 1.1**)
  - meet the needs of older people living with **dementia***, disability, **mental illness*** or **cognitive impairment***.

You can also talk with relevant community organisations, advocacy services and spiritual and community leaders to support older people with diverse needs. For example, you can connect older people with local services and community groups that are relevant to them.

Support older people to take part in partnerships.

Put in place strategies to support workers to partner with older people. For example, strategies or supports that educate and guide your workers to:

- inform older people about how they can take part in partnerships
- encourage older people to contribute their ideas. For example, if they:
  - are less inclined to speak up
  - live with **dementia***, **mental illness*** or disability
  - are affected by trauma.
- help older people contribute their ideas in a way they feel comfortable with. These can be:
  - one-to-one chats
  - anonymous **feedback*** boxes

- other ways that suit them.

Monitor processes* for partnering with older people and how well they are working.

To check if you're partnering with older people well, you can review:

- older people's care and service documents (**Outcome 3.1**). For example, **care and services plans*** and progress notes. Make sure you include **feedback*** from the older person when you develop their **care and services plan***.
- participation and feedback of older people involved in committees such as your Consumer Advisory Body
- the number and type of actions and improvements that you've made as a result of partnering with older people
- complaints and **feedback*** from older people (**Outcome 2.6**) about:
  - whether the partnering **process*** works for them
  - whether the partnering **process*** is improving **quality care*** and services
- **incident*** information (**Outcome 2.5**).

Also, talk with older people, their families and carers about the care and services they receive. For example, ask them:

- if they feel included in the **governance***, design, evaluation and improvement of care and services
- if they feel that you and others listen to their **feedback***
- if they have any suggestions to improve these **processes***.

These conversations can help you with **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through **system*** reviews and quality assurance.

If you find any issues or ways you can improve through your reviews and quality assurance, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

You will know things are going well if older people say that they are confident that they feel:

- safe to speak up
- feel heard.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.2

What is the outcome you need to achieve?

The **governing body*** leads a culture of safety, inclusion and quality that focuses on **continuous improvement***, embraces **diversity*** and prioritises the safety, health and **wellbeing*** of older people and the **workforce***.

Why is this outcome important?

Outcome 2.2 explains providers' obligations to make sure their **governing body*** involves older people and workers in the strategic and business planning, and **governance*** of care and services. This needs to have a focus on **continuous improvement***.

The **governing body*** must monitor the care and services you provide through regular reviews. These must consider legislative requirements and the wider organisational and operational risks and needs. This helps you to deliver safe and **quality care*** and services. It includes evaluating:

- how effective your care and services are
- the safety and **wellbeing*** of older people and workers.

By considering and understanding older people's needs, preferences and feedback, the **governing body*** can encourage a culture of quality, safety and inclusion. This makes sure older people with specific needs and diverse backgrounds can receive care and services that are accessible, appropriate, inclusive and meet their needs. This supports you to deliver **person-centred care***.

By engaging with workers and reviewing relevant quality and safety data, the **governing body*** can identify areas for improvement. This is important to make sure your strategic and business planning addresses the needs of older people. This includes people with diverse backgrounds, such as:

- people who identify as Aboriginal and Torres Strait Islander
- people from culturally and linguistically diverse backgrounds
- people living with **dementia***.

This helps the **governing body*** to lead a positive culture of **continuous improvement*** and **quality care*** and services that are accessible and appropriate.

You need to give focus to:

- strategic and business planning
- addressing the needs of older people from a diverse range of backgrounds, including:
  - Aboriginal and Torres Strait Islander people
  - people from culturally and linguistically diverse backgrounds

- people living with **dementia***.

Key tasks:

Report concerns about the organisation's culture of quality care* and services.

Governing bodies of organisations have members with diverse skills, backgrounds and experience and are a useful source of information and knowledge which can be used to seek advice. **Regularly*** reporting quality performance information and performance monitoring (**Outcome 2.3**) to the **governing body*** will enable you to leverage their knowledge and expertise in a timely manner.

Gather and report information about your **quality and safety culture*** (**Outcome 2.3**) to your **governing body***. This information can come from:

- **feedback*** from older people, their families, carers, representatives and workers (**Outcome 2.6**). This can also include **feedback*** from Consumer Advisory Bodies.
- older people's care and service documents (**Outcome 3.1**)
- results from evaluating workers' performance and how well they're using the quality **system*** (**Outcome 2.9**).

Review this information to encourage **continuous improvement***.

Make sure workers follow the **Code of Conduct for Aged Care**. This will help your organisation and workers to:

- promote a safe and inclusive environment
- protect older people from harm.

Report any serious issues or situations where older people have been harmed or were at risk of harm by following the Serious Incident Response Scheme (SIRS) **process***. For example, situations such as negligence need to be:

- communicated to the relevant Consumer Advisory Bodies
- reported to the **governing body***.

Talk with workers to find out their needs for safety, health and **wellbeing***. Encourage and monitor the safety, health and **wellbeing*** of your workers. Do this by following the governing body's strategic and business plan. For example, identify instances where you haven't met workforce health and safety needs. This can include one-off occurrences or organisation-wide issues. Report this to the **governing body***.

The guidance for **Outcome 2.8** has more information on supporting and maintaining a satisfied and **psychologically safe*** workforce.

Resolve issues in a **timely*** way by using the **processes*** in your:

- **incident management* system*** (**Outcome 2.5**)
- risk management **system*** (**Outcome 2.4**)
- **feedback*** and **complaints*** management **system*** (**Outcome 2.6**).

Outcome 2.3

What is the outcome you need to achieve?

The **governing body*** is accountable for the delivery of **quality care*** and services and maintains oversight of all aspects of the organisation's operations.

The **provider***'s quality **system*** enables and drives **continuous improvement*** of the care and services.

Current **policies*** and **procedures*** guide the way workers undertake their roles.

Why is this outcome important?

Outcome 2.3 explains providers' obligations to have a quality **system*** that supports you to deliver **quality care*** and services to older people. The **governing body*** is accountable for the delivery of **quality care*** and services. This is informed and supported by an effective quality **system***. The governing body's oversight supports providers with **continuous improvement*** and making sure you meet your outcomes.

Outcome 2.3 highlights how important practising **open disclosure*** and being accountable are. **Open disclosure*** involves honest communication with older people, their families and carers about any issues or mistakes that have happened. It's important for providers to acknowledge when things go wrong and put in place strategies to stop them from happening again.

You also need to monitor how effective your **systems*** are. This includes evaluating care and service delivery outcomes to make sure they follow **contemporary, evidence-based practice*.** By **regularly*** monitoring and reporting Quality Indicator data and the outcomes of how you deliver services, you can identify where you can improve. You can then make changes to improve the quality of your care and services. This helps support an open and trusting organisation.

Outcome 2.3 highlights the need to make sure you clearly define workers' **roles and responsibilities*** in your organisation's **policies*** and **procedures*.** This is to guide practice and can help to encourage consistency and safety across all care and services you provide. Workers should

understand and be able to access **policies*** and **procedures*** based on **contemporary, evidence-based practice*.**

You need to give focus to**:**

- having a quality **system***
- monitoring investments in priority areas to improve outcomes for older people
- **regularly*** reporting on the quality **system*** and its performance to older people, families, carers and workers.

Key tasks:

Put in place a quality system* that supports you to deliver safe and quality care* and services.

Make sure this **system*** supports safe and **quality care*** and services that centres around older people's needs.

Put in place a quality **system*** that explains:

- who's accountable and responsible for specific tasks
- 'what good looks like' for your organisation and range of services. This includes identifying key performance indicators (**Outcome 2.8**)
- how you will monitor performance in line with what the **governing body*** expects
- how you will monitor quality to make sure you achieve outcomes of the Quality Standards
- how you will report the results of monitoring activities in a way that supports you with **continuous improvement*** and practising **open disclosure***. This includes how you will share this information with older people and your **governing body***.

Where relevant, use your quality **system*** to make sure:

- you deliver safe and **quality care*** and services to older people. This means care that is **person-centred***, **culturally safe***, **trauma aware and healing informed*** (**Outcome 1.1**). Provide this in line with the organisational **governance*** and quality **system*** frameworks.
- you give older people current, accurate and **timely*** information about their care and services. Make sure this information is easy to understand and supports the older person to make informed decisions (**Outcome 1.3**).
- older people give **informed consent*** when you need it. For example, before a treatment, procedure or intervention (**Outcome 1.3**)
- prices, fees and payments are accurate and transparent for older people (**Outcome 1.4**)
- you support older people to take part in **partnership*** activities (**Outcome 2.1**)
- workers have the necessary skills, qualifications and competencies to perform their role (**Outcome 2.9**)
- your care and services assessment and planning **processes*** are working (**Outcome 3.1** and **Outcome 5.4**)

- your **processes*** to coordinate care and services are working (**Outcome 3.4**)
- older people receive care and services in a physical environment that is safe and supports their needs (**Outcomes 4.1** and **4.1b**).

You should also use your quality **system*** to:

- recognise, stop and respond to discrimination, abuse and neglect (**Outcome 1.2**)
- manage organisational risk (**Outcome 2.4**)
- record, investigate, respond to and manage incidents and near misses that happen while delivering care and services (**Outcome 2.5**)
- receive, record, respond to and report on **feedback*** and complaints. Use this to support you with **continuous improvement*** (**Outcome 2.6**).
- analyse risks and their causes
- securely manage records (**Outcome 2.7**)
- put in place **workforce*** planning strategies (**Outcome 2.8**)
- care for older people living with **dementia*** (**Outcome 3.2**)
- communicate structured information about older people and their care and services (**Outcome 3.3**)
- prevent and control **infection*** (**Outcomes 4.2** and **5.2**)
- support the appropriate use of personal protective equipment (**Outcome 4.2**)
- put in place the **clinical governance*** framework to drive the safety and quality of care and services (**Outcome 5.1**)
- integrate clinical information into nationally agreed electronic health and aged care digital records (**Outcome 5.1**)
  - For regional and remote providers, limited access to internet and infrastructure may affect digital maturity. These providers should consider strategies to make sure they're working towards putting in place a **digital clinical information system***.
- support the safe and quality use of medicines (**Outcome 5.3**)
- monitor and continue to improve the food service (**Outcome 6.1**)
- have services and supports for daily living that improve the **quality of life*** of older people (**Outcome 7.1**)
- transition older people to and from hospital, other care services and stays in the community (**Outcomes 7.2** and **3.4**)
- measure against Quality Indicator data.

Use your quality system* to report quality performance information.

Report quality information to the **governing body***. Also report this information to older people, their families and carers.

Make sure you write and distribute reports in line with the **governing body***'s expectations and directions. This also includes monitoring the performance of any subcontracted providers.

Make sure reports clearly explain the results from performance monitoring, including where:

- things have gone well
- things have not gone well
- you will make changes to make sure similar situations don't happen again.

When things go wrong, you need to practise **open disclosure*** (**Outcome 2.3**). This means you should:

- be open about what's gone wrong
- acknowledge that something has gone wrong and the affect it has had on the older person receiving care
- apologise for what has gone wrong
- put in place strategies in partnership with older people to mitigate the risk of things going wrong again
- monitor and evaluate strategies to mitigate risk
- share this information with older people, their family and carers.

Use this information to develop strategies to stop things going wrong again. You should include **processes*** to investigate what has gone wrong in your organisation's **clinical governance*** framework (**Outcome 5.1**).

Put in place strategies to help workers use the quality system*.

Put in place **policies*** and **procedures*** that support the use of your quality **system***. Make sure these are:

- current and informed by the latest **contemporary, evidence-based practices***
- **regularly*** reviewed
- clear and accessible for workers and relevant people.

Provide workers with guidance and training on how to use the quality **system***. This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand:

- their role in the quality **system***
- how to use the **system*** to tailor and improve care and services for older people.

The guidance for **Outcomes 2.8** and **2.9** has more information about **workforce*** planning and human resource management.

Monitor how well you use your quality system*.

Regularly* review your quality **system*** to make sure it works well. Look for ways to improve the **system***.

To check if your quality **system*** works well, you can review:

- older people's care and service documents (**Outcome 3.1**)**.** For example, **care and services plan***s and progress notes. This makes sure care and services meet the needs and preferences of the older person.
- **complaint***s and **feedback*** (**Outcome 2.6**)
- risk and **incident*** information (**Outcomes 2.4** and **2.5**)
- Quality Indicator data
- **worker*** performance and how well they're using the quality **system***. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).
- **policies*** and **procedures***.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). For example, ask the older person if any issues they've raised have been recognised and addressed. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Analyse the service's quality data to:

- identify organisation-wide issues that need resolving. To help with this, it's useful to compare actual performance against expected practice. If actual performance falls short of planning targets, you may need to act. This may include asking for additional investment from the **governing body***.
- identify and resolve any issues that aren't organisation-wide. For example, if a particular **worker*** or older person needs more targeted support.

If you find any issues or ways you can improve your **quality and safety culture***, you need to report them. This way, issues are addressed promptly. Report this information to the **governing body*** and the Quality Advisory Committee.

Outcome 2.4

What is the outcome you need to achieve?

The **provider*** uses a risk management **system*** to identify, manage and continuously review risks to older people, workers and the **provider***'s operations.

Why is this outcome important?

Outcome 2.4 explains providers' obligations to manage and respond to risk. You're responsible for having a **risk management system*** to identify, assess, document and mitigate risks. This supports the safety and **wellbeing*** of older people, workers and the organisation.

A provider's **risk management system*** should focus on risks to:

- older people
- workers
- operations
- emergency situations.

This involves clearly defining the **roles and responsibilities*** of those involved in managing risk and having strategies to identify, assess, manage and **regularly*** review these risks. **Regularly*** analysing risk data and engaging with older people and workers supports you to identify organisation-wide issues and trends. You can then base your risk assessment and management **processes*** on this. By addressing risks before they lead to harm, you can support your overall quality **system*** and drive **continuous improvement***. This helps you to make sure you deliver safe care and services.

You need to give focus to:

- using an effective **system*** for managing risk. This needs to include strategies and actions to mitigate risk.
- analysing data to understand risk
- engaging with older people and workers to inform you to assess and manage risk and the quality **system***.

Key tasks:

Put in place a risk management system*.

At a minimum, make sure your risk management **system*** has clear and documented **processes*** and **roles and responsibilities*** on:

- managing risks to:
  - older people
  - workers
  - your operations
  - business continuity
  - emergency and disaster management (**Outcome 2.10**)
  - emerging infectious diseases (**Outcome 4.2**)

  - your information management **system*** (**Outcome 2.7**) including data and digital records, such as cyber security risks.
- how to:
  - identify risks
  - assess risks
  - document risks
  - manage risks
  - review risks.
- the strategies to manage the risks you identify. Include how you:
  - prevent risks
  - control risks
  - minimise risks
  - eliminate risks.

Use your risk management system* to identify, manage and review risks.

Have clear **processes*** to:

- identify and escalate risks. Escalate new risks straight away as you identify them. You should use your broader performance monitoring to inform this (**Outcome 2.3**). In particular, reviews of **feedback*** and business data such as incidents and near misses. The risk management **system*** needs to encourage you to report and escalate issues. This makes sure you can deal with key risks promptly. This may mean you need to escalate certain risks to the **governing body***. Risks found through this **process*** include any risks that can harm the organisation and its people. For example, risks to safety, older people, finances and reputation.
- assess risks. Once you identify risks, do a 'risk assessment' to check if there's a chance of a negative **outcome*** and how severe that outcome would be. Document the risk assessment and use it to see if you can do an activity or take more actions to minimise the risk. You can also use a risk assessment to prioritise actions. In some cases, you may need a more detailed risk assessment. For example, an older person who is receiving home care services will need a risk assessment of their home environment when they start to have services in their home. You should also do this risk assessment **regularly*** to help identify possible risks to the older person or workers in the home (**Outcome 4.1a**).
- manage risks. Allocate actions and resources to minimise risks. Act to eliminate risks where possible. Use ways to control and minimise risks if you can't eliminate them. Act to stop risks from happening again. This is particularly important if the risk is 'high'. Actions may be related to key business goals, like workforce planning (**Outcome 2.8**). They could also relate to outcomes of the Quality Standards (**Outcomes 5.4, 5.6** and **4.2**). For example, using personal protective equipment to reduce the spread of an **infection***.
- monitor risks. Gather and analyse data to make sure you continue to prevent or minimise risk as much as possible. Identify and address organisation-wide issues (**Outcome 2.3**).

Have at least one organisation-wide risk register and periodically review it for new and emerging risks and those already identified for any change in circumstances. If the organisation has multiple

sites and locations, you may need a risk register for each one. You may also need to complete a separate assessment for high-risk activities.

Put in place strategies to help workers manage risk well.

Put in place **policies*** and **procedures*** that support you to use your risk management **system***. Make sure these are:

- current and informed by the latest **contemporary, evidence-based practices***
- **regularly*** reviewed
- clear and accessible for workers and relevant people.

Provide workers with guidance and training on how to use the risk management **system*** (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- workers' **roles and responsibilities***.

Make sure workers understand:

- their role in the risk management **system***
- how to use the **system*** to manage risks when delivering care and services to older people. For example, how to report a risk.

The guidance for **Outcomes 2.8** and **2.9** has more information about **workforce*** planning and human resource management.

Monitor how well you use the risk management system*.

Regularly* review your risk management **system*** to make sure it works well. Look for ways to improve the **system***.

To check if your risk management **system*** works well, you can review:

- older people's care and service documents (**Outcome 3.1**)
- complaints and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**)
- **worker*** performance and how well they're using the risk management **system***. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).
- **policies*** and **procedures***.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if they feel their provider engages with them to identify, manage and review their risks. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, be open about it. Share what went wrong with older people, their family and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance on **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.5

What is the outcome you need to achieve?

The **provider*** uses an **incident management*** **system*** to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.

Why is this outcome important?

Outcome 2.5 explains providers' obligations to manage and respond to **incidents*** well. You're responsible for having an **incident management*** **system*** to identify, document, respond to and manage incidents. This includes making sure responses to incidents and **near misses*** are **timely***. This is important to safeguard the health and **wellbeing*** of older people. This also helps to create an environment that encourages accountability, transparency, trust and safety.

By collecting, analysing and integrating incident data in your **quality system***, you can identify organisation-wide issues and trends. This can help you to learn from incidents, strengthen your strategies to mitigate risk and improve the safety of care and services you provide. Managing incidents in this way supports your overall **quality system*** and drives **continuous improvement*.**

You need to give focus to:

- supporting and encouraging older people and workers to:
  - report incidents
  - identify ways to stop incidents from happening
- **incident management*** responsibilities for workers.

Key tasks:

Put in place an incident management* system*.

At a minimum, make sure your **incident management*** **system*** outlines:

- clear and documented **processes***, **roles and responsibilities*** on how you:

  - acknowledge **incidents***
  - record incidents
  - assess and investigate incidents
  - respond to incidents
  - manage incidents
  - resolve incidents
  - learn from incidents, to prevent or reduce future incidents from happening again.
- categories to define an **incident***. Be clear about what an '**incident***' or '**near miss***' includes. This definition needs to be clear about what an incident is in the context of the organisation's scope of services. Include situations that have, or could, cause harm to a person. The categories need to be in line with the Serious Incident Response Scheme (SIRS). They also need to include harm or possible harm to:
  - an older person
  - a member of their family
  - a **worker***
  - another person providing care and services.

Incidents can be clinical or non-clinical. Incidents can also relate to **worker*** safety.

Use your incident management* system* to report and respond to incidents.

Have clear **processes*** to respond to each type of **incident*** that can happen when you deliver care and services. Outline who needs to be involved and the timeframe when you need to carry out key activities. Key activities can include reporting, investigations and sharing information.

Incidents that you need to report include **near misses***, as well as incidents that:

- have happened
- are alleged or suspected, even if you can't confirm the **incident***.

Serious incidents must be reported following the Serious Incident Response Scheme (SIRS) process. These are incidents where older people have been harmed or were at risk of harm.

Have clear **processes*** to record and report different types of incidents. Include:

- who reports incidents
- how to document an **incident*** report
- what level of detail to put into an **incident*** report
- how to submit the **incident*** report
- how long you have to submit an **incident*** report.

After an **incident***:

- be clear who is responsible for deciding on immediate actions to keep older people and workers safe

- review an older person's **care and services plan*** if an incident involves them (**Outcomes 3.1** and **5.4**)
- investigate the cause of an **incident***. Make sure incidents are investigated. This is to find and manage the underlying cause of an **incident*** and prevent it from happening again. Be open about the **outcome*** of the investigation. Share this with the older person, their families and carers if the older person chooses to.
- look for trends to find organisation-wide issues and ways to improve. Do this as part of your broader performance monitoring activities (**Outcome 2.3**). For example, an organisation-wide issue could be:
    - aspects of care which aren't delivered well. These may suggest that your organisation needs additional **worker*** training.
    - older people **regularly*** fall in a particular spot at the service delivery location and you need to redesign the area to be safer.
- use your **incident management*** **system*** to monitor and review the strategies you have to manage the cause of the incident and the risk of it happening again.

If you receive a **complaint*** after an **incident*** or **near miss***, integrate this information with your **feedback*** and **complaints*** management **system*** (**Outcome 2.6**).

Have an **incident*** reporting form and **incident*** register. Record key information about each **incident*** that has happened.

Put in place strategies to help workers manage incidents well.

Put in place **policies*** and **procedures*** that support you to use your **incident management*** **system***. Make sure these are:

- current and informed by the latest **contemporary, evidence-based practices***
- **regularly*** reviewed
- clear and accessible for workers and relevant people.

Provide workers with guidance and training on how to use the **incident management*** **system*** (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- workers' **roles and responsibilities***.

Make sure workers understand:

- their role in the **incident management*** **system***
- how to use the **system*** to manage incidents when delivering care and services to older people.

The guidance for **Outcomes 2.8** and **2.9** has more information on **workforce*** planning and human resource management.

Monitor how well you use the incident* management system*.

Regularly* review your **incident*** management **system*** to make sure it works well. Look for ways to improve the **system***.

To check if your **incident*** management system works well, you can review:

- older people's care and service documents (**Outcome 3.1**)
- **complaint***s and **feedback*** (**Outcome 2.6**)
- information about **incidents***
- **worker*** performance and how well they're using the **incident management*** **system***. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).
- **policies*** and **procedures***.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if they feel their provider supports them to report incidents and involves them in finding ways to reduce incidents. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, be open about it. Share what went wrong with older people, their family, and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.6

What is the outcome you need to achieve?

Older people, workers and others are encouraged and supported to provide **feedback*** and make complaints about care and services, without reprisal. **Feedback*** and complaints are acknowledged, managed transparently and contribute to the **continuous improvement*** of care and services.

Why is this outcome important?

Outcome 2.6 explains providers' obligations to acknowledge, manage and respond to **feedback*** and **complaints***. A strong feedback and complaints management **system*** is important for addressing issues that come up in the delivery of care and services in a **timely*** way. By

encouraging older people, workers and others to share their **feedback*** and make **complaints*** without fear of reprisal, you can support an environment of confidence and trust.

Outcome 2.6 highlights how important **continuous improvement*** is. By thoroughly recording, investigating, and learning from **feedback*** and **complaints***, you can mitigate the risk of issues happening again and improve the quality of care and services. This can also help you to identify and address areas to improve. **Regularly*** collecting and analysing **feedback*** and **complaints*** data helps you to identify organisation-wide issues and make sure you quickly address any patterns or trends. This informs how you manage **feedback***, **complaints*** and your overall quality **system***. This also supports a culture of **continuous improvement***.

You need to give focus to:

- reporting outcomes from **feedback*** and **complaints*** to older people, workers and the **governing body***
- monitoring and evaluating the **complaints*** resolution **process*** to see if it's working.

Key tasks:

Put in place a feedback* and complaints* management system*.

Make sure your **feedback*** and **complaints*** management **system*** outlines:

- clear and documented **processes***, roles and **responsibilities*** on how **feedback*** and **complaints*** are:
  - received
  - registered and acknowledged
  - recorded
  - investigated
  - responded to
  - managed
  - resolved
  - learnt from to improve care and services.
- how to encourage and support older people and workers to provide **feedback*** and make **complaints***. For example, by providing access to language services and advocates.
- how you keep **feedback*** and **complaints*** confidential. This needs to be in line with your **information management system*** (**Outcome 2.7**). Make sure:
  - older people or workers do not face retribution because they give **feedback*** or raise a **complaint***
  - you make efforts to reduce administrative burden
  - you resolve all **feedback*** and **complaints***
  - you identify any patterns or trends.
- how stakeholders can:
  - escalate **feedback*** and **complaints***. This is so that you can deal with **feedback*** in a **timely*** way.

  - access information about external **complaint***s and **feedback*** mechanisms, including the Serious Incident Response Scheme (SIRS)
  - provide positive **feedback***. This can encourage and strengthen good practices they observe.
- what **feedback*** or **complaints*** workers need to record. Make sure the system describes any situations where you don't need to record **feedback***. For example, if the older person chooses not to have the feedback recorded.
- any **feedback*** or **complaints*** that you need to respond to. Include:
  - who you should involve in this **process***
  - timeframes
  - situations where you need an investigation, such as after an **incident*** or **near miss*** (**Outcome 2.5**).
- how you discuss and resolve **complaints***. You should do this in consultation with the person who made the **complaint***. Communicate with older people in a way that meets their needs and preferences. Consider their:
  - spoken language
  - culture
  - medical conditions, including cognitive ability
  - needs and preferences (**Outcomes 1.1** and **3.3**).
- how you analyse and resolve **complaints*** and **feedback***. Focus on identifying any trends or organisation-wide issues during performance monitoring. For example, aspects of care which aren't delivered well may suggest that your organisation needs additional **worker*** training (**Outcome 2.3**).

The **feedback*** and **complaints*** management **system*** should also provide guidance and information on how to practise **open disclosure*** (**Outcome 2.3**) when things go wrong.

Use your feedback* and complaints* management system* to manage and respond to feedback and complaints.

Have mechanisms to provide **feedback*** and **complaint***s that work well for older people, their family, carers and workers. Consider the language and communication needs and preferences of older people (**Outcome 1.1**). These can include:

- the **process*** to escalate **complaints***
- **feedback*** forms
- the Serious Incident Response Scheme (SIRS) **process***
- through a Consumer Advisory Body.

If you find issues or ways you can improve through this process, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

Look for trends to find organisation-wide issues and ways for the service to improve. Do this as part of your broader performance monitoring activities (**Outcome 2.3**).

Have a **feedback*** register to monitor **feedback*** and **complaints***.

Put in place strategies to help workers use the feedback* and complaint*s management system* well.

Put in place **policies*** and **procedures*** that support and encourage using your **feedback*** and **complaint***s **system***. Make sure these are:

- current and informed by the latest **contemporary, evidence-based practices***
- **regularly*** reviewed
- clear and accessible for workers and relevant people (**Outcome 2.7**).

Provide workers with guidance and training on how to use the **feedback*** and **complaints*** management **system***. This needs to be in line with:

- the organisation's **policies*** and **procedures***
- worker's **roles and responsibilities***.

Make sure workers understand:

- their role in the **feedback*** and **complaints*** management **system***
- how to use the **system*** to manage **feedback*** and **complaints*** you receive when delivering care and services to older people.

The guidance for **Outcomes 2.8** and **2.9** has more information on **workforce*** planning and human resource management.

Monitor how well you use the feedback* and complaint*s management system*.

Regularly* review your feedback and **complaints*** management **system*** to make sure it works well. Look for ways to improve the **system***.

To check if you're managing **feedback*** and **complaints*** well, you can review:

- older people's care and service documents (**Outcome 3.1**)
- complaints and **feedback** *
- **incident*** information (**Outcome 2.5**)
- **worker*** performance and how well they're using the **feedback*** and **complaints*** management **system***. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).

- feedback meeting minutes and records

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). For example, ask them if they know about the ways they can make a **complaint*** or give **feedback*** on their care and services. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

You will know things are going well if older people say that they are confident that:

- their complaints had been closed out appropriately in a timely manner
- they feel heard.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.7

What is the outcome you need to achieve?

Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it. The information of older people is confidential and managed appropriately, in line with their **informed consent***.

Why is this outcome important?

Outcome 2.7 explains providers' obligations to have an **information management system*** to safely manage the information of older people with their **informed consent*.** This outcome explains the need to make sure information is:

- confidential
- secure
- able to be identified
- current
- accurate
- integrates information from different sources.

Timely* access to the right information at the right time supports workers to deliver **quality care*** and services tailored to the older person's needs. Information stored in this **system*** must be clear and easy to understand, enabling efficient access for workers. **Outcome 2.7** also highlights how you need to **regularly*** review and improve how effective the **information management system*** is. This includes current technologies and data practices. This informs the overall quality **system*** and drives **continuous improvement*** in how you deliver care and services.

You need to give focus to:

- access to information
- making sure information is accurate and complete
- reviewing and improving the **information management system***.

Key tasks:

Put in place an information management system* to manage records.

Put in place a **system*** for managing information, including the **clinical information system*** (**Outcome 5.1**), that:

- gives workers and others such as visiting health professionals, agency workers and contractors access to the right information at the right time
- enables older people to access the information they need to receive **quality care*** and services
- makes sure stored information is accurate and complete. This also applies to information that's shared between services that provide support to the older person such as **telehealth*** services.
- makes sure that you get **informed consent*** (**Outcome 1.3**) to collect, use and store older people's information. You also need **informed consent*** to disclose older people's information with other people or organisations. This includes assessment information. If an older person withdraws their consent, record and communicate this.
- integrates information from different sources where needed, such as information from hospitals.
- manages cyber security risks (**Outcome 2.4**)
- has enough data storage for the records you need to keep.

The **information management system***, including the **clinical information system***, should be digital where possible. This will be specific to each **provider***. There should always be ways to access critical information when digital systems are offline. For example, you can:

- put in place processes to make information available offline
- put in place processes to record clinical information on paper during internet or power outages.

Use your information management system* to record information.

Use the **information management system*** to make sure you securely manage any records at the service. Use the **information management system*** during **processes***, **systems*** and strategies to do with:

- choice, independence and **quality of life*** (**Outcome 1.3**) and transparency and agreements (**Outcome 1.4**). Make sure information about the older person's care, services, and agreements and care commencing (whichever comes first) is:
  - is current, accurate, **timely*** and easy to understand
  - supports the older person to make informed decisions
  - is accessible by workers
  - helps workers to partner with older people to make informed decisions based on accurate and **timely*** information.
- human resource management (**Outcome 2.9**). Store information from possible candidates and existing workers accurately against their profile.
- assessment and planning (**Outcome 3.1**). Each older person's **care and services plan*** needs to include information about the risks associated with the delivery of care and services. It also needs to include how workers can support older people to manage these risks (**Outcome 2.4**). Make sure you securely store information from assessment and planning and risks and use it to inform the **systems*** for:
  - **comprehensive care*** (**Outcome 5.4**)
  - safe and quality use of medicines (**Outcome 5.3**) and **antimicrobial stewardship*** (**Outcome 5.2**)
  - clinical safety (**Outcome 5.5**)
  - infection prevention and control in the environment (**Outcome 4.2**) and when you deliver clinical care (**Outcome 5.2**)
  - **palliative care*** and **end-of-life care*** (**Outcome 5.7**)
  - food, drink and the **dining experience*** (**Outcomes 6.1**, **6.2** and **6.4**).

Put in place a **clinical information system***. This should be digital if possible. Use it to record and manage older people's clinical information. For example, transitions of care (**Outcome 3.4**), assessment and planning (**Outcome 3.1**) and **medication management*** (**Outcome 5.3**). This will help you to deliver safe and **quality care*** and services. Where possible, the **clinical information system*** should also record Quality Indicator data. The guidance for **Outcome 5.1** has more information on the **clinical governance*** framework.

Workers need to monitor and record each older person's preferences, function and changes during **activities of daily living***. For residential care providers, the guidance for **Outcome 7.1** has more information on supporting older people with **activities of daily living***.

During **transitions of care***, make sure you give the family, carers, **health professionals*** or organisations that are involved the older person's care **timely***, current and accurate information about them. Make sure you provide this information with the older person's **informed consent***. The guidance for **Outcome 3.4** has more information on coordinating care and services. For residential care home providers, the guidance for **Outcome 7.2** has more information on transitions.

For home care providers, information about the older person's care, such as nutritional needs or activities of **daily living***, can be stored in the clinical sections of your database. This doesn't need to be a dedicated **clinical information system***. Make sure information about a person's safe delivery of care and services is assessed and those involved in their care can access it. This includes contractors.

Put in place strategies to help workers to use the information management system* well.

Make sure all workers and others involved in a person's care can access your **information management system*.** Make sure their access to your **system*** is appropriate to their role. This includes any **system*** workers or others, such as Commission Quality Auditors, use. This also includes any **policies*** and **procedures***. Check with workers and others that they can access the **information management system***. If they can't, make sure you give them access.

Make sure **policies*** and **procedures*** support people to use your **information management system***. Make sure these are:

- current and informed by the latest **contemporary evidence-based practices***
- **regularly*** reviewed
- clear and accessible for workers and others involved in care and services.

Provide workers with guidance and training on how to use the **information management system*** (**Outcome 2.9**). This includes training to support digital skills if needed. This needs to be in line with:

- the organisation's **policies*** and **procedures***
- workers' **roles and responsibilities***.

Make sure workers understand:

- their role in the **information management system***
- how to use the **system*** to safely manage information about older people and their care and services.

The guidance for **Outcomes 2.8** and **2.9** has more information on **workforce*** planning and human resource management.

Monitor how well you use the information management system*.

Regularly* review your **information management system*** to make sure it works well. Look for ways to improve the **system***.

To check if you're managing information well, you can review:

- older people's **care and service plans*** (**Outcome 3.1**)
- complaints and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**)
- **worker*** performance and how well they're using the information management **system***. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).

- **policies*** and **procedures***.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, be open about it. Share what went wrong with older people, their family, and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.8

What is the outcome you need to achieve?

The **provider*** understands and manages its **workforce*** needs and plans for the future.

Why is this outcome important?

Outcome 2.8 explains providers' obligations to have a **workforce*** strategy that makes sure there are enough qualified workers with the right skills to deliver quality and safe care and services. Providers must assess the skills, qualifications and competencies workers need to perform their role and meet older people's needs. You also need to have strategies to be ready for possible workforce shortages, absences or vacancies. Your **workforce*** strategy should include information about your:

- **workforce***
- specific working needs
- plans for the future.

This can help you to mitigate risks and make sure you provide continuity of care and services. It also helps you maintain the best mix of skilled workers.

Outcome 2.8 highlights how important **psychological safety*** is to create a satisfied and engaged **workforce***. A healthy workplace culture where workers feel safe to raise concerns, can help providers reduce staff turnover and improve workforce retention. It's important for providers to identify worker risks, both psychological and physical. Addressing these risks can help workers to feel **psychologically safe*** and supported to perform their role and deliver **quality care*** and services.

You need to give focus to:

- putting in place a **workforce*** strategy
- supporting and maintaining a satisfied and **psychologically safe*** **workforce***.

Key tasks:

Put in place a workforce* strategy.

To develop an effective **workforce*** strategy, make sure you understand and assess the needs of older people receiving care and the business. This will help you make sure there are enough workers and a good mix of qualified workers to provide safe and **quality care*** and services.

Make sure your **workforce*** strategy includes **processes*** to:

- identify the skills, qualifications and competencies your workers need to deliver safe and **quality care*** and services. Make sure these relate to what older people receiving care need and want. It's important to understand older people's clinical needs (**Outcome 5.4**). This includes the supports they need to eat and drink safely (**Outcome 6.4**). Workers' skills and competencies must meet these needs.
- screen and hire suitably qualified and competent workers. Potential candidates should only be hired if you can confirm they can deliver quality and safe care and services. You can assess this through a pre-employment validation **process*** as part of your human resources management **system*** (**Outcome 2.9**). These can include background checks, **processes*** to confirm education, qualifications (relevant to their role) and employment history, reference checks, and competency and skill-based tests. Review any history of **complaints*, incidents*** or other **feedback*** relating to the worker to understand if there are any issues in their ability to deliver tailored care for each older person. If you find any issues through your reviews and assessments, assess if you can fill a candidate's gaps in skills with training (**Outcome 2.9**). However, these **processes*** do not apply to any workers listed on the Aged Care Banning Orders Register, as they must not be hired regardless of their competencies.
- identify the number and mix of skilled workers you need to provide the care and services that meets the older people's needs (**Outcome 2.8**). To do this, consider:
  - the number of older people you're caring for
  - the specific needs of the people under your care. This includes their clinical needs (**Outcome 5.4**). It also includes their emotional, spiritual, cultural and psychological needs (**Outcome 1.1**).
  - the number and mix of current workers along with the skills and services they can deliver.
- support diverse workers. For example, sexual and gender diverse, culturally and linguistically diverse, and Aboriginal and Torres Strait Islander workers.
- review rostering **processes***. Make sure these **processes*** support flexible working for directly employed staff.

Make sure enough workers are available at times when older people need more support. For example, during mornings, bedtime and mealtimes. Also, try to maximise **worker*** continuity (**Outcome 3.2**). Follow processes to:

- meet the requirements of your 24/7 registered nurse and care minutes responsibilities. This is a legislative requirement for residential care providers.
- mitigate the risk and impact of **workforce*** shortages, absences or vacancies. Make sure:
  - you maintain relationships with aged care hiring agencies and labour hires
  - staffing needs are met on an ongoing basis. This is important when preparing for busy periods
  - consider the use of digital platforms to meet workforce needs.
- use direct employment where possible and minimise the use of contractors such as agency staff. This can help continuity of care. Only use contractors when staff who are directly employed aren't not available. If you need contractors, aim to roster the same contractors for the older person unless the older person has asked not to. Complete competency checks in line with your **policies*** and **procedures***. Properly induct and monitor the contractor (**Outcome 2.9**).

Document your **workforce*** strategy. Have key initiatives to make sure you meet **workforce*** needs. How you document this needs to be based on how complex the organisation is and its context. For example, some organisations can build these **processes*** into risk management **systems*** (**Outcome 2.4**) and rostering **processes***. More complex organisations may need to build this into strategic business planning (**Outcome 2.1**).

Put in place strategies that promote a healthy and safe workforce*.

When developing these strategies, consider:

- **feedback*** mechanisms, such as worker surveys
- worker health and safety risks that you've identified through your risk management **system*** (**Outcome 2.4**).

To find these risks, analyse the **incidents*** recorded in your risk management **system*** (**Outcomes 2.4** and **2.5**). Make sure these strategies outline how you will support a healthy and safe **workforce*.** You can do this by completing risk assessments in situations that can cause harm to workers, such as new home environments or traumatic events.

Use risk assessments to understand:

- workers' physical and psychological risks
- how to manage these risks on a case-by-case basis (**Outcome 2.4**).

Make sure you:

- put in place **processes*** to identify and support workers in distress. For example, if they're experiencing fatigue, bullying or harassment (**Outcome 2.2**).
- complete regular checks to identify any new risks in the **service environment*** (**Outcome 4.1b**)**.** For example, risks of slips and trips. Make sure you manage these risks well.

- provide workers with guidance and training on how to respond to traumatic and emergency events and any other hazardous situations. Make sure training helps workers to manage their own health and the health of people receiving care. Make sure training meets the needs of workers (**Outcome 2.9**).
- match training needs to the type of service. For example, training in home care could include how to do manual tasks safely when assisting with personal care, cooking or cleaning. Make sure workers know their **responsibilities*** to identify and report any concerns they have to the provider. The guidance for **Outcomes 2.4** and **2.5** has more information on managing risks and incidents in home care.
- put in place incentives for workers to promote a safe working environment. For example, recognise quality and safe work that meets the needs of older people and workers. This can also help to make sure workers are satisfied in their role and receive the support they need. This can help minimise stuff turnover.
- put in place Key Performance Indicators (KPIs) for health and safety. Include these KPIs in strategic business planning (**Outcome 2.1**) and performance reporting (**Outcome 2.3**).

Document these strategies. Include your key initiatives for making sure you meet your workers' health and safety needs. How you document these strategies should be based on how complex the organisation is and its context. For example, some organisations can build these **processes*** into risk management **systems*** (**Outcome 2.4**) and **workforce*** planning **processes*** (**Outcome 2.8**). More complex organisations may need to build this into strategic business planning (**Outcome 2.1**).

Monitor how well the workforce* strategy is working.

Regularly* review your **workforce*** strategy to make sure it works well. Look for ways to improve the workforce strategy.

To check if your **workforce*** strategy is working well, you can review:

- older people's care and service documents (**Outcome 3.1**)
- **complaint***s and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Assess your workers':

- qualifications, skills and competencies
- performance. You can do this through quality assurance and **system*** reviews (**Outcome 2.9**).

This needs to be a key part of how you evaluate quality and care outcomes (**Outcome 2.3**).

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, be open about it. Share what went wrong with workers, older people, their family and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance on **Outcome 2.3** has more information on monitoring the quality **system***.

Monitor that the workforce* is healthy and safe.

Regularly* review your workforce strategies to promote a healthy and safe **workforce***. Look for ways to improve your strategies.

To check if your **workforce*** is healthy and safe, you can:

- ask workers if they feel supported to be healthy and safe. This includes any resources or **processes*** they can use to support their health and safety.
- analyse risk (**Outcome 2.4**), **incident*** (**Outcome 2.5**) and **feedback*** and **complaint***s (**Outcome 2.6**) data to see if any issues are recurring. If this is the case, take action in a **timely*** manner to reduce or prevent these issues from happening in the future.
- complete assessments or checks to make sure workers are delivering care and services that are safe for older people, themselves and their coworkers (**Outcome 2.3**). If assessments identify any issues or concerns, take action in a **timely*** manner to address these. For example:
  - the quality **system*** may need to be modified
  - workers may need extra training so they understand how to perform their role safely.

Report your findings to the **governing body*** (**Outcome 2.3**).

Outcome 2.9

What is the outcome you need to achieve?

The care and services need of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide **quality care*** and services. Workers are provided with training and supervision to effectively perform their role.

Why is this outcome important?

Outcome 2.9 explains providers' obligations to make sure workers are skilled, competent and supported to deliver quality and safe care and services that meet older people's needs. Providers must have **processes*** for human resource management that confirm a worker's qualifications, experience, skills and if they're suitable for the role before you hire them.

Outcome 2.9 highlights how important competency-based training is to maintain safe and **quality care*** and services. Providers should have a comprehensive **training system***. This **system*** must

adapt to the changing needs of the service and make sure workers are well prepared to do their roles. There should at least be training on core matters such as:

- **person-centred care***
- caring for people living with **dementia***
- responding to medical emergencies
- **culturally safe***, **trauma aware and healing informed care***
- what is required by the Code of Conduct for Aged Care, the Serious Incident Response Scheme (SIRS) and the Quality Standards.

Providers need to do regular competency assessments and performance reviews. This makes sure workers have the skills they need to deliver safe and **quality care*** and services. Reviewing how effective the **training system*** is, helps you to support your overall quality **system*** and drive **continuous improvement*** in how you deliver care and services.

You need to give focus to:

- providing workers with access to supervision and resources
- using a training **system*** that:
  - uses the experience of older people
  - is based on input from a range of areas, such as **feedback***, **complaints***, risks and regular worker performance reviews
- regular reviews and **continuous improvement*** of the training **system***
- competency-based training for workers.

Key tasks:

Put in place a human resources management system*.

Put in place a pre-employment validation **process***. This checks that the information job applicants give you about their qualifications, skills and experience are accurate. Include:

- background checks
- **processes*** to verify education and qualifications
- **processes*** to confirm employment history
- reference checks
- competency assessments.

This helps make sure that potential workers have the right skills and experience to provide safe and **quality care*** and services (**Outcome 2.2**). It can also confirm if your organisation's training **system*** can update the person's skills if needed.

Store this information in line with your **information management system*** (**Outcome 2.7**). Make sure you store all the information from applicants accurately. That means documents you receive from applicants matches their profile.

Put in place strategies to roster workers for quality and safe care and services.

Rostering needs to be informed by the organisation's **workforce*** strategy (**Outcome 2.8**).

When rostering, make sure you:

- consider the skills, number and mix of workers you need to deliver safe and **quality care*** and services. Make sure enough workers are available when older people need more support. For example, during mornings, bedtime and mealtimes. This could also include when responding to high risk or complex situations. For example, when an older person shows signs of **deterioration*** or **changed behaviours*** (**Outcome 5.4**).
- assign an appropriate number and mix of workers to specific shifts and tasks. Base this on workers' skills, qualifications and competencies.
- consider **worker*** continuity. This supports a person's continuity of care (**Outcome 3.4**). Use direct employment where possible and try to minimise the use of contractors such as agency staff. You can also try to offer shifts to staff who are directly employed first. If you need contractors, aim to roster the same contractors for the older person, unless the older person has asked not to. Complete competency checks for contractors in line with your **policies*** and **procedures***. Properly induct and monitor the contractor.

Make sure rostering supports the delivery of quality and safe care and services at all times. Care and services need to be centred on the needs and preferences of older people (**Outcome 3.2**). Where possible, include the older person's input when choosing their worker.

Provide workers with adequate and appropriate supervision, support and resources. This includes guidance and training on how to provide quality and safe care.

Monitor and report Quality Indicator data about the turnover of your workers and the reasons for their departure.

Put in place a training system*.

Develop your training **system*** in consultation with workers and older people. This can include:

- **regularly*** analysing training needs. List the skills needed for each role and what training can build these skills. Make sure training is based on **contemporary, evidence-based practice***. Make sure training also meets the organisation's scope of services and the **diversity*** of older people. It's important to conduct training to fill any competency gaps identified during:
  - hiring activities (**Outcome 2.8**)
  - broader performance monitoring (**Outcome 2.3**)
  - assessment of the organisation's **quality and safety culture*** (**Outcome 2.2**).
- putting in place training strategies and a 'training matrix' (or equivalent) which lists:

  - all **worker*** role types. For example, care **worker***, chef, cleaner and administration roles.
  - the training needed for each role type, to help workers perform that role.
- delivering training in line with any identified training needs. This may include training on how workers can:
  - deliver **person-centred***, rights-based care
  - provide **culturally safe***, **trauma aware and healing informed care***
  - care for people living with **dementia***
  - provide **palliative and end-of-life care***
  - respond to medical emergencies
  - meet the requirements of the Code of Conduct for Aged Care
  - meet the requirements of the Serious Incident Response Scheme (SIRS)
  - meet the requirements of the Quality Standards
  - meet other requirements relevant to their role. For example, an understanding of **Infection Prevention and Control***, relevant to their role. This includes training for **Infection Prevention and Control Leads***. This also includes specific training for people who have a formal role in an emergency, such as fire wardens and first aiders (**Outcome 2.10**).
- reviewing workers' skills and understanding. After training, include **processes*** to check that workers' have the right skills and capabilities for their role. This can include competency evaluations and quality assurance. This can also include tracking who has completed training. Make sure that workers can provide quality and safe care for each older person.

Make sure training strategies consider the diversity of your **workforce*** (**Outcome 2.8**). For example, provide workers with the support they need to take part in and complete training.

Keep training records for all workers, including contractors. This includes records that show they have completed training and the competency they need to perform their role. Record this information in line with the organisation's **information management system*** (**Outcome 2.7**). You can put in place a **system*** to track workers' licenses and registrations that alerts you when they are about to expire. Make sure workers and others understand the **policies*** and **procedures*** relevant to their role (**Outcome 2.7**).

Make sure the training **system*** is relevant for and accessible to contractors and employees.

Put in place strategies to regularly* assess, monitor and review the performance of workers.

Make sure workers are providing quality and safe care and services. Strategies to monitor workers' performance can include:

- developing and monitoring performance measures. The performance measures of a **worker*** will depend on their **role and responsibilities***. For example, positive **feedback*** from older people for carers and hiring targets for administrative workers.

- completing regular performance reviews to an agreed schedule. Consider all monitored performance measures and **feedback***. Workers should have the opportunity to clarify or provide reasons for any **feedback*** that does not meet their expectations. Make sure performance reviews:
  - fairly assess workers based on **feedback*** provided by older people, other workers, supervisors and people they work with (**Outcome 2.6**)
  - provide workers with support in areas identified for improvement in the training needs analysis. This is part of the training **system***.
  - encourage workers to deliver quality and safe care and services (**Outcome 2.3**)
  - consider outcomes from the training **system***.
- having **processes*** to assess all performance review outcomes. This can help to work out where you can make improvements. Recognise workers with positive outcomes. Develop improvement plans with workers who need to improve. Do this in partnership with the worker. Make sure improvement plans show how the **worker*** can provide **quality care*** and services (**Outcome 2.3**). Store information about **worker*** performance using your **information management system***. This will make sure it's accurate, secure and accessible (**Outcome 2.7**).

Monitor how well your strategies to roster workers for quality and safe care and services are working.

To check if the staff resource needs of the organisation are being met:

- talk with workers, older people, their families and carers
- review older people's care and service documents (**Outcome 3.1**)
- review **complaints***, **feedback*** and **incident*** information (**Outcomes 2.6** and **2.5**)
- make sure skilled workers are available to deliver safe and **quality care*** and services.

If you find any issues or ways you can improve your rostering address them. If things go wrong, be open about it. Share what went wrong with workers, older people, their family, and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

Monitor how well you use your training system*.

Regularly* review your training **system*** to make sure it works well. Look for ways to improve the **system***.

To check if workers have the capabilities, supervision, support and resources they need to perform their role, you can review:

- older people's care and service documents (**Outcome 3.1**)
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**)
- **worker*** performance and how they're using the training **system***. You can do this through quality assurance and **system*** reviews. (**Outcome 2.9**).

- training records to make sure workers have completed training as needed and in a timely manner
- **policies*** and **procedures*.**

Also, talk with:

- workers to see if they feel supported to:
  - complete their training
  - perform their role well and safely.
- older people, their families and carers about the care and services they receive (**Outcome 2.1**).

These conversations can help you with **continuous improvement*** actions and planning (**Outcome 2.1**).

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, be open about it. Share what went wrong with workers, older people, their family and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 2.10

What is the outcome you need to achieve?

Emergency and disaster management planning considers and manages the risks to the health, safety and **wellbeing*** of older people and workers.

Why is this outcome important?

Outcome 2.10 explains providers' obligations to have strategies to prepare for and respond to emergency and disaster situations. Providers need to make sure workers have the skills and resources to respond to any of these situations. Providers need to mitigate risks by having comprehensive emergency and disaster management plans that cover different emergencies including:

- natural disasters
- medical emergencies
- pandemics and outbreaks.

These plans are based on emergency and disaster risk assessments. Risk assessments can help providers develop plans that support the safety of older people and workers in an emergency or disaster. These plans also support older people with specific needs, including those that need extra support because of disabilities or diverse backgrounds. This makes sure that you identify and manage health, safety and **wellbeing*** risks for older people and workers.

Under **Outcome 2.10** to prepare for and respond to emergencies and disasters, providers need to communicate and work with:

- older people
- families and carers
- workers
- emergency response partners.

It's important that those involved in emergency and disaster planning understand the service's plans and **procedures***. Providers should **regularly*** review and test these plans through emergency drills.

You need to give focus to:

- having emergency and disaster plans and strategies to prepare and respond
- communicating and engaging with older people, families, carers and workers
- testing and reviewing emergency and disaster management plans.

Key tasks:

Put in place emergency and disaster management plans.

Develop emergency and disaster management plans. This helps to reduce risks to the health, safety, and **wellbeing*** of older people and workers.

Make sure emergency and disaster management plans:

- are based on an emergency and disaster risk assessment. This assessment identifies emergency and disaster situations that can happen when delivering care and services. These can include environmental events or disasters, such as floods, heatwaves, fires, and damage to infrastructure. This can also include medical emergencies. The risk assessment also helps assess how you and your workers need to respond to manage these situations. Make sure you do the emergency and disaster risk assessment as part of the organisation's broader risk assessment (**Outcome 2.4**).
  - in residential care, the emergency plan applies to all older people and workers. The plan describes how the organisation and workers will respond to an emergency or disaster and how you will manage risks. The plan also considers extra supports that each older person may need. You need to communicate these extra supports to workers so they can act appropriately in an emergency.

  - in home care, the emergency plan needs to address the older person and the home care environment. It may be helpful to complete risk assessments for home care in regional and remote communities with local services from the area. This may also help you find ways to share resources during an emergency. Local services can understand particular risks that others may not (**Outcome 4.1a**). For example, high kangaroo activity on a road may be a risk to the worker when travelling, or a road may be more likely to flood. There can also be higher risks for those who don't have access to transport in areas at risk of bushfires, heatwaves or floods. Use your **incident management*** and risk management **systems*** in this **process*** to identify and manage these situations (**Outcomes 2.4** and **2.5**).
- are based on the service context. Use the emergency risk assessment to decide if you need an emergency and disaster management plan specific to the service. This depends on the context of the organisation. Sometimes a high-level plan can be enough. For example, in home care, a high-level plan can be enough if there is a broader risk assessment for each home setting (**Outcome 4.1a**). The broad risk assessment for each home setting needs to assess any particular challenges in emergency responses. For example, during heatwaves and in flood prone areas.
- include strategies for communication and management planning during an emergency
- are developed in consultation with older people, their family, carers, workers, visitors and other response services. This makes sure the processes meet older people's needs (**Outcomes 2.1** and **1.1**). Make sure strategies are included in a person's **care and services plan***s if needed. For example, where an older person has a disability or culturally diverse needs that may need to be considered during an emergency.
- are shared with older people and their families in a variety of ways. This can be by displaying the plans on noticeboards or email alerts (**Outcomes 2.2** and **3.3**). Make sure this information is shared in a way the older person understands (**Outcome 1.3**). Consider each older person's language and communication needs and preferences (**Outcome 1.1**).
- tested on a periodic basis. For example, once a year. Use a variety of different emergency scenarios in your emergency drill schedule. If you find any issues through these tests, review and update the emergency plans. Issues can include workers not being sure what to do. Drills need to be done with workers, older people, their families and carers, visitors and other response partners (**Outcome 2.1**). These can be desktop drills. This will help to reduce disruption to older people. These drills can also include scenarios like power and internet outages.
- are evaluated and updated. After a drill, or if a real emergency happens, assess the responses and emergency plan to check if they worked well. Make changes if needed.
- include processes to respond quickly to outbreaks of infectious diseases. You need to do this even if the disease is only suspected (**Outcome 4.2**). You can develop an outbreak management plan.

Note: Response partners can include:

- government agencies
- the state emergency service
- other service providers
- community organisations

- local health services
- local public health units.

Make sure your workers have the time, support and resources to use emergency and disaster management plans.

Put in place a **workforce*** strategy (**Outcome 2.8**) that considers:

- **transitions of care*** (**Outcome 3.4**)
- continuity of care (**Outcome 3.4**)
- assessing workers' abilities during the hiring **process*** (**Outcome 2.8**)
- additional staff or **workforce*** supports that may be needed during an emergency (**Outcome 2.9**)
- providing workers with guidance and training on their **roles and responsibilities*** in an emergency or disaster.

Guidance and training needs to be in line with:

- the organisation's **policies*** and **procedures***
- workers' **roles and responsibilities***.

The guidance for **Outcomes 2.8** and **2.9** has more information on **workforce*** planning and human resource management.

Monitor how well your emergency and disaster management plans are working.

To make sure emergency and disaster management plans are working well, you can:

- talk with workers, older people, their families and carers
- assess emergency and disaster drill records.

You can also review:

- **complaints*** and **feedback*** (**Outcome 2.6**)
- risk and **incident*** information (**Outcomes 2.4 and 2.5**)
- **policies*** and **procedures***.

Review your emergency plans and update them if needed. This will help to make sure your emergency plans stay current and effective. For example, review your plan:

- if you move or renovate
- if the number of older people in your care changes significantly
- if your workforce changes significantly

- after you do an emergency management drill
- after an emergency.

If you find any issues or ways you can improve, address them. If things go wrong, be open about it. Share what went wrong with workers, older people, their family and carers (**Outcome 2.3**). Put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Standard 3: Care and services

What is the intent?

Standard 3 describes the way providers must deliver care and services for all types of services being delivered (noting that other Standards describe requirements relevant to specific service types). Effective assessment and planning, communication and coordination relies on a strong and supported **workforce*** as described in Standard 2 and is critical to the delivery of **quality care*** and services that meet the older person's needs, which are tailored to their preferences and support them to live their best lives.

In delivering care and services, providers and workers must draw on all relevant Standards, with particular reference to Standard 1, including to ensure care is tailored to the individual and what's important to them. Family and carers are recognised as having an important role in assisting or providing care and services.

Outcome 3.1

What is the outcome you need to achieve?

Older people, and others involved in their care, are actively engaged in developing and reviewing their **care and services plans*** through ongoing communication.

Care and services plans* describe the current **needs, goals and preferences*** of older people, including risk management and **preventative care*** strategies. **Care and services plans*** are **regularly*** reviewed and are used by workers to guide the delivery of care and services.

What are needs?

Needs are the essential requirements or conditions that must be addressed to optimise the older person's health, safety and **wellbeing***. These may include medical treatment, assistance with **activities of daily living***, social support and specialist health services.

What are goals?

Goals, also known as **goals of care***, are the clinical and personal **outcomes*** the older person wants to achieve when they receive care and services. Goals are set collaboratively with the older person, their family, carers, representatives and **health professionals*** involved in their care through a **shared decision making*** **process***. Goals may focus on optimising the older person's **quality of life***, **reablement*** and maintenance of function, or addressing personal preferences.

What are preferences?

Preferences are the things the older person chooses, likes or dislikes when it comes to their care, services and lifestyle. It's the way they like or wish for their care and services to be delivered. These may include preferred types of care (such as at home or in a residential care home), treatment options, daily routines and activities they want to do.

Why is this outcome important?

Outcome 3.1 explains providers' obligations to make sure they have thorough **assessment and planning*** **processes***. **Systems*** and **processes*** for **assessment and planning*** are essential for guiding how providers deliver **quality care*** and services that meet older people's **needs, goals and preferences***. These **systems*** and **processes*** should support older people's **quality of life*** and **reablement***. They should also help older people to maintain their physical, mental and cognitive functions.

Assessment and planning* **processes*** are important guidance for developing **care and services plans*** that meet the **needs, goals and preferences*** of each older person. You need to do your **assessment and planning*** should be done using a **person-centred care*** approach and in line with the **providers*** policies and procedures. This means ongoing communication and partnership with:

- older people
- their families and **carers***
- their representatives
- **health professionals*** involved in their care.

Identifying and assessing risks to the older person's health, safety and **wellbeing*** is also an important part of **assessment and planning***. You need to identify and assess these risks in **partnership*** with older people, their families, **carers***, representatives and **health professionals*** involved in their care. This includes completing clinical assessments where required by qualified **health professionals*** to identify, document and plan for clinical risks (**Outcome 5.4**). **Outcome 3.1** highlights the need to have strategies to manage the identified risks. These strategies should focus on supporting each person's **quality of life***, **reablement***, right to make choices and maintaining their function.

Regular reviews of **care and services plans*** are essential to updating an older person's care and services if there are any changes in their preferences, condition or circumstances. **Outcome 3.1** also highlights how important it is to communicate any changes in their care and services to the older person and others involved in their care. This helps make sure care and services are suitable and effective. It also helps build trust between providers and the older people they care for.

Advance care planning* is an important component of **person-centred care***. Providers are expected to have **systems*** and **processes*** to support older people in **advance care planning***, if the older person wishes to develop an advance care plan. **Advance care planning*** is a voluntary **process*** and offers an opportunity to consider, discuss and document the older person's preferences about their care. It's important to provide information and support to older people about the benefits of **advance care planning***, so they can make their own informed choices. Open and transparent communication about an older person's future care needs can also help to make sure care and services are in line with their choices, values and preferences.

You need to give focus to:

- considering **quality of life***, **reablement*** and maintaining function
- using strategies to manage risk to an older person's health and wellbeing
- outlining when **care and services plans*** need to be reviewed.

Key tasks:

Put in place a system* for assessment and planning.

Assessment and planning is an important part of delivering **quality care*** and services. In your **system*** for assessment and planning, make sure you prioritise:

- the older person's **quality of life***
- their **reablement***
- maintaining their physical, mental and cognitive functions.

Making these areas a priority will support you to:

- deliver **quality care*** and services
- create **care and services plans*** that meet the **needs, goals and preferences*** of older people.

Make sure your **system*** includes **processes*** to:

- partner with the older person about who they want involved in their assessment and planning. Use your organisation's **system*** to identify and guide workers about how to involve the older person and others (such as family or carers) who the older person

chooses to involve in assessment and planning (**Outcome 1.3**). If the older person lacks the capacity to make decisions, the provider has the responsibility to know and record:
  - who the **substitute decision-maker*** is
  - the types of decisions they are authorised to make on behalf of the person.
- talk with the older person and other people the older person would like involved in their care and services (**Outcome 2.1**). This will help workers to understand each older person's **goals of care***. It will also help support their **quality of life*** and **reablement*** and to maintain their function. Make sure these discussions are in line with culturally and **psychologically safe*** care principles. This will help to plan and deliver care that is **culturally safe***, **trauma aware and healing informed*** (**Outcome 3.2**).
- document the older person's **needs, goals and preferences*** (**Outcome 1.1**) in their **care and services plan***. This includes their:
  - culture, diversity and religious beliefs
  - connection to Country and community. For example, for older people who identify as Aboriginal and Torres Strait Islander or live in regional and remote settings.
  - individual background and life experiences
  - language and communication needs and preferences
  - gender identity and sexual orientation
  - decision to share this information, who to share this information with, and their preferences to talk or not talk about their experiences.
- consider risks to the older person's health, safety and **wellbeing***. Also include how you will manage these risks (**Outcome 2.4**). Do this in **partnership*** with the older person.
- provide the resources and support each older person needs when delivering care and services. Make sure this information informs the supports what older people need to perform their **activities of daily living***. For residential care providers, the guidance for **Outcome 7.1** has more information on how you can support older people with **activities of daily living***. For older people receiving care and services in a home setting, this could also involve identifying if referrals to other care services or providers may be needed.

- share information (**Outcome 2.1**). Workers need to inform older people that their own **care and services plans*** are available and accessible to them. Use your **information management** (**Outcome 2.7**) and communication **systems*** (**Outcome 3.3**) to do this.
  - involve appropriate **health professionals*** and support services where you need to**.** For example, you may need to involve:
    - a mental **health professional*** if the person has psychological **deterioration***
    - **dementia*** support specialists if the person has cognitive **deterioration***
    - a dietician to provide nutrition care in response to identified weight loss (**Outcome 5.5**).
  - make sure **care and service plans*** are accessible and available to workers as well as older people. Workers need to access, refer to and understand **care and service plans*** to guide how they deliver care and services.
  - enable reporting your Quality Indicator data about the quality of care.

Create **care and services plans*** that:

- are individualised and **person-centred***. **Care and service plans*** need to show the older person's unique **needs, goals and preferences*** (**Outcomes 3.2** and **3.3**). This will make

sure care and services are delivered safely and in line with the older person's needs and preferences. When making **care and services plans***, consider each older person's:
  - culture, diversity and religious beliefs
  - individual background and life experiences
  - language and communication needs and preferences
  - gender identity and sexual orientation (**Outcome 1.1**).
- are comprehensive (**Outcome 5.4**). Consider each older person's:
  - individual needs and preferences (**Outcome 1.1**)
  - **goals of care*** in collaboration with their family, carers, **health professionals*** and others they wish to involve in their care (**Outcome 5.4**)
  - choices so that you can support them in optimising their **quality of life***, **reablement*** and maintenance of function
  - clinical needs and risks. For example, individual nutrition, hydration and dining needs and preferences (**Outcome 6.2**).
- consider which **health professionals*** and services are needed to meet the older person's clinical needs, with their **informed consent***. For example, a person may need:
  - medical
  - rehabilitation
  - allied health
  - oral health
  - specialist nursing
  - **dementia*** support services.

  This will help make sure older people receive coordinated, **multidisciplinary care*** (**Outcome 5.4**)
- are available to older people and people they want involved in their care and services. This may include the older person's family and carers if requested by the older person. You need to share this information in a way each older person understands (**Outcome 1.3**). This should consider each older person's language and communication needs and preferences (**Outcome 1.1**). For example, if an older person has a **cognitive impairment***, workers should support them to understand the information. This needs to be based on each older person's needs to support their understanding.
- are clear and accessible.

Care and services plans* need to be up-to-date and informed by assessments. Review the plans **regularly***, including:

- if there are changes in the older person's circumstances. This can include a change to:
  - their needs, goals or preferences (**Outcome 1.1**). For example, if an older person's dietary preferences change.
  - their **mental health***, cognitive or physical function, capacity or condition. This includes if their function, capacity or condition **deteriorates***, improves or changes (**Outcome 5.4**). For example, if an older person's mobility decreases after a fall.
  - their ability to perform **activities of daily living*.** For example, if an older person is no longer able to walk without help
  - the care that family or carers can provide to the older person

- the care responsibilities of the people providing care and services to the older person. This means, if any services or **allied health*** and **health professionals*** involved in the older person's care and services change. For example, when an older person's GP retires and they organise a new one, make sure you review and update the person's **care and services plan***.
- after an **incident*** (**Outcome 2.5**). After an **incident***, document any changes to the **care and services plan*** that are needed.
- if the **care and services plan*** is not reflecting the needs, goals and preferences of the older person. Older people, their family, carers or others may raise issues through **feedback*** or **complaints*** (**Outcome 2.6**). Workers may raise issues through established escalation pathways using the **information management*** (**Outcome 2.7**) and communication **systems*** (**Outcome 3.3**).
- if risks are identified (**Outcome 2.4**). Document the risks, any strategies to prevent or reduce risk in the future and how you plan to monitor and assess these strategies. For example, if an older person is identified as being at risk of choking or have difficulties swallowing (**Outcomes 5.4** and **5.5**), make sure assessments are undertaken to evaluate the risk and documented, and update their **care and services plan***. Recommendations and strategies to mitigate risk should be individualised to each older person in line with their assessed needs. The **care and services plan*** should also outline when the older person needs to be reassessed and who should do this.
- at **transitions of care***. For example, when an older person is discharged from hospital or changes from home care to residential care services. The guidance for **Outcome 3.4** has more information on coordinating transitions. For residential care providers, the guidance for **Outcome 7.2** has more information on how you can support older people during transitions.

Put in place processes* for advance care planning*.

These **processes*** need to:

- support the older person to talk about their future medical treatment and care needs. Talk with the older person about their **needs, goals and preferences***. This includes their beliefs, cultural and religious practices and traditions (**Outcome 1.1**)
- support the older person to complete and review **advance care planning*** documents, if they choose to
- support the older person to have choices and exercise **dignity of risk*** (**Outcomes 1.2** and **1.3**). For example, if an older person makes the informed decision to not use recommended pressure relieving devices or walking aids (as prescribed by a relevant **health professional***).
- support the older person to nominate and involve a **substitute decision-maker*** for health and care decisions, if and when they choose. The guidance for **Outcome 1.3** has more information on **supported decision making*** and the role of **substitute decision-makers***.
- make sure you store, manage, use and share **advance care planning*** documents with relevant people if needed, including at **transitions of care***. Use your **information management system*** (**Outcome 2.7**) and communication **system*** (**Outcome 3.3**) to do

this. **Informed consent*** should be obtained from the older person to share their information and advance care plan (**Outcome 1.3**).
- be integrated with your **systems*** and easily accessible for quality **clinical care*** (**Outcome 5.1**) where relevant.

Make sure workers who provide care and services have the time, support, resources and skills to plan for and deliver care and services tailored to each older person's needs and preferences.

Provide workers with guidance and training on how to plan for and deliver tailored care and services for each older person (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary**, **evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers who deliver care and services understand how to:

- undertake assessments
- develop **care and services plans***
- use this information to plan and deliver care and services tailored to the older person's **needs, goals and preferences*** (**Outcome 3.2**).

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Make sure workers can assess and understand **care and services plans*** when they need them. **Care and services plans*** need to be stored in line with your **information management system*** (**Outcome 2.7**).

Monitor how well your processes* for assessment and planning are working.

To check if your assessment and planning **processes*** work well, you can review:

- older people's care and services documents (**Outcome 3.1**). For example, **care and services plans***, progress notes and **advance care planning documents***. Check that each older person's **care and services plans*** include their current **needs, goals, and preferences***.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- **incidents*** have happened where the wrong service or care has been provided
- a **care and services plan*** was not reviewed and updated after a change in circumstances
- an older person's needs, goals or preferences were not documented in their **care and services plan*** or **advance care planning documents***.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). For example, ask them if they were involved in the assessment and planning **process*** of their care and services. Ask them if their **needs, goals and preferences*** have been understood and considered in their **care and services plan*** and **advance care planning***. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Outcome 3.2

What is the outcome you need to achieve?

Older people receive **quality care*** and services that meet their **needs, goals and preferences*** and optimise their **quality of life***, **reablement*** and maintenance of function. Care and services are provided in a way that is **culturally safe*** and appropriate for people with specific needs and diverse backgrounds.

Why is this outcome important?

Outcome 3.2 explains providers' obligations to deliver **quality care*** and services. It focuses on providing care and services that are **culturally safe*, trauma aware and healing informed***. This should be included in each older person's **care and services plan*** (**Outcome 3.1)**.

Providers must make sure older people receive care and services that are:

- tailored to their individual **needs, goals, and preferences***
- based on **contemporary, evidence-based practices***.

This helps to optimise older people's **quality of life***, **reablement*** and **maintenance of function***. It also supports older people's independence. This includes where the use of a **restrictive practice*** may be assessed as necessary.

Providers must make sure they deliver care and services in collaboration with **health professionals*** and **multidisciplinary*** teams. This makes sure older people are appropriately referred for early assessment and intervention. Coordinating care in this way helps you to identify health issues and facilitate treatment in a **timely*** manner. This then helps to reduce the risk of **deterioration***.

Providers can tailor care to meet the specific needs of each older person by:

- working closely with a **multidisciplinary*** team
- supporting workers to identify, escalate and communicate risks or concerns.

This supports providers to deliver **comprehensive*** and **coordinated care***.

Culturally safe*, trauma-aware and healing-informed care* helps you to meet the **diverse*** needs of older people, including people living with **dementia*.** Providers need to respect older people's backgrounds and recognise their past experiences. Using the same workers helps to maintain continuity of care. Involving older people in choosing their own workers where possible can:

- improve the older person's experience
- reduce stress
- support better **outcomes***
- improve quality of care and services.

Outcome 3.2 discusses how to communicate effectively with older people including people with cognitive impairments or people living with **dementia*.** Providers need to understand each older person's language and communication needs and preferences. There are many ways to support communication when speaking to a person. It's important to recognise that some older people may not be able to communicate their needs and may rely on other ways to express, such as body language, tone, actions, and behaviour.

Providers should collaborate with **health professionals*** to understand older people's language and communication needs and preferences. Strategies should be tailored to the older person's preferences and needs. For example, strategies recommended by a Certified Practising Speech Pathologist may include using clear, simple language, active listening and appropriate gestures for tailoring communication to meet individual needs. It's also important that older people have access to appropriate tools or equipment that support sensory loss, such as glasses and hearing aids. Occupational Therapists may assist in training workers and older people to use assistive communication devices and visual aids. Providing access to interpreters and translators when needed can help older people actively engage in decisions about their care and services.

You need to give focus to:

- **culturally safe***, **trauma-aware and healing-informed care***
- using **contemporary**, **evidence-based practice***
- tailoring care and services to the **needs, goals and preferences*** of each older person
- supporting a person's **quality of life*** and **reablement*** and to maintain their function
- supporting older people to use equipment, aids and devices
- using referrals to support early assessment and intervention after changes or **deterioration***
- strategies for workers to:
  - detect and assess risks to older people
  - identify **deterioration***
  - respond and escalate risks in a **timely*** manner
- using a **system*** to identify and review the skills and strengths of people living with **dementia***. This helps encourage them to use these skills and strengths each day.
- involving older people in selecting their workers where possible
- effective and ongoing communication
- supporting workers to understand the way different older people communicate.

Key tasks:

Put in place strategies for providing quality and safe care and services.

These strategies need to explain how you will deliver **care and services plans***. Make sure these strategies describe how care and services will:

- meet the **needs, goals, and preferences*** of older people (**Outcome 1.1**)
- be based on **contemporary, evidence-based practices*** (**Outcome 2.3**)
- be **culturally safe*** and appropriate for people with specific needs and diverse backgrounds (**Outcome 1.1**). For example, if an older person has specific cultural dietary or food preferences, you should document this in their **care and services plan***. For residential care home providers, the guidance for **Outcomes 6.2** and **6.3** has more information on how you can support older people's needs and preferences on food, nutrition and the **dining experience***. You can also support cultural safety by:
  - providing older people with a **culturally safe*** and sensitive environment
  - providing opportunities for older people to take part in cultural activities that are meaningful to them, if they wish to do so. This includes supporting them to exercise **dignity of risk*** (**Outcome 1.3**). For example, when an Aboriginal and Torres Strait Islander older person wishes to attend cultural activities or ceremonial responsibilities on Country.
- be **trauma aware and healing informed*** (**Outcome 1.1**). Make sure you understand and respond to the impacts of trauma and situations that may be triggering of trauma responses. Care and services also need to consider the older person's psychological needs and past experiences. For example, an older person who has experienced war may be

particularly sensitive to loud or unexpected noises. Care leavers may also have difficulty interacting with workers, **allied health*** and **health professionals*** based on their past experiences or trauma. Provide older people with a safe and healing environment in line with **trauma aware and healing informed care***. For example, make sure the environment or interactions with workers do not resemble an institution.

You can support **trauma aware and healing informed care*** by:

- providing a safe and supportive environment where older people:
  - feel accepted and valued (**Outcomes 1.1** and **1.2**). For example, approaching and responding to older people with empathy and positivity.
  - can speak up without reprisal (**Outcome 2.6**). For example, older people can ask for help which will not lead to criticism. This includes encouraging and providing older people with help to complete surveys and give **feedback*** and **complaints*** anonymously if they wish.
- respecting the older person's autonomy and dignity (**Outcomes 1.1** and **1.2**). For example, asking for the older person's permission before attending any care tasks or touching their belongings.
- making sure older people don't experience discrimination, abuse and neglect when receiving care and services (**Outcome 1.2**)
- offering older people choices for how you deliver their care and services (**Outcome 1.3**). This includes recognising the older person's choice to exercise **dignity of risk*** and decline tasks they receive care and services.
- working in predictable and transparent ways. You can do this by working in partnership with the older person, their family, carers and others involved in their care and services (**Outcome 2.1**).
- practising **open disclosure*** and communicating with older people, their family and carers when things go wrong (**Outcome 2.3**)
- supporting the older person to select their workers (**Outcome 3.2**). This can include supporting the older person to choose workers based on their gender and the language they speak (**Outcome 1.1**). For example, for males from an Aboriginal and Torres Strait Island background, this may include organising a male worker of their choice to attend personal care or treatment (**Outcome 1.2**).
- minimising the use of **restrictive practices*** (**Outcome 3.2**)
- recognising signs of distress or situations where the older person's **psychological safety*** is at risk (**Outcome 5.5**)
- having strong safety protocols.

Also, make sure these strategies describe how your care and services will:

- optimise older people's **quality of life***, **reablement*** and help maintain their function. This will support the older person to be as independent as possible. For example, make sure it's clear how you will:
  - make appropriate and **timely*** referrals to **health professionals*** (**Outcome 3.4**) when you identify risk. This includes professionals from a range of different disciplines. For older people using home care services, this also includes referrals to My Aged Care for

them to be reassessed. For example, accessing a physiotherapist in the community for physical reablement after a fall. Use your organisation's communication **system*** to manage referrals (**Outcome 3.3**). This will help you to deliver quality, **multidisciplinary care*** (**Outcome 5.4**)

- support older people to make informed decisions about the care they receive (**Outcome 1.3**). For example, you can organise a case conference with the older person and the people they want involved in their care with any additional support they need. This can help the older person to feel confident and supported to participate in the discussion.
- support older people to understand the information you give them. This includes how you give older people access to extra supports to help them to understand the information. This can include advocates, interpreting services to support discussions about care and services and translation of written information into the older person's preferred language. In addition. This could also include speech pathologists to support communication or use communication aids for those with communication impairment.
- support older people to exercise **dignity of risk*** (**Outcome 1.3**). For example, if an older person has a history of **falls*** but still wants to go for a daily walk to the shops on their own, you should support them to do this. This includes talking with the older person about the risks and consequences involved. The older person needs to be able to understand how the risks or consequences may affect them. (**Outcome 5.5**).
- support older people to take part in **activities of daily living***. This includes supporting them to maintain social connections with friends, family and the community (**Outcome 1.1**). For example, for older people living in a residential care home, provide them opportunities to take part in activities that are meaningful to them. This may include gardening, music and trips in the community (**Outcome 7.1**). For older people receiving care in the home, provide strategies that support them to take part in social activities with friends, family and the community where possible. This should be informed by each older person's **needs, goals and preferences***.

- maximise worker continuity. For example, having the same care workers **regularly*** supporting an older person where possible, safe and preferred. This will support the provision of continuity of care (**Outcome 3.4**).
- provide reasonable opportunities for the older person to choose their workers, where possible. For example, you can support older people to choose workers based on their gender and the language they speak (**Outcome 1.1**).

Put in place a system* to provide care for people living with dementia*.

Make sure this **system*** supports safe and **quality care*** and services for people living with **dementia***.

It's important your system includes **processes***:

- to recognise early signs of **dementia***. The strategies you use for this should be informed by **contemporary**, **evidence-based practices*** (**Outcomes 2.3, 5.4** and **5.6**)

- for workers to assess the strengths and skills of people living with **dementia***. Make sure you encourage older people to use and maintain their strengths and skills (**Outcome 1.1**). You can collaborate with **allied health*** and other **health professionals*** to support older people's **activities of daily living*** and **quality of life*** and to maintain physical, mental and cognitive functions. For example, encourage and provide opportunities for people with dementia that are meaningful and in line with their preferences, such as rinsing their own dishes after a meal. For residential care providers, the guidance for **Outcome 7.1** has more information on how you can support older people with **activities of daily living***.
- to partner with the older person, their family, carers and **health professionals***. You need to involve these people when planning and delivering care and services to the older person (**Outcome 2.1**).

Put in place **processes*** to make sure **care and services plans*** for people living with **dementia*** reflect meet their individual behaviour support needs (such as mood, memory, thinking and behaviour), as well as their individual **needs, goals and preferences***. You need to tailor care and behaviour support strategies to the older person's individual needs and preferences following best practice behaviour support. This should also be recorded in their **behaviour support plan*** as part of their **care and services plan*** (**Outcomes 3.1** and **5.6**). You need to identify, assess and record any changes in their individual care and behaviour support needs. For example, if a person living with **dementia***:

- experiences **changed behaviour*.** This can include:
  - agitation. For example, when an older person calls out distressed, doesn't recognise their surroundings and wants to leave.
  - changes in their perception of time.
- Is no longer assessed as needing the use of **restrictive practices*** as part of their care to manage risks of harm, after they have settled into a new home or environment
- has behaviour support strategies that are no longer effective.

Put in place strategies to minimise the inappropriate use of restrictive practices.

To prevent harm to the older person, or other people, make sure **restrictive practices*** are:

- only used as a last resort. This means, you need to try tailored and individualised alternative strategies to the extent possible first. Document the use of these strategies in the older person's **behaviour support plan*** as part of their **care and services plan*** (**Outcomes 3.1** and **5.6**). This includes evaluating the effectiveness of these strategies and considering the likely impact of the use of **restrictive practices*** on the older person.
- used in the least restrictive form and for the shortest time necessary. This means, there is effective assessment, monitoring and review **processes*** to make sure the least restrictive option is used.

Also, make sure **restrictive practices*** are:

- only used if the older person or their **restrictive practices*** **substitute decision-maker*** provides **informed consent*** to the use of the restrictive practice and how it will be used. If the older person lacks the capacity to give their **informed consent***, this needs to be obtained from their **restrictive practices*** **substitute decision-maker***. Make sure you document a description of the consultation about the use of the restrictive practice and the giving of valid **informed consent***. The guidance material for **Outcome 1.3** has more information on **informed consent***.
  - monitored, reviewed and evaluated **regularly*** or if there is a change in the older person's circumstances. Check if there are any appropriate alternative strategies, even if it has been agreed that **restrictive practices*** can be used. This also includes evaluating the use of these strategies with the aim to reduce and eliminate the need for a restrictive practice.
  - documented in the older person's **behaviour support plan*** as part of their **care and services plan*** if used or assessed as necessary. This will guide the safe and appropriate use of **restrictive practices***. This includes:
    - any alternative strategies that have been considered and used prior to the use of **restrictive practices*** (**Outcomes 3.1** and **5.6**)
    - the documented success and failure of these attempted strategies to inform the older person's care
    - the **changed behaviours*** relevant to the need for the use of the restrictive practice
    - how the restrictive practice will be used. This includes its duration, frequency and intended outcome.
    - how the restrictive practice will be monitored and reviewed.

Where **restrictive practices*** have been assessed as necessary, make sure they are used in line with relevant legislation and the older person's assessed needs.

Put in place strategies to support workers to deliver quality and safe care and services.

You need to develop these strategies to meet the requirements of your risk management **system*** (**Outcome 2.4**).

These strategies need to support workers to:

- recognise risks or concerns about an older person's health, safety and **wellbeing***
- identify **deterioration***, changes to an older person's physical, mental and cognitive functions, or changes in their ability to perform **activities of daily living***. This includes changes to an older person's circumstances, **needs, goals and preferences*** (**Outcome 1.1**). For residential care providers, the guidance for **Outcome 7.1** has more information on identifying, monitoring and recording older people's function in relation to **activities of daily living***.
- respond to and escalate risks. Have escalation **procedures*** to make sure workers know who they can contact if they need support. For example, how to call for assistance and who to escalate concerns to after an older person has a **fall***.

Even if you don't deliver **clinical care***, you need to be aware of the **clinical care*** that has been delivered to the older person so you can support workers to identify risks. For example, if an older person has a wound dressing, you, as the provider, will need to understand how you will deliver showering services. This includes how your workers:

- engage with the wound while showering the older person in line with **health professional*** instructions and advice
- identify signs of wound **deterioration*** (such as pus) so clinical issues can be appropriately escalated and in a **timely*** way.

Also, make sure your strategies support workers to:

- make appropriate referrals and confirm these have been made in a **timely*** manner such as referrals to **health professionals*.** For example, when workers notice **deterioration***, changes to an older person's physical, mental and cognitive functions, or changes in their ability to perform **activities of daily living***.
- make sure older people have access to **multidisciplinary care***. This involves input from a variety of **health professionals***. Make sure processes are in place to support workers to communicate with each other effectively (**Outcome 3.3**).
  - for regional and remote providers, limited resourcing may affect **timely*** access to **multidisciplinary care***. These providers should consider strategies to make sure older people are appropriately referred to **allied health*** and **health professionals*.**
- maintain and support the older person's **mental health***, cognitive or physical function. Make sure you arrange a medical review if you notice **deterioration*** in any of these areas (**Outcome 5.4**).
- share information with older people when they're delivering care and services based on their language and communication needs and preferences. This can include both verbal and non-verbal communication.
- support older people to use equipment, aids, devices and products safely and effectively. The guidance for **Outcomes 4.1a** and **4.1b** has more information on managing equipment at home and in the service environment.
- involve older people in choosing workers who provide their care.

Make sure your strategies support workers to provide care to people living with **dementia***. This includes:

- providing care that is informed by **contemporary, evidence-based practices*** (**Outcome 2.3**)
- understanding the way different older people want information to be shared with them. Do this by identifying each older person's language and communication needs and preferences (**Outcome 1.3**).
- recognising and responding to **changed behaviours*** in people living with **dementia***. This includes making sure workers have access to behaviour-specific training (**Outcome 2.9**).

Also, make sure your strategies support workers to minimise the use of **restrictive practices***. This includes:

- understanding how to minimise the inappropriate use of **restrictive practices***
- clearly and consistently documenting the use of **restrictive practices*** and how they were monitored
- confirming **restrictive practices*** were used as a last resort to prevent harm to the older person or other people
- documenting the alternative strategies that have been considered or used prior to the use of **restrictive practices***.

Make sure workers who deliver care and services have the time, support, resources and skills to perform their role.

Provide workers with guidance and training on how to deliver quality care and services, relevant to their role (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to deliver care and services that:

- are **culturally safe***, **trauma aware and healing informed***
- meet the older person's **needs, goals and preferences***
- optimise the older person's **quality of life***, **reablement*** and maintenance of function
- recognise and respond to risks, concerns, changes and **deterioration*** of an older person
- support people living with **dementia***. This includes older people experiencing **changed behaviours***.
- minimise the use of inappropriate use of **restrictive practices***. Where **restrictive practices*** are assessed as necessary, make sure they are used in line with the older person's assessed needs.
- include the provision of person-centred behaviour support and best practice alternatives before the consideration or use of a restrictive practice
- enable effective verbal and non-verbal communication with older people. This includes people living with **dementia***, or older people who have difficulty communicating and changed communication needs.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Make sure that you deliver care and services safely and meet older people's needs and preferences.

Regularly* review how you deliver care and services across a sample of older people and workers. You can use information from these reviews to check whether you're delivering care and services as planned. This can include:

- completing experience surveys with people receiving care
- observing how workers are delivering care
- analysing **incident***, **feedback*** and **complaints*** information (**Outcomes 2.5** and **2.6**)
- reviewing clinical and care documents
- talking with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if they feel they're receiving safe and quality care and services that meet their **needs, goals and preferences***. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Use this information to find out if:

- workers understand how to:
  - make **timely*** referrals to **health professionals***
  - care for people living with **dementia***. This needs to be in line with **contemporary, evidence-based practices***.
  - minimise the use of inappropriate **restrictive practices***
  - involve older people in selection of workers who provide their care
  - share information with older people when delivering care and services
  - support the older person to use equipment, aids, devices and products safely and effectively.
- the older person's records are comprehensive and have enough detail to determine what decisions were made, why they were made and who made them. You need to include this information in care and service documents such as progress notes or **care and service plans***.
- workers are delivering care in line with the older person's **care and services plan***.

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 3.3

What is the outcome you need to achieve?

Critical information* relevant to the older person's care and services is communicated effectively with the older person, between workers and with family, **carers*** and **health professionals*** involved in the older person's care. Risks, changes and **deterioration*** in an older person's condition are escalated and communicated as appropriate.

Why is this outcome important?

Outcome 3.3 explains providers' obligations to communicate **critical information***, where appropriate, to older people and those involved in their care and services in a **timely*** manner. It also outlines how important effective communication is with older people, their family, **carers***, workers and **health professionals*** to raise concerns.

Timely* sharing of **critical information*** with workers, older people, families, **carers*** and **health professionals*** helps you to provide safe and **quality care*** and services. This includes:

- during **transitions of care***
- when an older person's condition deteriorates
- when an older person has **communication barriers***.

Putting in place effective **processes*** for sharing **critical information*** will help you make sure everyone involved in the older person's care are informed about their needs. **Outcome 3.3** highlights how important it is to share information with older people in a way that they understand and meets their communication needs and preferences.

Care statements* are provided to older people in residential aged care. They play an important role in keeping older people, their families and **carers*** **regularly*** informed about the care and services they receive. Older people and their representatives should find it easy to access **care statements***, so they can make informed decisions about the care they receive.

Providers must have **processes*** in place to make sure older people are correctly identified and matched to appropriate care and services. This helps make sure older people receive care that meets their unique **needs, goals, and preferences*.**

You need to give focus to:

- effective communication of critical **information***
- **timely*** communication
- formal **processes*** for escalating concerns about older people's health and **wellbeing***
- **processes*** to:

- identify and match older people to their care and services
- provide **care statements*** to older people in residential aged care.

Key tasks:

Put in place a communication system*.

This **system*** should include **processes*** that make sure:

- the older person and those involved in their care are provided with **critical information***. This can include their family, carers or others, workers and **health professionals***. Information needs to be shared in a **timely*** manner. This will help make sure older people receive the care and services they need. **Critical information*** can include:
  - information in a person's **care and services plan*** when they start receiving care and services (**Outcome 3.1**)
  - risks and control strategies (**Outcome 2.4**)
  - **incidents*** that can affect an older person (**Outcome 2.5**)
  - **clinical information***. For example, **comprehensive care*** needs, changes or deterioration that can affect an older person (**Outcome 5.4**).
  - **transitions of care*** (**Outcome 3.4**).
- you correctly store older people's records, such as **care and services plans***, in your **information management system*** (**Outcome 2.7**). Make sure you can identify these records, so the right records are matched to the right person. For example, you could use the older person's **Healthcare Identifiers***.
- you correctly identify and match older people to their care and services. You can do this can using the older person's full name, date of birth and their **Healthcare Identifiers***. For example, make sure you follow these processes* in situations where you are:
  - delivering care and services to an older person. For example, before administering medication or referring an older person to an **allied health*** or **health professional***.
  - generating clinical handover, transfer or discharge information. This can also include information about an older person's agreement, fees and invoices (**Outcome 1.4**).
- there are ways to escalate concerns about the older person. Older people, their families, carers, and **health professionals*** involved in the older person's care need to be able to escalate concerns. Contact details for those involved in the care and services of the older person should be kept up to date and easily accessible. This information needs to be stored using your **information management system*** (**Outcome 2.7**).
- workers can communicate and share information with older people safely and effectively. They should base this on each older person's language and communication needs and preferences.

If you provide residential care and services, your communication **system*** needs to have **processes*** to prepare and provide care statements to older people.

If you provide home care and services, make sure you have processes to communicate **clinical information*** to older people, families and other service providers.

Make sure workers are supported to communicate for safety and quality.

You can support workers by developing communication guides, training and strategies that are part of your organisation's **clinical governance*** framework (**Outcomes 2.9 and 5.1**). It may be helpful to develop a list of common scenarios and how workers can share information in each situation.

Make sure workers use the communication **system***:

- when the older person starts receiving care and services
- when the older person's **needs, goals and preferences*** change. You should **regularly*** partner with the older person and those involved in their care and services (**Outcome 2.1**).
- when risks have been found (**Outcome 2.4**)
- when there is a change of circumstance, **deterioration***, or after an **incident*** has occurred (**Outcome 2.5**)
- during handover or **transitions of care*.** For example, during a transfer to hospital (**Outcome 3.4**). For residential care providers, the guidance for **Outcome 7.2** has more information on how you support older people during transitions.
- to correctly identify and match older people to their care and services.

When workers use the **processes*** and **systems*** in place to communicate for safety and quality, encourage workers to consider:

- what information they need to share
- how quickly they need to escalate information
- who should be involved
- how they can best share this information. For example, it may be better to make a phone call, send an email or have a conversation in person. Make sure these communications are documented in the **information management system***. Workers should consider each older person's language and communication needs and preferences (**Outcome 1.1**) and share information in a way that they understand (**Outcome 1.3**). This can include:
  - using strategies such as simple language, large text and images as recommended by **allied health*** professionals (where relevant)
  - language services like interpreters and translators
  - routinely checking that the older person and those involved in their care have understood the information correctly.

You should record information that has been shared in progress notes or other documents in line with your **information management system*** (**Outcome 2.7**).

Monitor that workers communicate for safety and quality.

To check if your communication **system*** is effective, you can review:

- older people's care and services (**Outcome 3.1**) such as **care and service plans*** and progress notes.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- older people didn't know or understand something
- **critical information*** was not shared.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if they know and understand information about their care and services, including **critical information***. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality and communication **systems*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 3.4

What is the outcome that you need to achieve?

Older people receive planned and **coordinated care*** and services, including where multiple health and aged care providers, family and carers are involved in the delivery of care and services.

Why is this outcome important?

Outcome 3.4 explains providers' obligations to effectively plan and **coordinate care*** and services in partnership with older people, their families, **carers*** and others involved in their care and services. Clear, effective communication and using the **information management system*** is an important part of providing planned and **coordinated care*** and services. It's particularly important during **transitions of care***. For example, when a person moves between hospitals, homes or different care settings.

Including the older person, their families, **carers***, **health professionals*** and others involved in their care is also important. It helps to maintain continuity of care and make sure everyone involved knows about any changes. This can also help reduce **adverse events***, harm and disruption to the older person.

You need to give focus to:

- identifying other **health professionals*** and providers involved in an older person's care and communicating effectively to coordinate their care
- recognising and involving **carers*** as partners in the older person's care
- effective planning and coordination during **transitions of care*.**

Key tasks:

Put in place strategies to coordinate transitions.

Put in place strategies for planned and unplanned transitions in situations where an older person:

- is transitioning to and from hospital
- moves between other care services or stays in the community
- is receiving home support and is transitioning between short-term and ongoing service pathways.

Make sure:

- those involved in an older person's care and services have been identified. This includes:
  - family members
  - carers
  - health and aged care providers
  - workers
  - other **health professionals***.

  These people need to be involved in planning activities if the older person wants or needs them to (**Outcome 2.1**). For example, you should inform family members, carers and **substitute decision-makers*** when an older person transfers to and from hospital or between service providers. This makes sure they understand any relevant changes to care and services.
- the transition is planned and coordinated. You need to document the transition **process*** needs to be documented in line with the **information management system*** (**Outcome 2.7**). You need to communicate the transition **process*** to the older person and those involved in their care and services. Do this using your communication **system*** (**Outcome 3.3**). This supports continuity of care and services for the older person.

For residential care providers, the guidance for **Outcome 7.2** has more information on managing transitions for older people.

Make sure workers have the time, support, resources and skills to coordinate care and services.

Provide workers with guidance and training on how to coordinate care and services (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- identify who is involved in the older person's care
- talk with older people, their families and carers about transitions and coordinating care and services
- use your organisation's communication **system*** and **information management system*** to plan for and support transitions and coordinating care and services.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor that workers are partnering with older people and others involved in their care and services.

To check if workers are partnering with older people and other providers well, you can review:

- how well workers are following your **systems*** (**Outcome 2.9**)
- older people's care and services (**Outcome 3.1**) such as **care and service plans*** and progress notes
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- care and services have not been planned and coordinated effectively
- the older person, their family, carers and others involved in their care have not been included during **transitions of care***.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). Ask them if their provider and workers partner with them, their family, carers and others involved in their care during **transitions of care***. Ask them if they feel their care and services are effectively planed and coordinated. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Standard 4: The environment

What is the intent?

The intent of Standard 4 is to ensure that older people receive care and services in a physical environment that is safe, supportive and meets their needs. Effective infection prevention and control measures are a core component of service delivery to protect older people, their family, carers and workers.

Outcome 4.1a

What is the outcome that you need to achieve?

Providers support older people to mitigate environmental risks relevant to their care and services. Where equipment is used in the delivery of care and services or given to the older person by the **provider***, it is safe and meets the needs of older people.

Why is this outcome important?

Outcome 4.1a explains providers' obligations to make sure older people living in their own home receive care and services in an environment that:

- is safe and clean
- meets their unique preferences and needs
- supports their wellbeing, dignity, independence and **quality of life***.

Outcome 4.1a is about creating a safer home environment, so you can support older people to maintain their independence and **quality of life***. This helps them to do daily activities with reduced exposure to environmental hazards. Providers need to partner with the older person, their families and carers, to identify and mitigate possible environmental risks. Outlining a person's **needs, goals and preferences*** in their **care and services plan***, helps providers understand how best to maintain the person's independence and **quality of life***. Through a risk management **system***, providers can identify and address environmental risks. For example, poor lighting and slip, trip and fall hazards. This helps to mitigate the risk of harm to older people and workers.

Managing equipment is a key part of **Outcome 4.1a**. Devices and aids that workers and older people use must be safe, clean and suitable for the person's needs. Well-maintained and fit-for-

purpose equipment supports an older person's independence and **quality of life***. It also reduces the chance of injury when moving around the house or using mobility aids. **Regularly*** assessing equipment and aids and having maintenance plans helps to make sure all equipment is working and safe.
You need to give focus to:

- discussing environmental risks with older people.

Key tasks:

Put in place strategies that make sure the care and services you deliver in an older person's home are safe and meet their needs (Outcome 3.2).

These strategies need to cover all situations where you deliver care and services at a person's home. This helps make sure the environment is safe for the older person and workers.

When delivering care and services in a person's home, use the organisation's:

- risk management **system*** (**Outcome 2.4**). Do this to identify, assess, document, manage and review any environmental risks that may affect the safety of the older person and workers. This includes risks to do with any equipment or aids you use in the delivery of care and services. This also includes broader environmental risks such as overheating. Where the older person receives care and services from different providers, put in place **systems*** that enables workers to share information with each other to help identify risks.
- communication **system*** (**Outcome 3.3**). If you find any risks, discuss these and how you can manage them with the older person (**Outcome 2.1**). You also need to include other people, such as workers, family and carers in these discussions, with the older person's consent. Keep in mind that not all risks can be eliminated or mitigated, and older people have the right to **dignity of risk*** and choice during these discussions. **Dignity of risk*** is the right of the older person to live the life they choose, even if their choices involve some risk.
- information management **system*** to share information and communicate risks between providers, where the older person is receiving care and services from different providers.

When the older person first starts receiving care, you may need to do an equipment and aid assessment. This assessment is to make sure the equipment and aids you give to the older person, or that they already have, meets their assessed needs. This includes you finding and providing the equipment, aids, devices and products they need. You need to complete an equipment and aid assessment even if you're not providing equipment to the older person to assess that the older person's care needs are met.

Put in place strategies that make sure the equipment and aids you provide to older people are suitable, safe, clean and meet their needs.

Make sure that any equipment and aids you provide:

- meet each older person's needs and preferences (**Outcome 1.1**). Make sure this is based on the older person's **care and services plan*** as part of the assessment and planning process (**Outcome 3.1**). Some older people need a clinical assessment to identify what assistive equipment, aids and devices they need (**Outcome 5.4**). For example, an occupational therapist can assess the person to identify suitable mobility aids or transfer equipment, if they have difficulty moving around.
- are safe, clean and well-maintained for the older person to use. This includes equipment owned by providers and older people.

Also, put in place strategies to manage equipment. This can include:

- an inventory management **system*** to record information about the equipment, such as where it is, what condition it's in and who's responsible for maintaining it. You can also use this **system*** to record technical specifications of the equipment. This will help you to share and communicate information about the equipment and how it's used. If you have many items to keep track of, an inventory management **system*** can also help you track regular cleaning and maintenance needs.
- a maintenance plan that tracks when your equipment is scheduled for maintenance and repair works. This makes sure equipment is safe for ongoing use by the older person and workers. It needs to be clear whose responsibility it is to maintain equipment and aids. This can be documented in your agreements (**Outcome 1.4**).
- documented **processes*** to make sure you clean equipment **regularly***. For example, before you give it to an older person and when it's returned to you. This makes sure that equipment is cleaned and checked. Regular cleaning is important because dust, dirt or other materials can build up when equipment is used or has been stored. The **process*** you use to clean equipment should also be in line with **infection prevention and control*** practices (**Outcome 4.2**). For example, make sure equipment is cleaned straight away if it's visibly dirty or soiled. You may need to increase how often you clean for high touch surfaces and during infectious disease outbreaks. These processes will help reduce the risk of surface contamination and transmission of infectious diseases (**Outcome 4.2**). It also needs to be clear whose responsibility it is to clean equipment and aids. You can record this in agreements (**Outcome 1.4**) or **care and services plans*** (**Outcome 3.1**). Make sure equipment is cleaned with the right products, cleaning method, tools and following the manufacturer's instructions and safety advice.
- **processes*** to confirm that equipment contractors and older people supply and own and are safe and clean. This can include **processes*** to ask for maintenance schedules and photos of equipment before it's used, including equipment from the goods, equipment and assistive technology (GEAT) **provider*** or procured through the assistive technology and home modifications scheme (AT-HM).

Make sure workers who provide care and services in a home have the time, support and resources to manage risk.

Provide workers with guidance and training on how to assess, respond to and manage risks in a person's home (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- identify and manage risks using the risk management **system*** (**Outcome 2.4**)
- use the communication and information management **system***s to share critical information about identified risks (**Outcomes 2.7** and **3.3**)
- refuse to carry out an activity or provide care and services if they feel unsafe or threatened
- remove themselves from an unsafe or threatening situation and raise concerns if they need
- record **incident***s and **near miss***es using the **incident management system*** (**Outcome 2.5**).

The guidance for **Outcome 2.4** has more information on risk management.

The guidance for **Outcomes 2.8 and 2.9** has more information on workforce planning and worker training.

Make sure workers have the time, support and resources to check that equipment is safe, clean, well-maintained and meets the older person's needs.

Provide workers with instructions, guidance and training on how to check, maintain and clean equipment used in an older person's home (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- their **roles and responsibilities***.

Make sure workers understand how to:

- maintain and clean equipment following the manufacturer's instructions and safety advice and in line with your organisation's maintenance plan
- use the right cleaning products and method
- check that equipment and aids meet the older person's needs and preferences
- use equipment safely and support older people to use equipment and aids safely.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how well workers deliver care and services in an older person's home to make sure it's safe and meets their needs.

To check if you're managing risks in the home and the equipment you're using well, you can review:

- older people's care and service documents (**Outcome 3.1**). For example, care and services plans and progress notes.
- **feedback*** and **complaints*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- older people haven't been involved in deciding how you'll manage risks in their environment
- environmental risks haven't been managed well
- equipment or aids have been reported as unsafe, unclean, not functional or not suitable for the older person's needs.

Also, talk with older people, their families and carers about the safety, condition and comfort of their home when they're receiving care and services (**Outcome 2.1**). For example, ask them if their environment, equipment and aids are clean, safe, fit-for-purpose and meet their needs. Ask them if they feel their provider involves them when managing any environmental risks in their home. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). Assess if workers are using your risk management, communication and information management **systems*** to help identify and communicate risks. You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure***. This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system***.

Outcome 4.1b

What is the outcome that you need to achieve?

Older people access care and services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Equipment used in the delivery of care and services is safe and meets the needs of older people.

Why is this outcome important?

Outcome 4.1b explains providers' obligations to make sure older people receive care and services in a **service environment*** that is clean, safe and comfortable. A **service environment*** is the physical environment where a provider delivers care and services. This includes:

- residential care homes
- day therapy centres
- centre-based respite delivered in a community centre
- day and overnight respite services.

Outcome 4.1b highlights how important it is to improve older people's **quality of life*** by creating a **service environment*** that is welcoming, functional and accessible. Providers can make sure older people feel comfortable and included in their living spaces by designing spaces that:

- mitigate environmental risks
- promote movement
- support social interaction.

Focusing on identifying and managing environmental risks means providers can help older people maintain their independence and protect workers. Providers need to carefully manage risks such as not enough lighting or mobility barriers through a **risk management system***. This helps to create a safe and supportive **service environment***.

Managing equipment is a key part of **Outcome 4.1b**. Using suitable, well-maintained equipment makes sure older people receive care and services that is safe and meets their needs. Providers need to make sure equipment is **regularly*** cleaned and inspected. You also need clear **systems*** for maintenance and inventory management. This helps to protect older people's physical health and make sure they can do daily activities with reduced risk.

You need to give focus to:

- using fit-for-purpose equipment
- maintaining a **service environment*** that:
  - is accessible, including for older people with a disability
  - promotes movement and inclusion
  - reduces safety risks.

Key tasks:

Put in place strategies to maintain a safe, clean and comfortable service environment*.

Use your risk management **system*** (**Outcome 2.4**) when you put in place these strategies. This will help you to find, assess, document, manage and review any environmental risks that may affect the safety of the older person and workers. This includes risks related to the equipment or aids you use in the delivery of care and services.

Make sure strategies include:

- a cleaning **process***:
  - that makes sure the **service environment*** is clean, safe and comfortable. This can include buildings, access points, parking areas, gardens and the **service environment***'s general appearance and homeliness. Have a cleaning schedule that includes how often you recommend cleaning, as well as **procedures*** and the responsibilities of all workers. Providers must store cleaning products safely.
  - that is in line with **infection prevention and control*** practices (**Outcome 4.2**). Make sure you clean the **service environment*** and equipment straight away if it's visibly dirty or soiled. You may also need to increase how often you clean high touch surfaces and during infectious disease outbreaks. These **processes*** will help reduce the risk of surface contamination and transmission of infectious diseases.
- a cleaning and maintenance **process*** for equipment in the **service environment***. This makes sure that equipment is cleaned and checked **regularly***. Make sure equipment is cleaned and maintained using the right products, cleaning method, tools and following the manufacturer's instructions and safety advice.

Make sure the design and maintenance of the **service environment*** is fit-for-purpose and supports older people to do the things they want to do (**Outcome 7.1**). Do this in partnership with older people (**Outcome 2.1**) to make sure the environment meets their **needs, goals and preferences*** **(Outcome 1.1**). Also, consider **feedback*** from older people, their families and carers (**Outcome 2.6**). When designing and maintaining the **service environment***, consider spaces that:

- are welcoming, comfortable and provide older people with a sense of belonging
- have areas and equipment that keep older people safe while also:
  - promoting movement, engagement and inclusion among older people
  - enabling older people to move about indoors and outdoors.
- are **culturally safe***. For example, this includes the design of a culturally inclusive environment that:
  - meets the needs of the community you mostly deliver services in. For example, you may work with Aboriginal and Torres Strait Islander older people, their families and the wider community to design a **service environment*** that encourages cultural safety, respect and being inclusive of local cultures.
  - enables the increased presence of an older person's loved ones such as family, friends and carers to be with them more often during **end-of-life care*** and allows them to stay overnight if needed to follow cultural practices.
  - supports an older person to pray or practise other spiritual rituals
  - allows older people to host visitors.
- enable dementia-friendly design principles

- allow older people privacy when they want it.

For regional and remote providers, limited resources and higher costs may affect access to best practice design principles and design options. These providers should consider strategies to make sure their **service environment***:

- is safe
- is well maintained
- is fit-for-purpose
- meets older peoples' needs and preferences
- allows older people to do the things they want to do.

Make sure strategies consider if the **service environment*** is suitable for each older person. Consider the **service environment*** during the assessment and planning process (**Outcome 3.1**), and in partnership with the older person, to make sure it meets their **needs, goals and preferences*** (**Outcome 2.1**). For example, look for ways to:

- make the **service environment*** accessible, by considering the needs of each older person (**Outcome 1.1**). This includes older people living with disability. For example, installing entrance ramps or elevators in areas older people with mobility challenges may have difficulty accessing.
- identify and minimise risk. When you identify risks in the **service environment***, make sure you follow the risk management **system*** (**Outcome 2.4**) to address them. Do this in partnership with older people (**Outcome 2.1**) to understand how you can support their needs and preferences (**Outcome 2.1**) while also removing and reducing risk where possible. Consider the older person's right to exercise **dignity of risk*** if they choose to (**Outcome 1.3**). Make sure the controls you have to minimise risks:
  - are unobtrusive. This means you should minimise safety risks in a way that is least restrictive on an older person's freedom. For example, placing a fence around a secure area that is designed to blend into the landscape, or hidden using plants. Where it's in the interests of an older person's safety, it's appropriate to risk assess the controls (**Outcome 2.4**).
  - optimise useful stimulation. For example, by using visual cues such as appropriate contrast to highlight key features, direct visual access to spaces, and text and image in signs. This also includes reducing unnecessary clutter and background noise.
  - make the **service environment*** easy to navigate. For example, by placing objects older people commonly use in clear sight, clear signage on the bathroom door and motion sensor activated lights in hallways.
- maintain and design the **service environment*** to improve older people's **quality of life***, **reablement*** and maintenance of function (**Outcome 3.2**).

Older people should also have the choice to bring personal items to the residential care home (**Outcome 1.3**). For example, valuables, furniture or pictures. This can support the older person's daily living, including their **quality of life***, and help them to take part in meaningful and engaging activities (**Outcome 7.1**). Make sure you put in place **processes*** to identify, manage and minimise

risks related to personal items using the risk management **system*** (**Outcome 2.4**). This can include providing older people with enough secure storage for their belongings.

Put in place strategies that make sure the equipment used in the care and services you deliver are suitable, safe and clean and meet the needs of older people.

These strategies can include:

- an inventory management **system***. This **system*** is to record a list of your equipment. It includes details such as where they are and what condition they're in. It can also include their technical specifications. This may help improve information sharing, communication and use of your equipment.
- a maintenance plan. This plan is to track the schedules for maintenance and repairs of your equipment used inside and outside the **service environment***. This will help you to make sure equipment is maintained and safe for the older person and workers to use.
- a cleaning plan. This plan makes sure that your equipment is cleaned and checked regularly. Regular cleaning is important because dust, dirt or other materials can build up when equipment is used or has been stored. It needs to be clear whose responsibility it is to clean and maintain equipment and aids.

Make sure equipment that older people share is checked and cleaned between each use. This will help reduce the risk of infection and outbreaks of infectious disease as a result of contaminated equipment and surfaces (**Outcome 4.2**).

Make sure any equipment you use in the **service environment*** meets each older person's needs and preferences (**Outcome 1.1**). Make sure this is based on the older person's **care and services plan*** as part of the assessment and planning **process*** (**Outcome 3.1**). Some older people need a clinical assessment to identify what assistive equipment, aids and devices they need (**Outcome 5.4**). For example, an appropriately qualified health professional can complete an assessment to identify suitable mobility aids or transfer equipment if the older person has difficulty moving around.

Also, make sure there is enough equipment available to meet each older person's needs.

For regional and remote providers, limited resources may affect **timely*** access to equipment, **allied health*** and **health professionals***. These providers should have strategies to make sure equipment is safe, clean, well-maintained and meets the needs and preferences of each older person.

Make sure your workers have the time, support and resources to keep a safe, clean, comfortable and welcoming service environment*.

Provide workers with guidance and training on how to maintain a safe, clean, comfortable and welcoming **service environment***. This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- maintain a safe, clean, comfortable and welcoming **service environment*** that is fit-for-purpose and meets the needs and preferences of the older person
- use equipment safely and support older people to use equipment and aids safely
- use the risk management **system*** to identify and manage environmental risks in the **service environment***.

Assess if workers are following your quality **system*** (**Outcome 2.9**). Do this through quality assurance and **system*** checks.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Make sure the workers who use or manage equipment have the time, support and resources to maintain and clean equipment.

Provide workers with instructions, guidance and training on how to maintain and clean equipment used in the **service environment*** (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- maintain and clean equipment following the manufacturer's instructions and safety advice and in line with your organisation's plans
- use the right cleaning products and method in line with your organisation's cleaning plan
- do a risk assessment when equipment is faulty, damaged or causing risk of harm to people using it
- check that equipment and aids meet the older person's needs and preferences. This includes knowing **processes*** for how to escalate and refer to appropriately qualified health professionals (**Outcomes 3.2 and 5.4**) who can recommend suitable equipment and aids.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how well workers are maintaining a safe, clean and comfortable service environment*.

To check if you're maintaining a safe, clean and comfortable **service environment***, you can review:

- the older person's care and service documents (**Outcome 3.1**). For example, care and service plans and progress notes.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- you haven't involved older people in deciding how you'll manage risks in their **service environment***
- you haven't managed environmental risks or incidents well
- people have reported not feeling safe, welcome or comfortable at the service.

Also, talk with older people, their families and carers about the safety, condition and comfort of the **service environment*** (**Outcome 2.1**). For example, ask them if their environment is safe, fit-for-purpose and meets their needs. Ask them if they feel that their provider involves them when they manage any environmental risks in the **service environment***. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** checks. For workers caring for older people in a residential care home, you can do this as part of the monitoring **process*** in **Outcome 7.1**.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Monitor how well workers are using and managing equipment.

To check if workers are using and managing equipment well, you can review:

- older people's care and service documents. For example, care and services plans and progress notes (**Outcome 3.1**).
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**)

- reports from your inventory management **system*** and maintenance request records.

Look for situations where equipment or aids have been reported as:

- unsafe
- unclean
- not functional
- not suitable for the older person's needs.

Also, talk with older people, their families and carers about the safety, condition and comfort of the equipment and aids they use (**Outcome 2.1**). For example, ask them if their equipment and aids are clean, safe, fit-for-purpose and meet their needs. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews. For workers caring for older people in a residential care home, you can do this as part of the monitoring **process*** in **Outcome 7.1**.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Outcome 4.2

What is the outcome that you need to achieve?

The **provider*** has an appropriate **infection prevention and control* system***. Workers use hygienic practices and take appropriate **infection prevention and control*** precautions when providing care and services.

Why is this outcome important?

Outcome 4.2 explains providers' obligations to have practices and **processes*** that reduce infections. Maintaining an effective **infection prevention and control* system*** based on **contemporary, evidence-based practices*** is important for supporting a safe and healthy environment for older people and workers. **Outcome 4.2** strengthens the need for strong

infection prevention and control* **processes*** that aligns with obligations to reduce and manage infections during every aspect of care. This includes the appropriate use of **antimicrobial stewardship*** and **aseptic technique*** during clinical care (**Outcome 5.2**). Following these **processes*** can help providers to significantly reduce the risk and spread of infection to older people, their families, carers, visitors and workers.

Outcome 4.2 explains how having an **infection prevention and control system*** makes sure providers have **processes*** for:

- promoting immunisation
- managing infection-related issues
- responding to outbreaks.

An **infection prevention and control system*** should include a range of strategies to reduce infection and follow standard and transmission-based precautions. This can include:

- cleaning practices
- hand hygiene
- respiratory hygiene
- proper use of personal protective equipment (PPE)
- infection control procedures.

To support **continuous improvement***, providers need to monitor and review these practices **regularly***. You need to make sure they are effective and meet **contemporary, evidence-based*** guidelines for immunisation and infection control **processes***. Open communication about infection risks with older people, their families and carers also helps:

- providers to be transparent
- older people to make informed decisions.

You need to give focus to:

- responsibilities for the **Infection Prevention and Control Lead***
- making sure precautions are appropriate for the setting
- responding to novel viruses
- using immunisation rates to inform decisions
- responding promptly to outbreaks of infectious diseases
- using personal protective equipment.

Key tasks:

Put in place a system* for infection prevention and control*.

Make sure this **system*** reduces the spread of diseases and infections. This **system*** should be used together with **processes*** to prepare for, prevent and control infections in clinical care (**Outcome 5.2**).

Make sure your **infection prevention and control*** **system*** includes **processes*** to:

- appoint an **Infection Prevention and Control Lead*** for residential care homes. This role acts as the main point of contact for all infection issues. This role also oversees the **infection prevention and control*** **system*** and **processes*** to prepare for outbreaks. The **Infection Prevention and Control Lead*** needs to be a nurse who has completed, or is in the process of completing, the required specialist **infection prevention and control*** training. Consider how to best assign an **Infection Prevention and Control Lead*** during **workforce*** planning (**Outcome 2.8**). For home care providers, look for ways to appoint a worker or team to oversee your **infection prevention and control*** **system***.
  - for regional and remote providers, limited resources and increased workforce challenges may affect access to appropriately qualified and trained **Infection Prevention and Control Leads***. These providers should consider strategies to make sure their **infection and prevention control*** **system*** is overseen.
- put in place infection control strategies that are appropriate for the older person's home or **service environment*** (**Outcomes 4.1a** and **4.1b**). This includes standard and transmission-based controls. For example:
  - cleaning practices
  - hand hygiene practices
  - respiratory hygiene
  - cough etiquette
  - waste management and disposal.
- check **infection*** prevention controls and **processes*** to prepare for outbreaks are in line with **contemporary, evidence-based practice*** (**Outcome 5.2**)
- put in place **policies*** and **procedures*** to prepare for, prevent and control infections. This includes developing and maintaining outbreak management plans.
- manage infections and infectious disease outbreaks (**Outcome 2.10**). This includes both suspected and confirmed infectious diseases such as COVID-19, influenza, gastroenteritis or novel viruses. This means you need to act promptly when people are sick, even if you're not sure if it's an infectious disease.
- collect and analyse data on immunisation and **infection*** rates. This is to inform risk assessment and the ways you can improve your **infection prevention and control*** **system*** (**Outcome 2.4**).
- share information about **infection*** risks with older people, their families, carers, visitors and workers by using the communication **system*** (**Outcome 3.3**)
- prioritise the rights, safety, health and wellbeing of older people (**Outcome 3.2**). You need to include older people in deciding how to manage the risk of **infection*** (**Outcome 1.3).**
- meet public health notification needs, where relevant.

For residential care homes, undertake risk-based vaccine-preventable diseases screening and immunisation for older people and workers. This includes disease screening and immunisation requirements for visitors. This makes sure visitors or workers don't expose older people to infectious diseases.

Make sure you give older people current, accurate and **timely*** information about vaccines from relevant **health professionals***. Make sure you provide this information in a way older people can understand by considering their language and communication needs and preferences (**Outcome 1.1**). This information can include benefits, risks and costs (where applicable) of vaccinations. The older person can then make an informed decision and provide **informed consent*** if they have agreed to be vaccinated (**Outcome 1.3**).

Home care settings have unique infection risks. Older people are likely to have multiple workers and providers delivering care and services in their home. Workers may also be moving between multiple home settings. This can increase the risk of **infection*** between workers and older people. Put in place strategies to make sure workers are minimising or preventing the spread of **infection***. For example, support older people to maintain a clean and safe environment (**Outcome 4.1a**), perform hand hygiene and use personal protective equipment (PPE) appropriately.

The guidance for **Outcome 5.2** has more information on **infection prevention and control*** in **clinical care***.

Put in place a system* to manage the supply and use of personal protective equipment (PPE).

Put in place a **system*** to make sure PPE is suitable, available and has instructions on how to use it safely. In particular, where you are using PPE as a mitigative control to reduce disease and infection, as part of the risk assessment **system*** (**Outcome 2.4**). Make sure PPE is available for workers, older people, visitors and other care partners in your service, and you put in place strategies to make sure PPE is used correctly.

You need to develop, maintain and manage a PPE inventory to make sure there's enough PPE stock. The inventory manages:

- what PPE you need. For example, gloves, gowns, face shields/glasses and masks.
  - where to store PPE. Make sure you store PPE correctly, in a dedicated and accessible area.
  - when you need to replace PPE.

This inventory can be integrated with your **processes*** for managing equipment (**Outcomes 4.1a** and **4.2b**).

Make sure workers have the time, support and resources to manage infections and use PPE.

Provide workers with guidance and training on correct **infection prevention and control*** practices, including use of PPE (**Outcome 2.9**). This needs to be in line with:

- the organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***

- workers' **roles and responsibilities***.

Make sure workers and other care partners in your service understand how to:

- use and apply the **infection prevention and control* system***
- identify when to use standard and transmission-based precautions and apply this to the appropriate setting
- use and maintain PPE correctly. This applies to all people who need PPE, as well as to visitors and other care partners in your service.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor that workers follow the system* for infection prevention and control*.

To check if your **system*** for managing risks of **infection*** is working, you can review:

- older people's care and service documents. For example, care and services plans and progress notes (**Outcome 3.1**).
- **complaints*** and **feedback*** (**Outcome 2.6**)
- infection rates and trends
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- infections have been transmitted between workers, carers, older people or their families
- your organisation hasn't responded to outbreaks of infectious diseases or viruses in a **timely*** manner
- you haven't shared information on **infection*** risks well with older people, their family, carers or workers
- suitable PPE wasn't available, used when needed or it wasn't used correctly.

Also, talk with older people, their families and carers about the **infection prevention and control*** processes (**Outcome 2.1**). For example, ask them if they feel their provider and workers follow appropriate infection prevention and control precautions when delivering care and services. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews. This can be done as part of the monitoring **process*** in **Outcome 5.2**.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance material for **Outcome 2.3** has more information on monitoring the quality **system*.**

Standard 5: Clinical care

What is the intent?

Standard 5 aims to support providers improve the quality and safety of the clinical care* they deliver through Australian Government funded aged care services. It's a statement about the quality of clinical care* older people can expect when receiving aged care services, wherever they are in Australia.

The health needs of people receiving aged care are, usually, greater and more complex than those of the general population. We need to meet their complex health care needs in a coordinated* and multidisciplinary way that involves 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 and support 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 s**ystems*** 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 for Standard 5

The guidance for Standard 5 helps providers understand and put in place the actions they need to do for each outcome of the standard.

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 settings.

This guidance also includes 'key tasks' for each action.

Key tasks explain elements of **contemporary evidence-based practice*** in aged care. They include putting in place **systems*** and **processes*** and monitoring and continuously improving these.

The key tasks help providers to put in place each action. They're not meant to be a 'tick-box' or complete list of strategies to put in place.

Most key tasks can be used for residential and home service providers. However, there is sometimes a difference between how residential and home service providers need to (or can) use the key tasks for an action.

These differences are highlighted in the third column of the actions and key tasks tables called 'service context considerations'.

What will older people expect?

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

Key topics

The following key topics are covered by Standard 5 – Clinical Care. **These topics will be linked to the glossary.**

Key topics for all of Standard 5	Outcome 5.1 Clinical governance	Outcome 5.2 Infection prevention & control	Outcome 5.3 Safe and quality use of medicines	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
Quality Improvement	Governing body	Antimicrobial resistance	Medication administration	Comprehensive care	Sensory impairment	Cognitive impairment	Anticipatory medicines
Evidence-based	Routinely collected data	Antimicrobial stewardship	Medication management system	Clinical frailty	Eating and drinking with acknowledged risk (EDAR)	Behaviour support plan	End-of-life
Quality Care	Standard National Terminology	Aseptic technique	Quality use of medicines (QUM)	Comprehensive clinical assessment	Incontinence	Changed behaviours	Recognising end-of-life
Facilitate access	Clinical governance framework	Infection Prevention and Control (IPC) Lead	Medication review	Reablement	Incontinence associated dermatitis	Restrictive practices	Advance care planning
Allied Health	Conformant Software	Infection control	Polypharmacy	Reassessment	Falls		End-of-life planning conversations
Shared Decision Making	Scope of practice	Infection prevention	Medicine side effect	Telehealth	Functional decline		Bereavement support

Open Disclosure	Roles and responsibilities	Invasive devices	Medicine-related adverse event	ISBAR for structured clinical handover	Mental health	Last days of life
Supported decision-making	Clinical information system	Sepsis	Psychotropic medicines	Multidisciplinary care	Mental illness	Spiritual care
Dignity of risk	External health Professionals	Urinary Tract Infection (UTI)		Goals of care	Psychological safety	Palliative care
Informed consent	Healthcare Identifiers			Deterioration	Wellbeing	
	Interoperability				Oral health	
	My Health Record				Oral hygiene	
	Coordination of care				Preventative	
					Pain management	
					Pain-related communication barriers	
					Sensory impairment	

Outcome 5.1: Clinical governance

What is the outcome you need to achieve?

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 makes sure **clinical care*** is safe and high quality. It does this by developing a culture of **quality improvement*** and putting in place effective **systems*** and **processes***. Effective clinical governance* supports people to understand and follow the roles, relationships and responsibilities needed for an older person's care. To improve clinical outcomes and **wellbeing***, you need to:

- identify and manage clinical risks
- prevent harm
- improve **clinical care*** **processes***.

Everyone involved in **clinical care*** has a role in **clinical governance***.

The provider has **processes*** to collect and record data and **feedback*** from everyone involved in an older person's care, including the older person. They collect this information in a way that is safe, supported and confidential. They identify key areas that can be improved through **feedback*** and by analysing data on **clinical care*** **processes*** and **outcomes***. They share priorities and findings with the **governing body***, older people and staff in a way that is meaningful and useful.

There are **processes*** that describe the **roles and responsibilities*** of contracted, employed and external health professionals*, as well as the provider, to provide **clinical care***.

Using clinical information effectively can reduce risk to an older person during **transitions of care*** and when there is a change to their health or **deterioration***. **Timely*** access to up-to-date clinical information helps people to make clinical decisions. It also helps **health professionals*** to understand an older person's clinical history when providing care. It means providers can plan for appropriate **clinical care*** when a person comes into or returns to their service.

Service context considerations

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

Clinical governance* is put in place using a clinical governance framework that is appropriate to how complex the service is and where care is provided. Where there are multiple providers or **health professionals*** involved in a person's care, each **role and responsibility*** for that care should be clearly documented. The role of the older person, their family and other support people, should also be discussed and documented.

Actions and Key Tasks

Provider organisation		
Actions	**Key tasks**	**Service context considerations**
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.	• The decisions a **governing body*** make are informed by high-quality and accurate data and reporting from provider management. This includes the decisions they make about: - priorities for care - areas that can be improved - the strategic direction of the organisation - resources. Put in place systems* that drive safety and quality improvement*. The provider has **systems*** to monitor and evaluate the **clinical care*** the service provides. This includes **systems*** that use the results from monitoring and evaluation activities to improve care and services. Put in place **processes*** that make sure the **governing body*** has the information it needs to set priorities, strategic directions and monitor clinical **outcomes*** and **processes***.	**All residential and home service providers** have a **governing body*** who understands the organisation's priorities for the care they provide.

- Put in place a schedule for reporting to the **governing body*** on the quality of the care you're providing (**Outcome 2.3**).
- Use data you collect on how the service is performing to report to the **governing body***. This data should include:
  - **feedback*** from older people receiving care, their families, carers, **workers*** and other stakeholders, including information from **complaints*** and other types of **feedback***
  - clinical **incidents*** and other clinical measures or **outcomes***
  - clinical trends and reporting from other similar services
  - how effective the **clinical governance*** **system*** is in supporting **quality care*** and managing clinical risk
  - data collected for mandatory Quality Indicators (QI)
  - data from **routine data collection***, including when someone starts receiving care from your service
  - risks and **incidents*** including serious, non-reportable and **near misses***, as well as how they were managed and resolved
  - hospital transfers and the reasons for transfer.
- Make sure reports for the **governing body*** are clear and use accurate data and quality analysis.
- Make sure you have involved **workers***, **health professionals*** and older people receiving care in developing the goals for the service. You also need to share these

	goals with them.	
5.1.2 The provider implements the clinical governance framework as part of corporate governance*, to drive safety and quality improvement*.	**Put in place processes* and systems* in the clinical governance framework.** A **clinical governance*** framework describes the **systems*** an organisation uses to support **workers***, **health professionals*** and committees to understand and perform their roles. It also explains their responsibilities and accountabilities for providing **person-centred***, safe, **coordinated*** and effective care. • Put in place the endorsed **clinical governance*** framework by: - communicating a statement from the **governing body*** about the organisation's culture, priorities and commitment to providing quality **clinical care*** to all older people, **workers*** and **health professionals*** - outlining the roles, responsibilities and organisational structure for safely delivering quality **clinical care*** in the provider's **system*** - using measures of success in **clinical governance*** and safe and quality **clinical care*** and reporting on these measures - putting in place **processes*** for reviewing the **clinical governance*** framework - making sure plans, **policies*** and **procedures*** are accessible and used by **workers*** and **health professionals***. This includes documents **and systems*** that support the clinical governance framework and achieving safe, quality **clinical care***.	**Residential and home service providers** **All residential and home service providers** put in place a **clinical governance*** framework. To achieve **Outcome 5.1**, the **clinical governance*** framework needs to reflect the complexity of the **clinical care*** the service provides. **Home service providers** **Home service providers** aren't responsible for all aspects of an older person's care, all the time. However, they need to have **systems*** and **processes*** that meet all the **Actions in 5.1** appropriate to the size and service context.

  - putting in place **processes*** for **workers*** to help them monitor, evaluate and improve **clinical care***. This can include using risk management **systems***
  - clearly describing **roles and responsibilities*** for **clinical governance*** and safe, quality **clinical care*** in position descriptions. This makes sure that everyone working in the service understands, including contracted **health professionals***.
- Consider the resources you need to provide care based on **contemporary, evidence-based practice***, including training and development for **workers***.
- Make sure updates or changes to practice and assessment tools are identified and assessed against current legislation, guidelines and evidence.

Monitor, review and improve clinical care*.

- The decisions a **governing body*** makes are informed by high-quality and accurate data and reporting from provider management. This includes the decisions they make about:
  - priorities for care
  - areas that can be improved
  - the strategic direction of the organisation
  - resources.
- Use internal and external data you've collected about the service, to report to the **governing body***. This includes data on:
  - how effective clinical **processes*** are 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 issues and other clinical indicators
  - the **diversity*** or people who use their service including things like cultural background or disability (**Outcome 1.1**).
- Present data about the service in a way that is clear and useful to the **governing body***, managers, **workers*** and older people.
- Consider how you use the **clinical governance*** framework in practice and how you review it to make sure you're providing **quality care*** that is **person-centred***, safe, **coordinated*** and effective.
- Use information and reporting from the monitoring you do (explained above) to review and improve **clinical care***.
- Consider how you can measure success. Measures could include:
  - comparing **complaints*** data to show how you've improved
  - positive **feedback*** from older people
  - evidence **workers*** know your key **policies*** and **procedures*** for safe, quality **clinical care*** and are seen following them
  - **feedback*** from **workers*** show they're satisfied in their job
  - positive **feedback*** from visitors to the service

	- improvement in data reported through the National Mandatory Aged Care Quality Indicator program.	
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.	Put in place systems* for employing, contracting and managing clinical staff. • Make sure these **systems*** follow the **processes*** outlined in **Outcome 2.9**. • Verify and record credentials, qualifications, training and registrations. • Make sure management and **workers*** understand the **scope of practice*** for **clinical care*** staff and contractors. • Put in place **processes*** to make sure that contracted and visiting **health professionals*** have appropriate qualifications and experience to provide **clinical care***. Put in place processes* for managing clinical staff. • Make sure position descriptions and recruitment **processes*** clearly state the clinical skills, experience, knowledge and qualifications each role needs. • Make sure there are **processes*** for: - describing and monitoring the scope of clinical practice - providing clinical education and training - monitoring and managing performance - managing **health professional*** registration where required - ensuring **workers*** and **health professionals*** are aware and using the provider's safety and quality **systems*** and **processes***	**Residential and home service providers** **All residential and home service providers** have a responsibility to make sure they have **processes*** to verify the qualifications, training and experience of their **workers*.** **All providers** have responsibilities for **clinical governance*** as outlined in **Actions 5.1.1 to 5.1.5**. This includes using a **clinical governance*** framework that reflects the complexity of the **clinical care*** the service provides. The provider and **workers*** understand **workers'*** roles and **scope of practice***. There are **processes*** to make

- delegating work to support **quality care***, within **workers'* scope of practice***.

- Clearly describe **roles and responsibilities*** for **clinical governance*** and safe, quality **clinical care*** and make sure everyone working in the service understands them.
- Make sure that **roles and responsibilities*** for **clinical governance*** and safe, quality **clinical care*** are:
  - included in position descriptions
  - the terms of reference for committees
  - described in policy and **process*** documents.

Monitor, review and improve clinical care*.

- **Regularly*** review the organisational structure, position descriptions and contracts to make sure that **roles and responsibilities*** for safe, quality **clinical care*** are clearly explained at all levels of the organisation.
- Make sure a committee or specific person has the delegated responsibility for overseeing health professional registration and **scope of practice***.
- Ask older people for **feedback*** on the care they receive from **workers***.
- Make sure there are **processes*** to address concerns **workers*** raise about what is expected in their role.
- The provider should ensure sufficient and appropriately qualified staff tare available to provide the right care. The service culture should support clinical staff to report if they are not able to meet care

sure **workers*** perform their roles within their **scope of practice***.

Home service providers

Home service providers aren't responsible for all aspects of an older person's care, all the time. However, they should have **systems*** and **processes*** that meet all the **Actions in 5.1** appropriate to the size and service context.

	needs safely. Clinical staff must always work within their professional scope of practice. • Review **processes*** for monitoring, training and verifying competency and ensuring it aligns with evidence base practice (**Outcome 2.9**).	
5.1.4 The provider and health professionals* agree on their respective roles, responsibilities, and protocols for providing quality clinical care*.	Coordinated care* makes sures older people have access to the clinical care* that is right for them at the right time and in the right place. Put in place processes* for agreement between health professionals* and the provider. • The provider is responsible for facilitating access to care for older people when the provider can't meet their **clinical care*** needs. • These responsibilities could include: - working with visiting **health professionals*** or practitioners to develop clear **policies*** for **procedures*** and practices for **clinical care*** - preparing private spaces for visits if the older person prefers - working with the older person to get ready for appointments and understand what has been recommended for their care and their **care and services plans*** - supporting older people to access virtual care such as **telehealth*** - providing **health professionals*** access to **clinical information systems*** to make sure clinical information (like assessments, **medicines lists***, charts and notes) are:	For **Action 5.1.4**, there are important differences between **home and residential service providers.** The way this action is applied is different depending on the service context. **Clinical governance*** is put in place using a **clinical governance*** framework that is appropriate to how complex the service is and the type of service. Where there are multiple providers or **health professionals*** involved in an older person's care, the **roles and responsibilities*** for care should be clearly documented.

- available
- reviewed and updated
- securely stored in the provider's **system***

- making sure workers make any needed changes after **health professional*** reviews, including to **medicines***
- making sure the **health professional*** can access the older person's home (if this is the provider's responsibility) or the residential aged care home at the time of their appointment
- making sure the clinical workers and **external health professionals*** can access information about the services and level of care that the provider provides and how to refer to specialists when needed.

- Workers need to be informed and are responsible for keeping informed about any changes to an older person's care needs after treatment or assessment by **health professionals***, as appropriate, and with consent of the older person or their representative
- An agreement between **health professionals*** and a provider could include:
  - what the older person expects and what their **goals of care*** are
  - a list of responsibilities for **clinical care***
  - what behaviours and responsibilities are expected of both groups when providing **clinical care***

The role of the older person, their family and other support people, should also be discussed.

Home service providers

Older people in their own home may have several services or health care requirements met by **health professionals***, carers or others that have no relationship with the provider. What they do may affect the care the older person needs from the provider.

Communicate with other people and organisations that are also providing care. However, it's important to remember that this needs the consent of the older person or their representative. Where possible, have a written agreement between **health professionals*** and providers. This

	- the **processes*** for providing care that is included in the provider's clinical governance framework or the **processes*** the provider and the **health professional*** have agreed to - protocols for how clinical information is used including access, consent, sharing and editing - a timeframe to review the agreement - **Processes*** for updating **care and services plans*** and reporting **feedback*** and **incidents***. Monitor, respond and improve clinical care*. • Ask for **feedback*** from the older person to check that they're satisfied with their care. Use this to improve care. • Provide care in line with the agreed **processes***. • Review agreements **regularly*** between **health professionals*** and providers to make sure they're fit for purpose and support them to provide high-quality **clinical care***. • Review treatment and care plans **regularly*** to make sure they are in line with **contemporary, evidence-based practice***.	makes sure everyone involved in an older person's care know and understand their **clinical care*** needs.
5.1.5 The provider works towards implementing a digital clinical information system* that: a) integrates clinical information into nationally agreed	These key tasks can help all services **work towards** an integrated **clinical information system***. Consider how these can work in your service. Use **processes*** in **Outcome 2.7** to make sure information is secure and accurate and you use it with consent. 'Working towards', means if you don't yet have a **clinical information system***, the provider has: • looked at available **systems***	**Residential and home service providers** Providers are not expected to make sure external **systems*** are compatible. However, the provider should be working towards a

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.

- considered what they need the **system*** to do
- developed a detailed plan to put in place a suitable **system***.

An effective **clinical information system*** can support an older person's clinical safety. It can improve communication and continuity and coordination of care between settings, **health professionals*** and providers.

Using standard national terminology* means that information included in an organisation's **clinical information system*** are **interoperable*** with other **clinical information systems***. For example, the information can work with primary health provider **systems*** and can be used for de-identified data analysis.

It also means that clinical information in an organisation's **system*** can be understood and used by other **health professionals*** accessing this information. Using **health identifiers*** makes sure the right information is connected with the correct older person. It also identifies the **health professional*** or organisation that documented or reviewed the information in the **system***. Not all older people have, or have access to, **My Health Record***. Find out if older people have **My Health Record*** and document this information into your **systems***.

Put in place a system* to safely use clinical information.

- Include clinical information in care and service plans and use it to plan for care and when a person transitions between care settings and also for delivery of care and support of the older person not just planning.
- Consider how **outcomes*** of assessment

system* that can link with other **systems*** where and when this is possible.

Residential service providers

There are resources for **residential service providers** to help them to use **standard national terminology*** and **healthcare identifiers***. They can then use these when adding clinical information into their **clinical information system*** and whether the person has a **My Health Record***.

Home service providers

Consider how **the clinical information system*** will be used in the service by looking at current clinical information **processes***. This will help providers work out which **system*** is appropriate for their service or provider.

Consider where providers can combine data collection.

from more than one **health professional*** can be included in the providers **clinical information system*** to help plan care.

- Consider how you've structured and organised the information you collected. Consider how you can use it securely, with the older person's consent and in line with legislation.
- Manage clinical information using a digital **clinical information system*** that uses **conformant software*** and meets digital health standards.
- Consider how you can add data into **systems*** once and use it multiple times for different purposes. For example, work towards **systems*** that are integrated. This:
  - reduces mistakes
  - makes it easier for **health professionals*** to know where to find the most up-to-date information
  - makes sure data can be used for analysis and reporting.
- Providers should consider what data they collect and why they collect it to make sure they're collecting data for the appropriate reasons.

Consider how clinical information is managed when putting in place or working towards a new **system***.

Put in place processes* to manage clinical information.

- To safely manage clinical information, providers put in place **processes*** for:
  - transferring information from existing **systems*** into new **systems***. This helps mitigate the risk of incomplete, missing, unavailable or incorrect information in new **systems***.

- **medication management***. The guidance for **Outcome 5.3** has more information on documenting and managing **medicines***.
- **external health professionals*** to access the **clinical information system*** when needed and with consent. This allows them to document **outcomes*** of assessment and other relevant information. Also, consider how **health professionals*** can access your **clinical information system*** when offsite or during **telehealth*** or virtual appointments.
- **health professionals*** such as registered nurses, entering clinical information in the **clinical information system*** and using **health identifiers***
- workers to access the information they need for their role with the consent of the older person or their representative
- **health professionals*** to have access to clinical information in line with the older person's wishes and relevant legislation
- older people to access and review their **care and services plans***, if they ask to (**Outcome 1.3**). This should include considering displaying the plans onscreen or printing them.
- using the healthcare provider directory when sending secure messages, referrals, discharge summaries and test results.

- **Regularly*** review **advance care plans*** in

the provider's **clinical information system*** with the older person if that is their preference.

- Consider how you can support the older person to access and understand **advance care planning*** documents.
- The provider has **processes*** and the responsibility to:
  - ask for consent and record the **outcome*** for sharing and accessing clinical information
  - assign and communicate **roles and responsibilities*** for documenting and using clinical information.
- Eligible workers have **health professional*** identifiers and use these and the older person's individual **health identifier*** when accessing or adding information in an older person's **My Health Record*** or other health record **systems***. Using **healthcare identifiers*** supports interoperability* (exchange of information) with **nationally agreed health records** and other **clinical information system***, such as primary health provider **systems***.
- Develop and put in place a security and access policy to make sure workers keep older people's clinical information safe.

Monitor, review and improve processes* for clinical information accuracy and use.

- Assess your software **systems*** to understand how you manage and share clinical information currently.
- Identify gaps and areas where you can improve. For example, duplicating the same or similar information or manual entries that don't use standard

terminology or following the provider's **processes*** for recording clinical information.

- If you don't have a **system***, you can use the Australian Digital Health Agency's register of conformity to find suitable **systems*** that meet the service's needs.
- Use the resources on the Digital Health Agency's website to make sure relevant clinical information is integrated with other **systems*** using suitable software. If the provider doesn't have a **clinical information system***, they need to develop a plan to find a suitable software **system***.
- Review **processes*** and access requirements when you identify issues with the accuracy or security of information.
- Make sure workers and **health professionals*** understand **procedures*** for managing offline clinical information.

Outcome 5.2: Preventing and controlling infections in clinical care

What is the outcome you need to achieve?

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 has a role and a responsibility to prevent and control **infection*** in aged care, including:

- people providing and managing care in any aged care setting
- everyone going into a residential aged care home.

This includes aged care **workers***, **health professionals***, families, visitors, contractors and carers.

Older people are more vulnerable to infectious diseases. This is because of factors like:

- age-related physiological changes
- lower immunity
- co-morbidities. This means a person has more than one health issue at the same time. For example, someone might have arthritis, diabetes and depression.
- living with a group of other people in an aged care home
- **invasive devices*** used in their care.

These factors can also mean **infections*** can be harder to treat in older people. They might need more complex treatment or hospitalisation.

Outcome 5.2 is closely related to **Outcome 4.2**, in which general **infection prevention and control*** (IPC) **processes*** are required for all aged care **service environments***. **Outcome 5.2** specifically includes IPC in relation to **clinical care*** and includes the requirement for **antimicrobial stewardship*** (AMS) processes. The actions in **Outcome 5.2** support providers to use **systems*** and **processes***:

- to prevent people getting **infections*** from **clinical care*** **procedures*** and **invasive devices***
- to reduce exposure to and minimise the spread of **infections***
- to reduce resistance to **antimicrobial*** medicines such as antibiotics.

Providers can reduce the risk of **infection*** by following **evidence-based*** IPC strategies and national and local IPC guidelines. Clinically trained and qualified **workers*** and **health professionals*** should use **aseptic technique*** during relevant procedures. This can prevent people getting **infections*** from clinical **procedures*** such as inserting, maintaining and removing **invasive medical devices***.

AMS programs:

- promote appropriate use of **antimicrobials***
- improve care **outcomes***
- reduce negative effects of using **antimicrobials*** (including **antimicrobial resistance***, toxicity and unnecessary costs).

Service context considerations

Providers of both residential and home services are expected to have **systems*** and **processes*** for IPC and AMS. The provider's IPC focus may be different depending on the type of clinical services they offer and where they deliver these services.

Clinical **procedures*** in any service should only be done by qualified and trained **workers*** or **health professionals*** and within their **scope of practice***.

Actions and Key Tasks

Provider organisation		
Actions	**Associated key tasks**	**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.	While medical practitioners are responsible for prescribing **antimicrobials*** (such as antibiotics), there are many other **antimicrobial stewardship*** (AMS) strategies that aged care providers need to put into practice. The AMS Self-Assessment Tool and User Guide supports providers to monitor and understand their progress towards creating a comprehensive AMS program. *Chapter 16 of the Antimicrobial Stewardship Book – Antimicrobial stewardship in community and residential aged care and the Antimicrobial Stewardship Clinical Care Standard* have recommendations of **contemporary, evidence-based practice***. Put in place a system* for AMS. Document the parts of your AMS **system***, including: • **policies*** and **procedures*** to promote using **antimicrobials*** appropriately • **roles and responsibilities*** for AMS in your organisation, including leadership responsibilities • **processes*** for regular clinical reviews of the appropriate duration of	**Residential service providers** Put in place an effective **system*** and **processes*** for AMS. All key tasks for **Action 5.2.1** can support residential service providers to do this. **Home service providers** **Home service providers offering clinical care* including prescribing, supplying or administering antimicrobial medicines*** Put in place an effective **system*** and **processes*** for AMS. All key tasks for **Action 5.2.1** can support

antimicrobials* use, as well as specialist referrals, including microbiological testing where needed

- **processes*** outlining how the service accesses AMS expertise, if needed. For example, through a referral or by asking for advice from a suitably qualified **health professional***, such as a pharmacist credentialed to conduct **medication reviews***. For example, a clear process for collection and arranging laboratory testing of a wound swab.
- AMS education and training for **workers*** and **health professionals*** you employ or contract, suitable to their role
- **Processes*** for monitoring and reporting the effectiveness of the AMS **system***
- **quality improvement* processes*** for antimicrobial issues.

Put in place processes* for effective AMS.

Make sure **workers*** and **health professionals***:

- understand what they need to do to promote using **antimicrobials*** appropriately and reducing **antimicrobial resistance***. This includes their role in preventing **infection*** through:
  - hydration and diet
  - maintaining skin integrity
  - following appropriate hygiene and IPC practices such as hand hygiene.
- have the training and qualifications they

home service providers to do this.

Home service providers that <u>don't</u> prescribe, supply or administer antimicrobial medicines*

Put in place an effective **system*** and **processes*** for AMS. As there is less involvement with **antimicrobials*** in these services, the focus of AMS **systems*** and **processes*** may be on activities that support:

- preventing **infections*** through basic IPC practices such as hand hygiene
- educating home service **workers*** and **health professionals*** about using **antimicrobials*** appropriately and raising concerns about inappropriate use

need to perform their role

- understand how to monitor older people who have been prescribed **antimicrobials*** for effectiveness, side effects and **adverse events***
- understand how to recognise and escalate if they find **antimicrobials*** are being used inappropriately, including following appropriate **processes*** for raising concerns with **prescribers***
- have access to relevant clinical guidelines, such as ***Therapeutic Guidelines: Antibiotics, the Australian Medicines Handbook and other locally*** *endorsed* ***guidelines*.**

AMS activities can also include giving the older person information and an opportunity to discuss the risks and benefits of **antimicrobials***. This can help them make informed decisions with their **prescriber***.

Monitor, review and improve AMS processes*.

In proportion to the service's level of involvement in supplying, administering and monitoring **antimicrobials***, consider how to:

- monitor the frequency, duration and the clinical reasons for using **antimicrobials*** for the older people using the service
- analyse trends for using **antimicrobials***. This may include working with local pharmacies to gather data.
- **regularly*** monitor **infections*** and the use of **antimicrobials***. For residential services, this may include taking part in the Aged Care National Antimicrobial

- providing information to the older person receiving care about antimicrobial risks and benefits to support them make informed decisions.

	Prescribing Survey (AC-NAPS). • analyse the data you collect through this monitoring and report it to relevant stakeholders. This includes your **governing body***, **prescribers*** and to older people receiving care and their families. This can help you improve the effectiveness of your AMS **systems*** and **processes*** Some of the key tasks in **Action 5.3.6** on monitoring and evaluating **medication management systems*** can also be helpful when monitoring **antimicrobial*** use and trends in **adverse medicine related events*** and side effects.	
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 technique* b) using, managing and reviewing invasive devices* including urinary catheters* c) minimising the	Put in place an IPC system*. Document the parts of your IPC **system***, including: • **policies*** and **procedures*** that guide: - IPC practices relevant to the clinical services you provide - identifying people with suspected or confirmed **infections*** and notifying and escalating to local public health units and health and medical practitioners if relevant in a **timely*** way. • **roles and responsibilities*** for IPC, including senior leadership responsibilities and who holds the **IPC Lead*** role (where relevant) • clinical **procedures*** that need **aseptic technique*** and protocols for using **aseptic technique*** and clean **procedures*** • **invasive devices***and protocols for	**Residential and home service providers** Clinical **processes*** and **procedures*** should only be done by appropriately qualified and trained **workers*** or **health professionals***, within their **scope of practice***. **Residential service providers** Put in place an effective **system*** and **processes*** for IPC. All key tasks for **Action 5.2.2** can support providers to do this.

transmission of infections* and complications from infections*.	their insertion, monitoring, maintenance and removal • training **systems*** to support **workers*** and **health professionals*** to meet their IPC responsibilities, including education for care **workers*** to reduce the risk of contracting or spreading **infection***. Make sure the IPC **system*** is in line with: • endorsed national and state or territory guidelines, legislation and regulations • **contemporary, evidence-based practice*** in line with the Aged Care Infection Prevention and Control (IPC) Guide, a resource of the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Put in place IPC processes* for clinical care*. Make sure **processes*** support a risk-based approach to IPC for the service context. The **processes*** should consider: • the risk of **infection*** in the environment that you deliver care • types of services offered • **workers'*** and **health professionals'* scope of practice***. Make sure you support **workers*** and **health professionals*** to meet their IPC **roles and responsibilities***, including: • easy access to your IPC **policies***, **procedures*** and protocols • adequate training and time for **workers*** responsible for IPC, such as the **IPC Lead***, to carry out their IPC activities • adequate training and education for	**Home service providers** Put in place an effective **system*** and **processes*** for IPC. In the home service context, IPC is complicated by a reduced ability to control the environment where clinical **procedures*** are carried out. This may affect how you provide **clinical care*** and surveillance activities. Home service providers should design an IPC **system*** and **processes*** that use a risk-based approach. This makes sure they consider factors based on the type and context of their service.

those who perform aseptic **procedures*** and manage **invasive medical devices***

- appropriate equipment to perform aseptic **procedures*** and safely manage **invasive medical devices***
- making sure that workers can recognise the signs and symptoms of **infection***
- a **system*** to recognise and respond to older people with signs of **infection*** and escalate concerns. This may include escalation process, and workers roles in responding to infection.
- **processes*** to prevent, identify and manage urinary tract **infections***.

Monitor, review and improve IPC processes* and outcomes*.

As relevant to the service's context and level of involvement in clinical **procedures*** and using **invasive devices***, consider how to:

- monitor compliance with **processes*** and protocols for **aseptic technique*** and managing **invasive devices***, such as u**rinary catheters***
- assess and monitor risks of **infection*** and how effective your strategies to mitigate risk are
- use the data you collect from monitoring to identify opportunities where you can reduce exposure and transmission of **infection*** during **clinical care***.

Outcome 5.3: Safe and quality use of medicines

What is the outcome you need to achieve?

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?

Using **medicines*** safely and effectively supports an older person's health and **quality of life***. Unsafe use can cause significant harm. **Medication management*** is a common source of **complaints*** about aged care services. Medication errors are also one of the most common causes of clinical **incidents*** in aged care.

The provider is responsible for making sure medicines are used safely, consistently and appropriately in their services. They must create structures, **systems***, **processes*** and working practices to support correct medicine use. They need to set up robust medication **governance*** and **management systems***. The providers also need robust **processes*** to support workers to use medicines safely and to monitor and respond to an older person's changing clinical needs.

Actions under **Outcome 5.3** follow the principles and guidance of the *National Medicines Policy Guiding Principles Collection* for aged care, including residential services, home services and **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***.

Using **medicines*** safely and effectively is based on **person-centred care*** principles (**Outcome 1.1**). It relies on robust **clinical governance*** structures and **processes*** (**Outcome 5.1**).

Service context considerations

Providers of residential and home services involved in any part of **medication management*** must have **systems*** and **processes*** to use **medicines*** safely and effectively. **Medication management*** includes:

- prescribing medicines
- supplying medicines
- storing medicines
- administering medicines
- monitoring the effect of medicines
- providing information and an opportunity to discuss the risks and benefits of the medicine
- helping or assisting an older person with self-administration if required.

Medication administration* and medication assistance are different tasks. They have different legal conditions for who can perform them and when. All key tasks for **Outcome 5.3** are relevant for any provider that administers medication. This means all residential and some home services.

Some home service providers only assist with medication and don't administer medication. Medication assistance is when a worker supports a person to self-administer their **medicines***. Assistance doesn't include giving, measuring or dispensing a **medicine*** but can include prompting or assisting a person to open packaging. For these providers, it's still important to have robust **clinical governance*** **systems*** and **processes*** to make sure they meet **Outcome 5.3**. Specific considerations for these providers will be highlighted in the right-hand 'service context considerations' column of the key tasks table.

Actions and Key Tasks

Provider organisation		
Actions	**Key tasks**	**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,	Put in place a medication management system*. All providers whose workers are involved in any part of **medication management*** must have **systems*** and **processes*** that supports safe use of medicines in a way that meets state or territory legislation. Where the provider employs or contracts nurses, the provider must support them to meet the legal requirements of their registration and professional standards. The *e*-	**Residential service providers** Consider taking part in the national onsite pharmacist initiative to advise and assist with the safe and

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*

Therapeutic guidelines and ***AMH Aged Care Companion*** can support workers and **health professionals***.

When developing and reviewing your **medication management*** **policies*** and **procedures***, check the Department of Health and Aged Care's Guiding Principles for Medication Management in residential aged care, home service settings and community settings, or for **transitions of care***, as relevant to the service context.

A **medication management system*** sets robust **clinical governance*** for all **medicines***-related activities. A **medication management system*** includes:

- a **governance*** mechanism for managing and monitoring the **medication management system***. For providers that administer medication, this should be through an expert multidisciplinary group. In residential services, this group is called a Medication Advisory Committee (MAC).
- **policies*** and **procedures*** for any **medication management*** activities workers do, including:
  - discussing the risks and benefits with the older person
  - prescribing
  - procuring
  - dispensing
  - storing
  - administering
  - packaging
  - supplying
  - monitoring the effects of **medicines*** and escalate and report relevant

quality use of **medicines***.

Home and residential service providers

For services that administer medication

All key tasks for **Outcome 5.3** are relevant to providers and settings that administer medication. **Medication administration*** is different to medication assistance. **Medication administration*** is when someone gives a dose of a **medicine*** to a person. This can only be done by a qualified **health professional*** or, in some circumstances, a trained person being supervised by a qualified **health professional***.

Home service providers

Home service providers where medication

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.

adverse events or side effects

- assisting people to self-administer **medicines***.

- **policies*** on how **medicines*** are used and how to escalate a review for **health professionals*** and trained workers administering **medicines***
- standardised documentation and communication templates and protocols to make sure that you have a current and accurate record of all **medicines***. This list should be available to the older person and those involved in their care.
- an **adverse event*** and **incident*** monitoring and reporting **system*** and **processes***
- clear definitions of worker **roles and responsibilities*** for managing medicines. This needs to be in line with national and state or territory legislation, regulations and professional standards. These need to state:
  - who can administer or assist with medications in which situations
  - what competencies, qualifications and training they need
  - protocols for supervising and delegating medicine management
  - protocols for reporting medicine management concerns and escalating.

Put in place **processes*** for documentation and information access to make sure:

- there is a standard format in your information **system*** to document:
  - information about a person's **medicines***

assistance is given (but not administration)

If a provider only provides medication assistance, they still need strong **medication management systems*** and **processes***. Medication assistance is when someone helps a person to self-administer their **medicines***, such as through prompting or assisting them to open packaging.

The **systems*** should make sure that workers providing medication assistance have appropriate training, competency and supervision.

Workers providing medication assistance need to know about the limited scope of medication assistance tasks. These tasks don't include giving **medicine*** or making

- clinical reasons for their use
- a record of their use.

Make sure this information is documented in the provider's information **system***, using the *National Residential Medication Chart* or similar.

- there are standard protocols to support **timely*** communication about **medicines*** between the older person, **health professionals*** and **others involved in their care***. This is particularly important at **transitions of care***.
- all changes to a person's **medicines*** are documented in the provider's information **system*** in a **timely*** way. This includes when the changes are recommended by an **external health professional*** such as the person's GP.

Processes* for safe medication assistance should make sure that:

- workers understand what medication assistance tasks support self-administration, such as prompting or assisting the person to open packaging. Medication assistance doesn't include measuring, dispensing, or administering a dose of **medicine*** to a person or making any decisions about **medicine*** use.
- workers have the relevant training in medication assistance, are appropriately supervised and understand:
  - how to document the assistance they provided
  - how and where to escalate any concerns or observations about a person's **medicine*** use

any decisions about **medicines***.

Providers should have standard **processes*** to make sure workers understand:

- how to document the assistance they provided
- how and where to escalate any concerns or observations about how a person is using **medicine***
- what to do if an older person is unwell or they or their carer tells them about a medicine-related issue.

Home service providers delivering clinical services that don't involve any medication management*

Key tasks for these providers should at least make sure workers know how to document and escalate any

- what to do if an older person or carer tells them they are concerned about a medicine-related issue or the older person is acutely unwell.

observations or concerns about how an older person uses **medicines***.

Processes* for safe **medication administration*** should make sure:

- the difference between medication assistance and **medication administration*** is clear. **Medication administration*** (giving a dose of a **medicine*** to a person) is a complex and high-risk task that is strictly regulated under law.
- **health professionals*** understand their **roles and responsibilities*** for **medication administration*** under legislation, regulations and professional standards. The provider supports them to follow these, including through clear delegation and supervision protocols for making decisions.
- regulated **health professionals*** carry out administration, usually registered nurses or enrolled nurses with relevant training and supervision
- depending on local laws, in some situations, an appropriately trained and competent delegate, such as a care worker, can perform some **medication administration*** tasks. This must be under the supervision of a **health professional***.
- the older person's swallowing capacity and tolerance to different drugs are assessed and reviewed when needed. Recommendations should be documented and followed (**Outcome 5.5**).
- there is **timely*** and continuous access to

prescribed **medicines***, especially:

- at **transitions of care***
- when urgent clinical needs arise
- where there are changes to prescribed **medicines***.

In residential services, emergency stocks ('imprest') of a limited range of **medicines*** approved by the Medication Advisory Committee and in line with state or territory legislation, should be used for these purposes. Support for remote access for prescribing also helps make sure there is **timely*** and continuous access.

Processes* for **person-centred* medication management*** should make sure that:

- a person who is assessed as competent and willing should be supported to administer their own **medicines***
- older people, their carers and **substitute decision-makers*** are supported to take part in making informed decisions about their **medicines*** when they want this. Any decisions about **medicines*** need to be shared with the **prescriber***. Providers can support these decisions by:
- giving people an up-to-date, comprehensive and accurate **medicines list***
- giving people information about both non-pharmacological and pharmacological treatment options, where is this an option
- giving people information about the risks and benefits of **medicines*** so they can give **informed consent***, and to support adherence to medicine treatment plans
- involving the older person, carers and

	substitute decision-makers* in regular **medication reviews***.	
5.3.2 The provider has processes* to ensure medication reviews* are conducted including: g) at the commencement of care, at transitions of care* and annually when care is ongoing a) when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell h) when there is polypharmacy* and the potential to deprescribe* i) when a new medicine* is commenced, or a change is made to an existing medicine* or to the medication management plan j) when there is an adverse event potentially related to medicines*.	**Put in place processes* for regular and as-needed medication reviews*.** In 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 making sure **medicines*** are used safely. **Health professionals*** include medical practitioners, nurse practitioners and pharmacists. In practice, ongoing reviews of a person's **medicines*** routinely happen as part of usual clinical practice. For example, during an appointment with a GP. During hospital admissions, medications are often changed. **Transitions of care***, such as hospital discharge, are important causes for urgent **medication review***. Comprehensive **medication reviews*** by a credentialed pharmacist can also help to identify opportunities to: • provide more optimal therapies • identify side effects and interactions • encourage adherence • make sure medication is optimally administered • **deprescribe*** and reduce risk of harm from inappropriate **polypharmacy***. Certain medicines can increase the risk of clinical **incidents*** such as **falls***, and a **medication review*** should be considered as part of a comprehensive assessment after **incidents***. **Medication reviews*** should include identifying any medicines or remedies used by the older person that aren't prescribed, such as over the counter medicines or supplements. The following key tasks outline reasonable practice in **medication reviews*** for providers with services that involve **medication management***:	**Residential and home service providers offering clinical services that include any area of medication management*** All key tasks for **Action 5.3.2** are relevant. This includes where the **health professional*** performing a **medication review*** may be a GP or credentialed pharmacist who the provider doesn't directly employ or contract. In these cases, a provider may not have control over whether a review is done and how often. However, **systems*** and **processes*** should still make sure: • the need for a regular review is communicated to the relevant

- Put in place **processes*** to support regular (at least once a year) **medication review*** for each older person. If the **health professional*** completing this review isn't employed by or contracted to the provider, the provider needs to have **processes*** to tell the **health professional*** when there needs to be a review. This should include making sure any changes or recommendations that come from the review are documented in the person's **care and services plan*** and medication chart.
- Put in place **processes*** to monitor, document and communicate the effects and side effects of prescribed **medicines*** to the **prescriber***.
- Support workers and **health professionals*** to identify causes for **medication review***.
- Put in place **processes*** to encourage the use of standardised **processes*** for **medication reviews***. These should include:
  - documentation of available information about current (existing and newly prescribed) **medicines***
  - the history of medicine-related orders including oral and parenteral (ways other than oral), multiple and single-dose medicines.
- Reviews should consider things like:
  - Is there a documented reason or evidence base for using the **medicine***?
  - Does the older person still need the **medicine***?

health professional* and followed up if needed

- **outcomes*** from reviews are documented and changes are made to **care and services plans***
- workers and employed and contracted **health professionals*** know how to identify situations where a review is needed.

Home service providers

Home service providers not involved in medication management*

Key tasks should, at a minimum, be aimed at making sure workers know how to document and escalate any observations or

	- 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? • Consider the need for modification of administered medicines if an older person is acutely unwell or their health condition has changed. This may include acute exacerbations of chronic conditions.	concerns about an older person's **medicines*** to a relevant **health professional***. The concerns can then be communicated to the **prescriber*** where appropriate.
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.	Documenting and communicating each older person's allergies and previous reactions to **medicines*** is an important part of the safe and quality use of **medicines***. This should be recorded in the **medication management system*** described in **Action 5.3.1.** Put in place processes* to document allergies and adverse reactions. • Put in place a **process*** to make sure workers and **health professionals*** involved in the older person's care document known medicine allergies and any **adverse medicines-related event***. These will often be reported by the older person themselves. Also, make sure this information is kept up to date. • Make sure information about medicine allergies and adverse reactions is available to all **health professionals*** who prescribe, dispense or administer **medicines***. • Make sure workers know how to observe and document the older person's reactions to any **medicines***. This includes new allergies or side effects. Also, make	**Residential and home service providers** All key tasks for **Action 5.3.3** are relevant.

	sure they know how to escalate concerns to relevant **health professionals***.	
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 your **medication management system*** (**Action 5.3.1**), you need to set up clear **policies*, procedures*** and **processes*** for using **high-risk medicines***, in line with state and territory legislation. **High risk medicines*** include: • opioids • anticoagulants • insulin • **psychotropic medicines***, such as antipsychotics, antidepressants and anti-anxiety medicines. These pose a higher risk to older people if used in error. They can be associated with: • **adverse drug events*** • hospitalisation • poor health-related **quality of life*** • death. **Put in place processes* for safely using high-risk medicines*.** • Put in place **processes*** to identify, document, monitor, review and (**deprescribe*** where appropriate) the **high-risk medicines*** prescribed to older people in your service. • Put in place **processes*** to support safely using **high-risk medicines*** for each older person prescribed them, including:	**Residential and home service providers offering clinical services involving medication management*** All key tasks for **Action 5.3.4** are relevant. **Home service providers delivering clinical services that don't include medication management*** Home service providers should apply key tasks for **Action 5.3.4** that are relevant to their setting. Key tasks for home service providers should at least make sure that workers know how to escalate and document any concerns about an older person's

	- outlining clear **roles and responsibilities*** for handling and storing **high-risk medicines***, in line with legislation - putting in place effective channels for communication and information sharing between those involved in the older person's care, to monitor those taking **high-risk medicines***. This includes **external health professionals*** such as GPs and pharmacists. - documenting risk of harm and necessary mitigation strategies. This helps make sure the **medicine*** is used appropriately and the benefit for the person outweighs the risk. - consider planning regular **medication reviews*** by a credentialed pharmacist to monitor how effective medications are, their adverse effects and interactions with other medications and comorbid conditions. A comorbid condition is more than one medical condition happening at the same time. This also needs to include identifying any opportunities to reduce the dose or **deprescribe*** (**Action 5.3.2**). - supporting and facilitating the use of non-pharmacological strategies as a first line approach when appropriate. For example, when responding to **changed behaviours*** as outlined in the *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard*.	**medicines*** to a relevant **health professional***. They also need to record their concerns so they can be communicated to the **prescriber*** where appropriate.
5.3.5 The provider has processes* to report	**Adverse medicines-related events*** are the unintended and sometimes harmful **outcome*** of	**Residential and home service**

adverse medicine and vaccine events to the Therapeutic Goods Administration.	using a **medicine***, vaccine or medical device. Providers should respond to these adverse events following their **incident management system*** (**Outcome 2.5)**. • Providers should also report any **adverse medicines-related events*** to the Therapeutic Goods Administration. The Therapeutic Goods Administration regulates and investigates the safety, efficacy and supply of **medicines***. It has a national database of **medicines-related adverse events***. Put in place processes* for reporting to the Therapeutic Goods Administration. • Put in place reporting **processes*** for all new **adverse medicines-related events***. Train workers and **health professionals*** to use them. Make sure that workers and **health professionals*** know what an **adverse medicines-related event*** is, and what their **roles and responsibilities*** are. Depending on organisational policy, this may mean reporting to a manager or supervisor who reports issues to the Therapeutic Goods Administration.	**providers delivering clinical services involving medication management*** All key tasks for **Action 5.3.5** are relevant.
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** relates to monitoring, evaluating and improving the **medication management systems*** and **processes*** described in **Actions 5.3.1** to **5.3.5**. Put in place 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*.** Make sure these are endorsed by the organisation's medicines **governance*** group. For example, the Medication Advisory Committee in	**Residential and home service providers offering clinical services that include medication management*** All key tasks for **Action 5.3.6** are relevant.

residential aged care.

Put in place processes* to monitor, review and improve medication management*.

- Consider how to monitor for updates to relevant legislation and guidelines, put in place changes and evaluate your organisation's compliance.
- Consider how to assess if your **medication management system*** is successful in incorporating safe and quality use of **medicines*** in the everyday care of older people.
- Consider how to monitor if your **medication review*** **processes*** are being performed **regularly*** and when clinically indicated. Also, if your organisation communicates and acts on recommendations. This may include:
  - reviewing how **regularly*** routine **medication reviews*** happen 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 how effective your **processes*** are may include:
  - reviewing how you comply with the documentation you need to do at the start of care and at **transitions of care***
  - asking older people and their **substitute decision-makers*** if they feel informed and involved as much as

they want to be in decisions about their **medicines***. This includes in **medication reviews***.

- Strategies for assessing the safe and appropriate use of **medicines*** may include:
  - monitoring trends in the rate, type and effect of **medicines-related adverse events*** (such as those related to **falls*** and those leading to hospital admission)
  - analysing **incident*** reports and reviewing 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 your monitoring, identify and put in place **quality improvement*** strategies for **medication management***. Report the **outcomes*** of your **quality improvements*** to:
  - the **governing body***
  - workers
  - older people
  - other relevant organisations depending on the service context.

Outcome 5.4: Comprehensive care

What is the outcome you need to achieve?

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 a key approach to the planning, delivery and evaluation of all the **clinical care*** that an older person needs or asks for. The principles and practices of **comprehensive care*** support all other **clinical care*** outcomes and actions in Standard 5. **Comprehensive care*** considers the effect of clinical conditions on the older person's **quality of life*** and **wellbeing***. It also helps to make sure that risks of harm are minimised and managed.

To provide effective **comprehensive care***, providers need to build on principles of:

- **person-centred care* (Outcome 1.1)** and **reablement* (Outcome 3.1)**
- the assessment and planning **system* (Outcome 3.1)**
- **contemporary, evidence-based practice* (Outcome 2.3)**.

The aim of **Outcome 5.4** is to make sure **clinical care*** is driven by understanding and addressing the older person's clinical needs. It also needs to meet their individual preferences and **goals of care***.

Comprehensive clinical assessment by **health professionals*** provides the foundation for safe and high-quality **clinical care***. Providers should put in place **systems*** and **processes*** to partner with the older person in their care. In line with the older person's preferences, they involve:

- family
- **carers***
- **substitute decision-makers***

- others.

Information about options is provided in a way the older person can understand. This supports them to make informed decisions and provide **informed consent*** when needed. Older people's choices and decisions are respected. They're supported to exercise **dignity of risk*** to achieve their goals and optimise their independence and **quality of life***. **Dignity of risk*** is the right to live the life you choose even if those choices involve some risk.

The provider's assessment and planning **processes*** involve facilitating access to GPs, nurse practitioners, registered nurses and other primary and specialist **health professionals***. Together, in partnership with the older person they can identify clinical risks and plan their **clinical care***. Providers support continuity of care and older people are given the choice to maintain relationships with **health professionals*** of their choice. The provider's role in coordinating the delivery of care is included in their **processes***. This role encourages and supports multidisciplinary collaboration and communication between different **health professionals*** and services to meet the older person's clinical needs.

Service context considerations

Residential service providers have 24-hour responsibility for planning and managing the clinical needs and risks of older people. All the actions and key tasks under this outcome apply to residential services.

Home service providers have **systems*** in place to manage risks to older people that are in proportion to:

- how complex the older person's needs are
- the type of service
- context where they deliver care.

You work with the older person and others to understand and agree on arrangements for care provided by others.

Provider organisation			
Actions		**Key tasks**	**Service context considerations**
5.4.1	The provider implements an assessment and planning system* that supports partnering with	Put in place systems* for partnering with the older person, their family, carers and others in assessment and planning. • Comprehensive **clinical care*** **systems*** are designed to make sure **clinical care*** assessment and planning prioritises the **needs, goals and preferences*** of the	**Residential and home service providers** In **both residential and home services**, the provider puts in place **systems*** and **processes*** for partnering with the older person and

the older person, family, carers and others to set goals of care* and support decision-making.	older person. You need to have **systems*** that support **person-centred care* (Outcome 1.1)** and assessment and planning **(Outcome 3.1)**. You also need to put in place **systems*** and **processes*** to: - support older people to partner in all aspects of their care and decision-making - identify the older person's preferences for involving **substitute decision-makers***, family and **carers*** in their care - support workers and **health professionals*** to understand their **roles and responsibilities*** for partnering with older people. This includes supporting older people to understand the **outcomes*** of assessment and the role of **health professionals*** in their care. This helps to inform their choices and preferences for care and services (**Outcome 3.1**). - review ongoing and end-of-life documents (this may include an **advance care planning document*** if in place or being considered) with the older person, representatives and others to make sure they're complete and current (**Outcome 3.1**). This should be	others. This is in line with their **needs, goals and preferences***. **Home service providers** **Home service providers** have **systems*** in place for assessing and planning for older people that are proportionate to: • how complex the older person's needs are • the type of service • the context where care is delivered. Providers partner with the older person, carers and others to understand and agree on care arrangements. This includes the care provided by others.

done if and when the older person chooses.

Put in place processes* for partnering with the older person, their family, carers and others in assessment and planning.

- Partner with older people to set **goals of care*** through discussions about:
  - what is important to them
  - their needs and values
  - their goals for their health and **wellbeing***.

  These discussions need to be in line with the older person's preferences. These should also include the older person's family, carers and others they choose to involve in their care. If an older person lacks the capacity to make decisions, include their **substitute decision-maker***.
- Document and include **goals of care*** in clinical assessment and the **care and services plan***. **Regularly*** assess and evaluate progress towards achieving the person's **goals of care***.
- Support older people to access and understand information about their **clinical care*** and services, in line with their needs and preferences (**Outcome 3.1**)
- Provide workers with access to training on:
  - the principles of **person-centred care***

		- **supported decision-making*** - **informed consent*** - **processes*** to communicate with older people in line with their preferences. Monitor, review and improve systems* for partnering with older people. • Analyse **feedback*** from older people and others involved in their care about the quality and experience of **partnership*** in setting goals and decision-making. • Review clinical records to make sure **goals of care*** are included in clinical assessments and **care and services plans***. • Collect information about older people's experiences, reviews of documentation or other reporting and monitoring activities. Use this information to improve the safety and quality **of systems*** and **processes*** for partnering with older people. Report the results of the work you do to improve quality to the **governing body***, older people and workers.	
5.4.2	The provider conducts a comprehensive clinical assessment on commencement of care, at regular intervals and when needs change, that includes:	**Put in place processes* for comprehensive clinical assessment.** • You need to have robust **systems*** for **person-centred care*** (**Outcome 1.1**), assessment and planning and **reablement*** **(Outcome 3.1)**. Put in place **evidenced-based*** clinical assessment **processes*** that:	**Residential and home service providers** In **both residential and home services**, the provider has robust **systems*** and **processes*** for comprehensive clinical assessment.

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

- 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

c) identifying and providing access to the equipment, aids, devices and products required by the

- identify and address how complex the older person's clinical conditions, issues and risks are. The older person's **care and services plan*** needs to include strategies to prevent, mitigate and escalate:
  - acute conditions
  - exacerbations of chronic conditions
  - clinical risks of harm.
- provide opportunities for older people to maintain or regain function or skills to optimise their independence and **quality of life***.

- Make sure that reassessment includes evaluating 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, nurse practitioner and other appropriate **health professionals*** for clinical assessment and to support continuity of care. Use **telehealth*** where appropriate for the older person, if the provider can support a **telehealth*** appointment.
- Make sure **health professionals*** have the knowledge, training and skills to:
  - complete a comprehensive clinical assessment

How often clinical assessment is completed in **all care settings** is at a minimum:

- at the start of care
- at regular times (at least once a year)
- when there is change or **deterioration***.

Home service providers

Home service providers have **systems*** to manage risks to older people that are in proportion to:

- how complex the older person's needs are
- the type of service
- the context where care is delivered.

Providers partner with the older person, carers and others to understand and agree on care arrangements. This includes the care provided by others.

When completing clinical assessment, home service providers need to consider:

- how complex the older person's clinical needs are
- the type of service

older person	- document the **outcomes*** of the 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).** • Make sure there are **processes*** for workers to use assessment **outcomes*** to inform planning for continuity of care, including at **transitions of care***. • Make sure appropriate assessment is completed by a qualified **health professional***, including **allied health*** professionals. - Which includes supporting older people who have difficulty communicating. Monitor, review and improve assessment and care planning. • Analyse clinical data and **feedback*** about comprehensive clinical assessment such as: - assessment quality and frequency - whether the older person's preferred GP and relevant **health professionals*** were involved - how assessments are included in care planning. • Based on the **outcomes*** of your monitoring, identify and put in place **quality improvement***	• the context where care and services are delivered. Recent assessments completed by a GP or other **health professionals*** and hospital discharge instructions should be included in the older person's **care and services plan***.

	strategies for comprehensive clinical assessment. • Evaluate and report on the **outcomes*** of your **quality improvement*** activities to the **governing body***, workers, older people and other relevant organisations.	
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.	**Put in place processes* for referring to and facilitating access to health professionals*.** Develop robust **systems*** for **person-centred care*** (**Outcome 1.1**) and the assessment, planning and delivery of care (**Outcomes 3.1** and **3.2**), including **processes*** for referring to and **facilitating access*** to **health professionals***. • Develop referral pathways that facilitate access to a range of **health professionals*** and health services. These may include: - GPs and other primary health care professionals - nurse practitioners - registered nurses - pharmacists - specialist doctors such as a geriatrician or neurologist - **allied health*** professionals (who have distinct roles to support **reablement*** and maintain function). • Make sure referral pathways include ways to access: - geriatricians and other	**Residential and home service providers** In **both residential and home services**, the provider puts in place **processes*** for **facilitating access*** to relevant **health professionals*** to address the older person's needs and preferences. What is expected of providers will depend on: • the structure of their **workforce*** (including the **scope of practice*** of **health professionals***) • the service type • the context where services are delivered and any legislative or other provider obligations. **Home service providers** **Home service providers** have **systems*** in place to manage risks to older people that are in proportion to:

specialist doctors
  - dentists and **oral health*** practitioners
  - specialist nursing services
  - clinical advisory services
  - dementia support services
  - multidisciplinary specialist teams, such as a **palliative care*** team.
- Identify and access services that provide emergency and out-of-hours **clinical care*** such as medical and dental services when needed.
- Support the older person's preferences about referral to **health professionals*** and services. Identify and document their current relationships with **health professionals*** and private health insurance status (if they have this) to support choice and continuity of care.
- Make sure workers and **health professionals*** have the knowledge and skill to identify when older people need access to specific **health professionals**. This is based on assessments completed:
  - at the start of care
  - during scheduled clinical reviews
  - in response to change or **deterioration*** in the older person's condition or function
- how complex the older person's needs are
- the service type
- the context where care is delivered.

Providers partner with the older person, carers and others to agree on and document care arrangements. This includes the care provided by others and facilitating access to care provided by others.

  - when the older person's needs can't be met by the provider's **workforce***.

- Based on the older person's clinical needs and preferences, **facilitate access*** to relevant **health professionals*** and specialist services when needed.
- Have robust **processes*** to define the **roles, responsibilities*** and accountability for **health professionals*** involved in the **clinical care*** of the older person (**Outcome 5.1**). Document the details of the older person's preferred **health professional*** who is responsible for overall care (such as the GP or nurse practitioner). Make sure up-to-date contact details are available in the provider's **system***.
- Make sure workers and **health professionals*** use standardised clinical communication tools such as **ISBAR*** to support communication with **health professionals*** and use **standard national terminology*** (**Outcomes 3.4** and **Outcome 5.1**).

Monitor, review and improve processes* for referring and facilitating access to health professionals*.

- Collect, analyse and report data on referrals to **health professionals*** and health services, including barriers to access and waiting times.
- Support effective **partnerships***

	with **health professionals*** and services to address any barriers to access.	
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.	**Put in place processes* to deliver multidisciplinary care*.** • Have robust **processes*** for delivering **person-centred***, **holistic*** and **comprehensive care*** in **partnership*** with the older person. This care needs to address the older person's **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. • Develop robust **processes*** in **Action 5.4.3** and **Outcome 5.1** to collaborate with the multidisciplinary team to: - define **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 skills in effective multidisciplinary teamwork and communication. • Have robust **processes*** for access to after-hours and urgent **clinical care*** when you identify clinical	**Residential and home service providers** In **both residential and home services**, providers have robust **processes*** to deliver **comprehensive care***. **Processes*** will be proportionate to: • how complex the older person's clinical needs are • the provider's agreed role in care coordination • the service type • the context where care and services are delivered. **Home service providers** **Home service providers** have **systems*** in place to manage risks to older people that are proportionate to: • how complex the older person's needs are • the service type • the context where care is delivered. Providers partner with the older person, **carers*** and others to agree on and document care

deterioration* and need to escalate. This needs to be in line with the older person's **goals of care***.

- Consider how your service supports virtual care arrangements.
- Have robust communication **processes*** and protocols for notifying relevant people about clinical **incidents*** or changes, including:
  - GPs and other **health professionals***
  - **substitute decision-makers***
  - the older person's family and **carers***.

  Examples include notification of a **fall***, **transition of care***, changes in clinical condition and **incidents***.
- Make sure effective communication is supported by documenting and sharing **care and services plans*** and clinical information where appropriate.

Monitor, review and improve processes* for multidisciplinary care*.

- Consider strategies for monitoring and measuring the effectiveness of your **processes*** to deliver **comprehensive care***.
- Identify areas of improvement when communicating and working with a multidisciplinary team.
- Make sure the monitoring and measuring of the delivery of

arrangements. This includes the care provided by others.

Home service providers may need to consider assessing **carers*** to identify their role and ability to support the older person. Care and services planning can be based on this information.

	comprehensive care* includes: - reviews of **care and service plans*** - assessment **outcomes*** - **timely*** access to **health professionals*** that is in line with the older person's needs and preferences. • Consider **incidents*** and indicator data to identify areas of improvement for delivering **comprehensive care***, such as the **processes*** for access to after hours and urgent care.	
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*.	Put in place processes* for clinical monitoring and reassessment. • Develop robust **systems*** for **person-centred care*** (**Outcome 1.1**) and care planning and delivery (**Outcomes 3.2 and 3.3**). Do this by putting in place **processes*** to support **timely*** monitoring and reassessment of clinical conditions, including: - recognising and responding to signs and symptoms of clinical **deterioration*** in an older person's behaviour, cognition, **mental***, physical or **oral health***, and at **transitions of care*** - developing and using escalation pathways for older people's care - providing ways for older people, **substitute decisions-makers***, **carers*** and family to	**Residential and home service providers** **Residential and home service providers** have robust **processes*** to monitor and respond to clinical **deterioration***. The level of monitoring and response is proportionate to: • how complex the older person's condition is • the service type • the context where care is delivered. **Residential service providers** In **residential services,** providers are expected to deliver 24-hour care. This includes:

escalate concerns about changes or **deterioration*** in an older person's condition

- reviewing and evaluating the effectiveness of **comprehensive care*** **regularly***. You also need to review when someone is transitioning between care, experiences clinical **deterioration*** or changes in needs. This is done in **partnership*** with the older person, a multidisciplinary team and **substitute decisions-makers***, **carers*** and family.

- Train and support workers and **health professionals*** to identify, monitor and respond to changes or clinical **deterioration*** This should be in line with their **scope of practice***.

Monitor, review and improve processes* for clinical monitoring and reassessment.

- Review **feedback*** about how **timely*** and appropriately workers and **health professionals*** respond to change or **deterioration***.
- Review and analyse clinical assessment, monitoring and documentation of the older person's clinical condition to identify areas for improvement.
- Use **outcomes*** from this review to improve how you respond to
  - monitoring
  - documentation
  - management
  - escalation of a person's clinical change or **deterioration*** to **health professionals***, when needed.

Home service providers

Home service providers have robust **systems*** to manage risks to older people that are proportionate to:

- how complex the older person's needs are
- the service type
- context where care is delivered.

Providers partner with the older person, carers and others to agree on and document care arrangements. This includes the care provided by others.

Home services where providers don't deliver 24-hour care

Providers need to make sure that all relevant workers and **health professionals*** use **processes*** to identify and provide **timely*** escalation of changes or **deterioration***.

clinical **deterioration***.

Outcome 5.5: Clinical safety

What is the outcome you need to achieve?

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's important for older people to receive **clinical care*** that optimises function, minimises harm and is:

- high-quality
- safe
- **person-centred***
- **evidence-based***
- **coordinated***.

Clinical areas of risk that need to be a priority as identified by the Royal Commission into Aged Care Quality and Safety include:

- choking* **and swallowing**
- continence*
- falls* **and mobility**
- **nutrition and hydration**
- mental health*
- oral health*
- pain*
- pressure injury* **and wounds**
- sensory impairment*.

To reduce the risk of clinical **deterioration*** that can be prevented, providers need to consider:

- the effect of co-morbidities
- how one or more clinical conditions and risk interact
- psychological factors such as past experiences of trauma or abuse
- the older person's preferences for care (**Outcomes 1.1, 1.2** and **1.3**).

Evidence-based* **clinical care*** maintains and aims to optimise the older person's physiological and psychological function. It responds to clinical change or acute **deterioration***. Providers have **processes*** for identifying, monitoring and responding to changes in **clinical care*** needs and **facilitating access*** to specialist care when needed. Data is collected on **outcomes*** of care and **incidents*** and is used for mandatory reporting and **continuous improvement*** (**Outcome 5.1**).

Providers complete clinical assessment when care starts and **regularly*** throughout an older person's care. This is described as part of **comprehensive care*** in **Outcome 5.4**. **Processes*** for assessment or referring a person to a GP or relevant **health professional*** for assessment, are outlined in the provider's **policies*** and **procedures***. Clinical assessments may identify additional clinical risks to those described in **Actions 5.5.2 to 5.5.10**, that also need to be managed and monitored.

Outcomes* of assessments are documented in the **clinical information system***. **Coordinated care*** from relevant specialists and **allied health*** professionals are delivered when needed. Professionals who deliver **clinical care*** in line with an older person's preferences may include:

- provider clinical staff
- registered nurses
- GPs and other specialist doctors
- nurse practitioners or specialist nurses
- oral and **allied health*** professionals
- pharmacists
- Aboriginal and Torres Strait Islander health practitioners.

These people also have access to the older person's clinical information at the point of care, with their consent.

Using the **processes*** from Outcome 3.2, providers plan and document actions to reduce risk of harm from the prioritised list of clinical areas of risk, including risks highlighted in **Actions** 5.5.2 to 5.5.10. These plans are also communicated to older people, workers and **others involved in their care***.

As with all aspects of **clinical care***, improving clinical safety is within the context of shared and **supported decision-making***. It also involves respecting a person's choice to make decisions that may involve risk to their health. This is described in the Statement of Rights (**Outcome 1.2**).

Service context considerations

Home service providers have **systems*** in place to identify, manage and escalate risks to older people that is proportionate to the care and services you provide (**Outcome 2.4**). You work with the older person and others to understand arrangements for care provided by others (**Outcome 5.1**).

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

Actions and Key Tasks

Provider Organisation		
Actions	**Key tasks**	**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 line with the principles of care planning, **clinical governance*** and **comprehensive care*** (**Outcomes 3.1, 5.1** and **5.4**). This is so older people can access **health professionals*** who have the appropriate skills with a **scope of practice*** to manage and treat their clinical care needs. • Meeting clinical care needs includes providing older people with the information they need to make decisions about their care and making sure the person's goals and preferences guide decisions. This includes supporting **dignity of risk*** (**Outcome 1.3**). • **Health professionals*** referenced in these key tasks may include: - GPs and other primary health care professionals - geriatricians and other specialist doctors - nurse practitioners and specialist nurses - registered nurses	**Residential and home service providers** **All residential and home service providers** should have **systems*** and **processes*** to manage older peoples' **clinical care*** needs, to mitigate risk and make sure older people are safe. These key tasks describe common risks that often cause harm to older people when they're not managed appropriately. **Home service providers** **Home service providers** have **systems*** in place to

- enrolled nurses
- pharmacists
- **allied health*** professionals
- **oral health*** practitioners
- multidisciplinary specialist teams, such as palliative care teams.

- Providers should partner with older people and make sure they have access to, and understand, the information they need to make decisions about their care so they can give **informed consent***.
- Consider how you can support older people to maintain function through understanding what skills and supports **allied health*** professionals can offer to the older person.

Put in place systems* to promote clinical safety, particularly for identified high impact and high prevalence areas of risk.

- Using contemporary evidence and input from qualified **health professionals***, have robust **systems*** that include **processes*** to:
  - identify, monitor and respond to clinical risks
  - escalate care
  - support older people to take part in activities that reduce clinical risk, optimise reablement and maintenance of function.
- Define workers' **roles and responsibilities*** for **clinical care***. Document **outcomes*** of assessment and clinical care needs.

Put in place processes* for clinical safety.

identify, manage and escalate risks to older people that is proportionate to the care and services they provide (**Outcome 2.4**). Providers work with the older person and others to understand arrangements for care provided by others (**Outcome 5.1**). Providers should have standard **processes*** to make sure workers know where to document and how to escalate any concerns or observations about changes, **deterioration*** or risks. They must also know what to do if an older person or carer reports a concern to them.

Have robust **processes*** to support appropriately skilled and qualified workers to:

- identify clinical care needs:
  - at the start of care
  - **regularly*** during scheduled clinical reviews
  - when there is a change or **deterioration*** in an older person's health.
- use **validated assessments*** and refer to a qualified health professional* as agreed with the older person.
- document **outcomes*** of assessment and the treatment options as agreed with the older person in the **clinical information system***
- monitor **outcomes*** of assessment and care, working with appropriate **health professionals***, 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 for **holistic* clinical care***
- make sure **health professionals*** have the skills and competencies to manage and respond to the **clinical care*** needs of older people. This includes identified areas of risk outlined in **Actions 5.5.2 to 5.5.10** and other high prevalence areas of risk such as diabetes, enteral feeding, catheters and management of other **invasive devices***.
- consider how to transition older people

	appropriately and safely from your service to a health service. This includes sharing the necessary clinical information to care for the older person in a **timely*** way. **Monitor and review the effect of clinical safety risks and improve the safety of clinical care*.** • If you identify inappropriate clinical actions, review the effectiveness of clinical decision making, **processes*** for escalation and treatments. Use this information to improve care. • Providers should use clinical data to monitor clinical safety in their service.	
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.	Follow the principles of care planning and **comprehensive care*** as described in **Outcomes 3.1** and **5.4**. It's important that an older person's eating, drinking or swallowing difficulties are identified, assessed and safely managed by an appropriate **health professional*** in a **timely*** way. This needs to be in line the person's needs and preferences. This may mitigate the risk of **choking*** and other adverse **outcomes***. **Put in place processes* to support safe eating, drinking and swallowing.** • Make sure the **processes*** you develop to support safe eating, drinking and swallowing: - are **evidence-based*** - have input from, and regular review by, qualified **health professionals*** such as speech pathologists and dietitians. • Support and train workers to understand their **roles and responsibilities*** for	**Residential service providers** **Residential service providers** should have 24/7 onsite first aid capabilities. This means that trained clinical staff should be able to access and use suction devices to remove food and liquid from a person's mouth and throat if needed and within their **scope of practice***. **Home service providers** **Home service providers** have **systems*** to identify, manage and escalate

	eating, drinking and swallowing difficulties. This includes: - identifying risks to older people when providing food, fluids, oral care and **medicines*** - responding to **choking*** **incidents*** in an emergency - making sure food and fluids are provided safely, and that supervision and assistance is provided when needed. Also, making sure workers understand **best practice** for preparing and providing texture modified food and thickened fluids in line with frameworks used. - 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 needed. • Put in place **processes*** so you can partner with the older person and their representative to make informed decisions and to agree on strategies for managing risks around eating, drinking and swallowing. This must include getting the older person's consent and making sure they have enough information to make decisions and give **informed consent*** on the planned approaches for eating and drinking.	risks to older people that is proportionate to the care and services they provide (**Outcome 2.4**). Providers work with the older person and others to understand arrangements for care provided by others. There should be standard **processes*** to make sure workers know where to document and how to escalate any concerns about changes, **deterioration*** or risks. They should also know what to do if an older person or carer reports a concern to them. Document **outcomes*** of eating, drinking and swallowing assessments. At the start of care, make sure agreed strategies for managing risks from eating, drinking and swallowing are included in the **care and services plan***. Make sure the older person or their representative reviews and updates the **care and services plans***.

	• Healthcare professionals such as trained registered nurses or GPs can screen at the start of care and on a regular basis for eating, drinking or swallowing difficulties using a **validated assessment tool***. This may include recommending a simpler textured food, however should not include modifying or thickening fluids. They can manage risks in line with the service's **policy*** and as supported by a speech pathologist until a full speech pathologist assessment is completed in a **timely*** way. • Make sure eating, drinking and swallowing assessments are completed by a speech pathologist when risks are identified. • Make sure the **outcomes*** of the speech pathology assessment are documented in a report, with recommended management strategies, to reduce risks during: - eating - drinking - swallowing. For oral medicines, speech pathologists should refer to the prescriber and pharmacist for appropriate substitutions or alternative routes of medication provision. This should be documented in the older person's care plan and medication plan. - oral care. • Make sure relevant **health professionals*** know about the **outcomes*** of assessments, such as the need for a nutrition and hydration review,	Make sure workers and **health professionals*** know of agreed and documented strategies for managing risks as identified in the eating, drinking and swallowing assessment if supporting older people with **medicines***, oral care or eating and drinking.

	due to changes in clinical care needs. • If the older person makes an informed decision to eat and drink food and fluids that they choose rather than what has been recommended by **health professionals***, make sure appropriate guidance is in place such as an **eating and drinking with acknowledged risk (EDAR)*** management plan. • Document the individualised risk mitigation strategies agreed on with the older person in all documentation where information relating to eating and drinking is recorded. • Make sure necessary care changes are put in place when recommended by a qualified **health professional***, including texture-modified foods and thickened fluids. These must be agreed on with the older person. **Monitor, review and improve processes* to support safe eating, drinking and swallowing.** • **Regularly*** review formal **policies*** for safe eating, drinking and swallowing. • **Regularly*** review feedback to make sure you understand if the older person is satisfied with the level of input they have had into strategies to manage risk, including making decisions about their food, drink and **dining experiences***. • Make sure documented **incidents*** and **outcomes*** of care are used to inform **processes*** that support safe eating, drinking and swallowing and contribute to **continuous improvement*** plans.	
Continence **5.5.3** The provider implements	**Good** continence* **care** is very important to the health, **quality of life*** and **wellbeing*** of older people. Bladder and bowel problems are	**Residential and home service providers**

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*.

common in older people, particularly those with complex clinical needs. Providers need to make sure **continence*** care meets older people's needs and preferences, protects their dignity, and optimises their functional capability.

Put in place processes* for continence care.

- Put in place **processes*** to make sure **continence*** care is **person-centred***, **evidence-based*** and clinically informed, through assessment.
- Provide **person-centred care*** by partnering with the older person to find out their choice, values, goals and preferences for **continence*** care (**Outcomes 1.1** and **5.4**). Providers also need to document this information. Involve **carers*** as partners in care planning, in line with the older person's preferences.
- Support the older person to maintain and improve their mobility and function. This includes improving the physical environment to help maintain **continence*** and independence.
- Identify if the older person needs a comprehensive, **evidence-based*** **continence*** assessment. This is to identify risks and treat issues that can cause or contribute to incontinence and bladder or bowel dysfunction.
- Providers need to support the use of tools for assessment and monitoring of bowel and bladder symptoms. Use the assessment to inform **continence*** planning, care and evaluation.
- Assessment includes review of current **medicines*** by a qualified **health**

All residential and home service providers should have **systems*** and **processes*** to support **continence*** care for older people.

Residential service providers should include extra activities like reporting data on incontinence and IAD (**incontinence associated dermatitis***) as required by the National Aged Care Mandatory Quality Indicator Program**.**

Home service providers

Home service providers have **systems*** to identify, manage and escalate risks to older people that is proportionate to the care and services they provide (**Outcome 2.4**).

Providers work with the older person and others to understand and agree on arrangements for the care they provide. This includes the care

	professional* when bowel or bladder symptoms are identified, such as **urinary incontinence***, nocturia, constipation and overactive bladder. • Consider different approaches when incontinence or other bladder or bowel problems are identified. Lifestyle interventions may be considered as a first line therapy. • **Facilitate access*** to relevant **health professionals*** to support **continence*** care when needed (**Outcome 5.4**). This may include assessment by a **continence*** nurse. • Make sure a suitably qualified **health professional*** assesses the need for dietary changes to manage incontinence or other bladder or bowel symptoms such as constipation. **Health professionals*** can include a **continence*** nurse, GP or dietician. • Make sure strategies are in place to support both older people and workers to prevent, identify and manage urinary tract **infections***. • Identify, assess, monitor and evaluate decline in skin integrity and IAD. This includes putting in place a skincare program for preventing and managing IAD when needed. • Prevent, identify and manage constipation with regular assessment and **evidence-based*** tools. This may include assessment by a **continence*** nurse, GP or dietitian. • Make sure the use of **continence*** aids and products meet the older person's	provided by others (**Action 5.1.4**). Standard **processes*** should be in place to make sure workers know where to document and how to escalate any concerns or observations about changes, **deterioration*** or risks. They should also know what to do if an older person or carer reports a concern to them.

	clinical needs and preferences. • Make sure workers and **health professionals*** have the required knowledge and skills to meet **continence*** care needs. Make sure workers understand and communicate changes in an older person's **continence*** needs, or signs of IAD, and put in place strategies to reduce 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 if toileting assistance is: - **timely*** - meets the older person's needs - in line with their preferences. • Consider how workers deliver **continence*** care to support the older person's dignity, comfort, functional capacities and mobility. • **Regularly*** monitor the older person to make sure that adequate **continence*** products are available and provided.	
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*	**Falls*** are a major 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. **Falls*** prevention interventions: • are planned and delivered in line with the older person's goals and preferences • respect an older person's **dignity of risk***. Working with multidisciplinary teams, older people, family and **carers*** is important for **falls*** prevention. **Put in place processes* to minimise falls* and fall*-related harm.**	**Residential and home service providers** Best practice guidelines for minimising **falls*** and harms from **falls*** are different between residential and home services. Practices need to be proportionate to the type of services they provide.

b) delivering effective and timely* post falls* care

c) monitoring falls* and injuries and review the reason for and consequences from falls*.

- Put in place **person-centred***, **evidence-based*** and best practice guidelines for **falls*** prevention in residential services, community and home settings**.** These need to be in line with the type of services provided and the context where care is delivered.
- After an older person **falls***, undertake a post **fall*** assessment, monitor and escalate for review by an appropriate **health professional***. This can include **medication reviews***. Update the **care and services plan*** with assessment **outcomes*** (**Outcome 3.1**).
- **Facilitate access*** to **health professionals*** when needed, after talking with the older person. This can include GPs, nurse practitioners, registered nurses, pharmacists and **allied health*** professionals **such as:**
  - **physiotherapists**
  - **occupational therapists**
  - **exercise physiologists**
  - **dietitians**
  - **podiatrists**.

  They can carry out assessments, treatment, ongoing evaluation and monitoring of **falls*** prevention approaches.
- Make sure workers and **health professionals*** are given training in **falls*** prevention and decline in an older person's mobility or function (**Outcomes 3.1** and **3.2).**

Monitor, review and improve processes* to reduce falls* and harm from falls*

Residential service providers
Have several strategies to prevent **falls*** as part of routine care for all older people. This should include:

- **regularly*** assessing personal and environmental setting risk factors
- developing a targeted and personalised **falls*** prevention plan of care based on the findings of the **falls*** risk assessment
- providing education for workers.

Provide tailored, supervised exercise to all older people who want to take part.
Regularly* review **medicines*** where appropriate.
Make sure **health professionals*** (such as physiotherapists or exercise physiologists) or appropriately trained instructors design and deliver the exercise programs.

	• 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. Also, address access barriers. • Consider **feedback*** from older people, workers and others about **falls*** prevention strategies, including any **dignity of risk*** considerations.	Provide ongoing exercise to prevent **falls*** as part of a structured exercise programs. Plan and provide for the dietary needs of older people (**Outcome 6.2**). Make sure menus, foods and drinks offered provide the opportunity for people to meet their dietary requirements in line with **contemporary, evidence-based*** guidelines. Involve dieticians in designing menus that meet dietary needs and older people's needs and preferences. Discuss **evidence-based*** strategies or management options for reducing the risk of **fall***-related injuries. For example, fractures, where hip protectors may be recommended (as prescribed by a relevant **health professional***). Make sure these strategies or management options support the older person with **dignity of risk*** and informed decision-making (**Outcome 1.3**). Providers collect and analyse data on **falls*** and major **injury*** as

part of the National Aged Care Mandatory Quality Indicator Program.

Home service providers

Home service providers have **systems*** to identify, manage and escalate risks to older people that are proportionate to the care and services they provide (**Outcome 2.4**).

Providers work with the older person and others to understand and agree on arrangements for the care that they provide. This includes the care provided by others.

Standard **processes*** should be in place to make sure workers know where to document and how to escalate **falls*** or any concerns about changes, **deterioration*** or risks. This includes those identified by older people, carers and others.

Support all older people to exercise to minimise **falls***.

Exercise programs target balance and mobility and may include strength training.

Exercise programs are designed and

		delivered by a **health professional*** (such as physiotherapists or exercise physiologists). For older people with increased risks, **facilitate access*** to **health professionals*** such as: • a physiotherapist or exercise physiologist for personalised programs • an occupational therapist for home safety interventions and education. Consider ways to address specific **falls*** risk factors, such as podiatry assessment and recommendations for older people with foot health concerns or problems.
Nutrition and hydration **5.5.5** The provider implements processes* to maintain an older person's nutrition and hydration by: a) conducting regular	Preventing and responding to malnutrition and dehydration in a **timely*** way is important as these conditions carry high risk of rapid clinical **deterioration***. **Put in place processes* for maintaining nutrition and hydration.** • Make sure **policies*, procedures*** and **processes*** are in line with **contemporary, evidence-based practice*** guidelines and are developed in consultation with a dietitian. This is to identify, prevent and manage	Under key tasks to monitor, review and improve **processes*** as outlined in **Action 5.5.5**, the requirement for reporting is different for home and residential services. **Residential service providers**

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	malnutrition and dehydration. • Make sure workers and **health professionals*** talk with the older person about their needs and preferences for preventing and managing malnutrition and dehydration. This includes **cultural safety*** considerations, especially for older people who come from diverse backgrounds and have lived experience of trauma (**Outcome 1.1**). Document these in their **care and services plan***. • Include prevention of malnutrition and dehydration in the delivery of care and services, including (as relevant to the service): - making sure appropriate and varied foods and fluids with adequate nutrients are available that provide the opportunity to meet nutrition and hydration needs - considering the impact of chronic conditions - considering and minimising the impact of **medicines*** on risk for malnutrition or dehydration, including unplanned weight loss or gain, changes to appetite and bowel changes - **facilitating access*** to dietitians, speech pathologists, pharmacists, GPs, psychologists and other specialists and **allied health*** when clinically indicated. • Define workers' **roles and responsibilities*** to prevent malnutrition and dehydration and escalate concerns early. Identify tools and document	**Residential service providers** report on unplanned weight loss trends, as a requirement of the **National Aged Care Mandatory Quality Indicator Program.** **Home service providers** **Home service providers** put in place **systems*** to identify, manage and escalate risks of malnutrition and dehydration that is proportionate to the services they provide (**Outcome 2.4**). In home settings, the **roles and responsibilities*** for an older person's nutrition and hydration will depend on the level and type of service. Providers work with the older person and others to understand arrangements for care provided by others. There should be standard **processes*** to make sure workers know where to document and how to escalate any concerns about changes,

processes* for workers to monitor nutrition and hydration. These workers must be qualified and working within their **scope of practice*** or role description.

- Put in place **processes*** to identify dehydration and malnutrition early. Then, assess and manage these conditions. This includes:
  - screening, using a tool **validated*** in aged care, to **regularly*** assess nutrition and hydration and document findings. This includes re-screening in line with **contemporary, evidence-based practice***.
  - clinically assessing, reviewing and managing concerns **regularly*** and as clinically indicated in line with **contemporary, evidenced based practice***. This needs to be done by a multidisciplinary team of qualified **health professionals***, including a dietitian.
  - referring for specialist clinical assessment and advice where needed
  - involving **health professionals*** to decide if a nutrition or hydration intervention is effective
  - put in place recommended management strategies from **health professionals'*** assessments, and documenting these in the **care and services plan***. Strategies may include therapeutic diets (such as high energy, high protein diet), texture-modified foods and thickened fluids. These must be in line with the older person's preferences.

deterioration* or risks. This includes what to do if an older person or carer reports a concern to them.

Home service providers should still use data to monitor **outcomes*** and improve care.

This could include:

- **feedback*** from older people and workers
- **incidents***
- **outcomes*** of **complaints***
- hospital admissions.

Identified risk of malnutrition or dehydration should be monitored and addressed to reduce impact on the older person. There should be **processes*** to escalate concerns about nutrition and hydration.

Nursing services should monitor nutrition and hydration including using **evidence-based*** tools to

- Consider how the care, mealtime environment and access to assistive devices (as recommended by a qualified **health professional***) can optimise the older person's independence, function and **quality of life***.

Monitor, review and improve processes* for nutrition and hydration.

- Make sure the older person is satisfied with the strategies to manage risk. You can find this out by involving the older person in decision making and incorporating **feedback***.
- Have a dietitian review the documented **outcomes*** of care (including weight and malnutrition screening) and reported **incidents***. Use these to support **continuous improvement*** plans, including ongoing staff education.
- Monitor older people with chronic conditions or recent changes to **medicines*** that may increase the risk of malnutrition or dehydration.
- Consider referral or access to **health professionals***, in line with the older person's preferences, when chronic health conditions or lifestyle choices affect or are affected by nutrition and hydration.
- Analyse data collected and use these findings to improve care. This can include data on:
  - **incidents***
  - unplanned changes in weight
  - use of relevant **health professionals***
  - hospital transfers.

monitor for known signs of dehydration and malnutrition.

Outcomes* of assessment should be documented and recommendations from **health professionals*** should be supported if appropriate to the service.

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. Changes to **mental health*** and **wellbeing*** is not an inevitable part of ageing. When there are changes in the **mental health*** of an older person, it's important that you recognise these early and respond quickly.

Put in place processes* to optimise mental health* and respond to mental illness*.

Put in place **processes*** to make sure each older person is supported to maintain or improve their sense of **mental health*** and **wellbeing***. This means **processes*** which:

- encourage positive **mental health*** for all older people in working practices
- use **evidence-based*** strategies to promote mental **wellbeing***, such as:
  - serving and encouraging the eating and drinking of **nutritious*** foods and drinks
  - encouraging and organising physical activity and sleep hygiene. Sleep hygiene is the healthy habits, behaviours and environment older people can use to help them get a good night's sleep.
  - creating settings and supports that allow social connection and reduce loneliness and social isolation
  - encouraging activities that are meaningful for people like hobbies or community groups
  - encouraging sense of coping with stress.

Residential and home service providers

All residential and home service providers have a role to play in promoting positive **mental health***. The key tasks relating to optimising older people's **mental health*** are relevant in all care settings.

Residential and home service providers caring for or supporting older people who are at risk of or are experiencing **mental illness*** need to quickly recognise and respond to signs of distress or **deterioration*** in their mental state. This includes providing or **facilitating access*** to **evidence-based*** treatment and care for existing or developing **mental illness***.

Home service providers

Home service providers have **systems*** to identify, manage and escalate risks to older people

- define workers' **roles and responsibilities*** for older people's **mental health*** and **wellbeing***
- create a **psychologically***, physically and sexually safe setting for older people in supportive and non-restrictive ways.

Put in place **processes*** to support recognising and responding to **deterioration*** in **mental health***, to:

- prioritise working 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 stress in the past.
- make sure this knowledge and experience is included in both assessing **mental health*** needs at the start of care and planning a response to any **deterioration***
- identify signs of deteriorating **mental health*** in a **timely*** way
- escalate worker observations and concerns to qualified **health professionals***
- make sure workers are supportive and give **person-centred*** responses to older people who are distressed or who have symptoms of **mental illness*** (including thoughts of harm or suicide)
- make sure referral pathways are available to workers to escalate care

that is in proportion to the care and services they provide (**Outcome 2.4**). Providers work with the older person and others to understand arrangements for care provided by others. There should be standard **processes*** to make sure workers know where to document and how to escalate any concerns about changes, **deterioration*** or risks. This should include what to do if an older person or carer reports a concern to them.

- make sure workers refer the person quickly if they identify deteriorating **mental health***. Consider locally available options, which may include referral to:
  - **allied health*** professionals specialising in **mental health***
  - assessment by a GP or nurse practitioner for access to an older person's mental health team, a psychogeriatrician, psychologist or psychiatrist.
- monitor and document:
  - changes in **mental health***
  - interventions and strategies used to respond to changes
  - observations of how effective interventions and strategies are.
- record in the **care and services plan***:
  - the **outcomes*** of any assessments
  - recommended interventions and support strategies
  - responsibilities for implementing the recommended interventions and support strategies and reviewing progress.

Monitor, review and improve processes* to optimise mental health* and respond to mental illness*.

- Consider how to monitor the safety and quality of the organisation's **processes*** to optimise **mental health*** and respond to **mental illness***. Monitoring methods could include:

	- 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 you collect during monitoring to identify areas for **quality improvement***. • Report the results of **quality improvement*** efforts to the **governing body***, older people and workers.	
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*	**Oral health*** is important for overall health, **wellbeing*** and **quality of life***. In older people, poor **oral health*** is related to: • malnutrition • swallowing difficulties • pneumonia • **frailty*** • systemic inflammation • diabetes • cardiovascular disease • bone and joint health • depression • **delirium*** • **dementia***, including Alzheimer's disease • cancer. Oral **pain*** may affect an older person's ability to eat, drink, swallow, speak and sleep. It may also	**All residential and home service providers** need to have **processes*** to support older people to maintain their **oral health*** and prevent decline. These must be in proportion to: • how complex the older person's needs are • the service type • the context where care is delivered. **Residential service providers**

c)	assisting with daily oral hygiene* needs.	affect their mood and behaviour. Older people living with **cognitive impairment*** may find it difficult to report their own **pain*** and discomfort. **Oral health*** interventions: • are **person-centred*** • are planned and delivered in line with the older person's goals and preferences • respect the older person's **dignity of risk***. **Put in place processes* to support the older person to maintain their oral health*.** • Put in place **person-centred* processes*** **(Outcome 1.1)** that support the older person's independence and functional capabilities with **oral health*** care. • In line with individually assessed care requirements, encourage and assist older people with: - natural teeth, to brush their teeth, gums and tongue - dentures, to brush and clean dentures. The frequency of assistance, cleaning method and products used will vary based on individual needs and preferences, as well as recommendations by a dentist or **oral health*** practitioner. • **Facilitate access*** to and use **oral health*** products, aids and equipment. **Put in place processes* to support oral health assessment and management.** • **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	In **residential services,** where 24-hour care is provided, providers need to support **oral hygiene*** in line with the older person's preferences. **Home service providers** **Home service providers** have **systems*** to identify, manage and escalate risks to older people's **oral health*** that are in proportion to the care and services they provide (**Outcome 2.4**). Providers work with the older person and others to understand and agree on arrangements for the care that they provide. This includes the care provided by others.

strategies to prevent and manage issues.

- Complete an assessment of the older person's mouth and oral cavity using a validated oral health assessment tool. This is done by a trained **health professional***, such as a registered nurse, on commencement of care, **regularly*** and when changes or **deterioration*** are identified.
- Dentists or **oral health*** practitioners provide regular review and reassessment when you identify change or **deterioration*** (**Outcome 5.4**). Providers should refer older people to dentists or **oral health*** practitioners, including public dental services, in a **timely*** way. Recognise and respond to changes in an older person's **oral health*** or ability to manage it themselves due to physical **frailty*** or **cognitive impairment***. Escalate **oral health*** concerns to oral and dental health practitioners.
- **Facilitate access*** for review to other **health professionals*** such as doctors, pharmacists and speech pathologists as needed, such as when dry mouth is identified or when there is **polypharmacy***.
- Make sure workers are trained to:
  - deliver **oral hygiene*** (including assisted brushing). This can include supporting older people with complex needs or **changed behaviours*** to maintain their **oral health***.
  - identify poor **oral health*** and its impacts on the older person
  - refer older people to a dentist or **oral**

health* practitioner for further intervention and follow-up in a **timely*** way.

- Identify, prioritise and deliver regular and appropriate oral care to older people with higher **oral health*** care needs. This may include older people:
  - living with **cognitive impairment***
  - who are at the **end of their life***
  - with eating, drinking and swallowing issues
  - with dry mouth (xerostomia)
  - with altered salivation (reduced or excessive)
  - who are nil by mouth (**Outcomes 5.6 and 5.7**).
- Consider the link 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**).
- Consider the impact **medicines*** changes have on **oral health***.

Monitor, review and improve processes* to maintain oral health* and prevent decline.

- Analyse clinical records to identify where poor **oral health*** may be affecting the overall health of the older person. Do this in collaboration with **health professionals*** or **oral health*** practitioners and use this to improve care.
- Review clinical records on the frequency of **oral health*** assessments. Make sure that care and services plans include **oral health*** and the **outcomes*** of regular

	oral health* assessments. Include the older person's ability to manage their own **oral health*** and required products, aids and equipment. • Consider how to monitor **oral health***, hygiene and access to **oral health*** products to make sure older people's needs are met. • Use **feedback*** from older people and workers on oral health **processes*** to improve the quality of **oral health*** care. • Review and improve **processes*** for using validated oral health assessment tools.	
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 can't communicate their **pain*** verbally. This means that **evidence-based*** assessments are important in safe and **quality care*** for **pain***. **Contemporary, evidence-based practice*** to address **pain*** includes both non-pharmacological and pharmacological approaches. In many cases, non-pharmacological strategies can be highly effective. Strategies can include: • psychological • educational • physical activity and movement • nutritional • complementary approaches (see *Pain Management Guide Toolkit for Aged Care*). **Have processes* to optimise pain management*.** • Put in place **processes*** that support identifying and managing **pain*** in a **timely*** way. These include:	**Residential service providers** For **residential service providers**, all key tasks are relevant to provide safe and quality **pain management***. **Home service providers** **For home service providers providing clinical care* that includes pain management***, all key tasks are relevant. **Home service providers** have **systems*** to identify, manage and escalate risks to older people that is proportionate to the care and

- regular assessment by a suitably qualified **health professional*** using **validated assessment tools***. These include tools to assess older people:
  - who cannot verbally report **pain***
  - experiencing **delirium***, **dementia***, **cognitive impairment*** or **sensory impairment*** from health conditions such as diabetes and peripheral vascular disease.
- **evidence-based*** strategies for **pain management***, including non-pharmacological options, tailored to the needs and preferences of the older person
- monitoring and review by a qualified **health professional*** such as a GP, pain specialist or pain clinic for persistent uncontrolled **pain***.

- Put in place **processes*** to support **health professionals*** and workers to know their **roles and responsibilities*** to identify, assess, manage and monitor **pain***. These include:
  - for workers, identifying possible **pain*** (including where the older person can't express the severity of **pain***, its location or where their behaviour has changed) and escalating observations and concerns
  - for **health professionals***, assessing, planning and providing **pain*** relief (both non-pharmacological and pharmacological) in line with the type of **pain*** experienced and the preferences of the older person. This

services they provide (**Outcome 2.4**). Providers work with the older person and others to understand arrangements for care provided by others.

Standard **processes*** should be in place to make sure workers know where to document and how to escalate any concerns or observations about changes, **deterioration*** or risks. This includes what to do if an older person or carer reports a concern to them.

Home service providers not providing pain management* should at least have a standard **process*** for their workers to document any concerns or observations about a person's **pain***. This includes **processes*** to escalate concerns to a manager or **health professional***.

includes the need to monitor and evaluate the benefit of interventions.

- updating the **care and services plan***, putting in place any care changes needed and informing family and others as appropriate.

Monitor, review and improve processes* to manage pain*.

- Consider how to monitor the safety and quality of the organisation's **processes*** to improve **pain management***. Monitoring could include:
  - for residential services, analysis of trends in older people's responses to Question 2 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 opinion on how often their **pain*** is managed well.
  - 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 people who have challenges communicating their **pain***.
- 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 services.

	• Report the results of efforts to improve quality to the **governing body***, older people and workers. • Monitor benefits and safety of **pain management*** **processes***, including escalating care of **pain*** to qualified **health professionals***.	
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 breaks from pressure or other **injury***. Strategies to prevent wounds include **regularly*** inspecting skin and managing other related clinical risks such as those described in **Actions 5.1.3 to 5.1.10**. Using **processes*** as outlined in **Outcome 1.3 and 2.1,** put in place and plan **processes*** to prevent and manage **pressure injuries*** and wounds in older people. **Put in place processes* for preventing and managing pressure injuries* and wounds.** These include: • using **validated assessment tools*** to identify and assess wounds and monitor healing • having a registered nurse or other qualified **health professional*** assess the risk of **pressure injuries***, including but not limited to assessing: - the older person's skin - mobility - existing **pressure injuries*** or breaks in skin - the effect of conditions such as diabetes, incontinence and malnutrition • personalised, **evidence-based*** and risk-based **pressure injury*** prevention plans.	**Residential service providers** **Residential service providers** report on **pressure injuries*** as a requirement of the **National Aged Care Mandatory Quality Indicator Program.** **Home service providers** **Home service providers** have **systems*** to identify, manage and escalate risks to older people that is proportionate to the care and services they provide (**Outcome 2.4**). Providers work with the older person and others to understand arrangements for care provided by others. There should be standard **processes*** to make sure workers know where to document and how to escalate any concerns or observations about

Processes* for delivery of care include:

- defining workers' **roles and responsibilities*** to manage skin integrity and breaks in skin integrity. Workers also need to document **wound management plans** to manage acute and chronic wounds, and **regularly*** monitor wounds.
- referral pathways for escalating **pressure injuries*** and wounds when needed
- maintaining the dignity and **cultural safety*** of the older person when performing regular skin inspections
- referring the older person to qualified **health professionals***, including **allied health*** professionals, to prevent wounds happening and to support wound healing
- considering nutrition assessment by a dietitian to support wound healing
- considering the benefits of maintaining or improving mobility and balance in reducing harm from **pressure injuries*** and wounds.

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 make sure clinical interventions follow an **evidence-based*** pathway for wound care and that workers know what these are.

changes, **deterioration*** or risks. These should include what to do if an older person or carer reports a concern to them.

Home service providers 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.

	• Consider how aids and equipment, such as specialist mattresses may be accessed and used to reduce risk of **pressure injuries***. • Consider the use of data, on managing and preventing **pressure injuries*** and wounds, collected in the service, such as data on: - **incidents*** - quality indicator data - hospital admissions - trends in data related to **pressure injuries*** and wounds - **feedback*** from older people. • Analyse data collected to inform and develop plans for **continuous improvement*** in relation to preventing and managing **pressure injuries*** and wounds.	
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	**Put in place processes* to optimise support for people with sensory impairment*.** • When putting in place and reviewing the organisation's **policies***, protocols and **procedures*** for optimal care of people with **sensory impairment***: - make sure they follow **evidence-based*** guidelines for supporting people with vision or hearing loss and for people with balance disorders - support **timely*** identification of sensory loss and development of personalised care strategies - define the **roles and responsibilities*** of workers and **health professionals*** in supporting an older person with	**All aged care services,** whether they're involved in support for **sensory impairment*** or not, should put in place **systems*** and **processes*** that support workers and **health professionals*** to identify and escalate any concerns about **sensory impairment***. **Residential service providers**

independence, function and quality of life*.	**sensory impairment***. This may include making sure supports, such as glasses and hearing aids, are clean and functioning. - consider how the care setting, meal presentation and **dining experience***, and access to assistive devices can optimise the older person's independence, function and **quality of life***. Assistive devices and aids can include hearing aids, walking aids and glasses. - document requirements for assistive devices in the **clinical information system***. • Put in place **processes*** to: - identify changes and decline in sensory function in a **timely*** way - **regularly*** monitor the older person's hearing, vision and balance to identify changes in sensory function and to make sure aids and devices are appropriate - refer to specialist **health professionals*** for management including diagnosis, treatment and management of devices and aids - access assistive devices and aids and **regularly*** monitor their use and how well they're working - improve the care environment using strategies such as noise management, lighting, colour contrast, signage, textures and design.	**For residential service providers**, all key tasks are relevant to providing safe and **quality care*** for **sensory impairment***. **Home service providers** **For home service providers** providing advice, care, support or equipment for **sensory impairment***, all key tasks are relevant.

Outcome 5.6: Cognitive impairment

What is the outcome you need to achieve?

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 **changed 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 or long-term and can often become more severe over time. A specific diagnosis can help with a better understanding of symptoms and more effective, personalised care for a person experiencing **changed behaviours***.

Experiencing **cognitive impairment*** can be frightening for the older person and those close to them. Providers who actively identify, use and monitor personalised, non-medication strategies (best practice behaviour support) can reduce distress and prevent the inappropriate use of **restrictive practices*.**

The intent of **Outcome 5.6** is to make sure **person-centred***, safe and high-quality **clinical care*** is delivered to older people who are having changes in cognition such as **delirium*** or increasing decline in cognition because of a neurodegenerative disorder such as **dementia***. The principles of **partnership*** with the older person (**Outcome 2.1**), a **comprehensive care*** approach (**Outcome 5.4**) and non-restrictive care practices (**Outcome 3.2**) support **clinical care*** provided to people with any form of **cognitive impairment***.

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

- the impact of **cognitive impairment*** on how complex each person's care needs are
- contributing factors to a person's **changed behaviours*** such as **delirium*,** mental health, personality, relationships, lack of engagement, cognitive health, sensory problems, social history and environment etc.
- the person's preferences for support strategies
- how effective specific support strategies are for each older person using observation, monitoring and reporting.

Clinical guidelines outline safe, high-quality **clinical care*** for **cognitive impairment*** and highlight the need for a multidisciplinary team approach. Providers are 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's important that people involved in an older person's care can recognise changes that may show cognitive **deterioration***. They also need to know how to refer or carry out comprehensive assessment for this.

Service context considerations

Residential and home service providers must set up 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 have **systems*** and **processes*** to make sure workers and **health professionals*** know how to identify and respond to signs of **cognitive impairment*** or **changed behaviours*** (see **action 3.2.6**).

Actions and Key Tasks

Provider		
Actions	**Key tasks**	**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.	**Put in place processes* to identify and respond to complex needs.** • Put in place **policies*** and **procedures*** to make sure the older person's rights to dignity, independence and choice are a part of **processes*** to identify, monitor and provide 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 behaviour support needs associated with **cognitive impairment*** - the importance of learning about the person to better identify and understand their needs, and preferences. This includes their history, personality, roles in life, values, beliefs, culture. - their **roles and responsibilities*** for monitoring and mitigating clinical risks for the older person with **cognitive impairment***, including increasing risk of **falls***, **pain***, **pressure injuries***, oral **deterioration***, medication errors and **delirium*.** - the range of potential contributing factors to cognitive and behaviour	**Residential and home service providers** For providers of **both residential and home services**, all key tasks under **Action 5.6.1** are relevant. These will support providers to deliver **evidence-based*** care for people living with **cognitive impairment***.

changes, including clinical, environmental and medication-related factors. Consider that factors may be modifiable and require regular review to minimise impact.

- Put in place **policies*** and **procedures*** which explain how to identify signs of cognitive **deterioration*** and what to do when these are identified. This includes:
  - putting in place best practice strategies for early recognition and response to acute **delirium***, such as those recommended in the Delirium Clinical Care Standard
  - identifying older people with symptoms of **cognitive impairment***, including recording information about a person's specific diagnosis and considering referring them for specialist support service
  - identifying and addressing any clinical, psychosocial or environmental issues contributing to cognitive symptoms
  - escalating observations or concerns about cognitive change to relevant **health professionals***
  - screening and clinical assessment is completed in line with the older person's needs and preferences. This is when **cognitive impairment*** is first identified and when there is any change in cognitive status, including **delirium***.
  - identifying changing and related physical, social, psychological, communication and behaviour

support needs associated with **cognitive impairment***. These can then be thoroughly assessed, monitored, supported and escalated as necessary.

- assessing, managing and monitoring clinical risks including recent and repeated **falls***, **pressure injuries***, dehydration and medication changes or errors
- documenting risks, needs and strategies to support **cognitive impairment*** including changes behaviours in the c**are and services plan***. This may include strategies for identifying and supporting unmet needs, mealtime support, memory support, safe movement, and managing and preventing **falls***.
- identifying and addressing factors which can make cognitive or behaviour symptoms worse, as outlined in **Action 5.6.3**.

- Put in place **processes*** for ongoing monitoring and response to:
  - changing **clinical care*** needs which could include changes in behaviour, changes to medication
  - changing communication needs
  - 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 methods could include: - analysing trends in National Mandatory Quality Indicator Program data against indicators for clinical risks, such as hospital admissions, **restrictive practices*, falls*** and **pressure injuries*** - analysing 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 others about whether they feel that their full range of needs are understood and supported. • Consider how to use the information collected during monitoring to identify areas for **quality improvement***. • Consider how to measure if quality has improved. • Report the results of **quality improvement*** efforts to the **governing body***, older people and workers.	
5.6.2 The provider collaborates with older people with	**Put in place processes* to partner with older people with cognitive impairment*.**	**Residential and home service providers**

cognitive impairment*, family, carers and others to understand the person and to optimise clinical care* outcomes*.	Put in place **policies*** and **procedures*** that support collaboration, effective communication and **shared decision-making*** between workers, **health professionals*** and the older person, their family and carers (**Outcome 3.2**). This can include: • developing or identifying information on care for people with **cognitive impairment*** that is easy to understand. Then, making this information available to the older person and their support people (where required) in several formats. • providing workers with access to training on how to identify individual communication needs, and on methods for communicating with the older person, their family and other support people to understand: - the person - their preferences - interests - goals - 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 needed, in their **behaviour support plan*** (**Action 5.6.3**). **Monitor, review and improve processes* to partner with older people with cognitive impairment*.** • Consider how to monitor the quality of the organisation's **partnerships*** with older people with **cognitive impairment***.	For providers of **both residential and home services**, all key tasks under **Action 5.6.2** are relevant. These will support providers to deliver **person-centred care*** for people with **cognitive impairment***.

	Possible ways to achieve this include: - **feedback*** from workers about their ability to partner with older people, their families and other supporters in a meaningful way - **feedback*** from older people with **cognitive impairment***, their families and other supports: ▪ whether they're involved as much as they can or want to be in decisions about their care. - whether they feel their needs and preferences inform the strategies used to prevent and reduce the impact of distress from **changed behaviours***. • Use the information to consider where there are opportunities for **quality improvement*** 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 workers. Closing the **feedback*** loop is following up with the older people, their families, representatives and workers who have provided you with **feedback***.	
5.6.3 The provider implements processes* to: a) identify and minimise situations that may precipitate changes in behaviour b) identify and respond to	**Put in place processes* to prevent and support changed behaviours*.** • Consider how to make sure that care is informed by assessment and understanding of any clinical, situational, psychosocial and environmental factors that may cause **changed behaviours*** for an older person. Avoid assumptions that changes are caused by **cognitive impairment***. • Identify and reduce stressors in the care	**Residential and home service providers** For **residential and home service providers** supporting people with **cognitive impairment***, all key tasks under this action are relevant. These will support providers to deliver **person-centred care***.

clinical and other identified causes of changes in behaviour.	environment and the day-to-day routines and **processes*** that can increase the risk of acute behaviour changes happening. • Put in place non-pharmacological strategies known to be effective and acceptable to the older person, as identified in **Action 5.6.2**, such as: - access to outdoor spaces - engagement in meaningful activities and interests, to reduce distress or harm, and changes in well-being from **changed behaviours*** and to minimise use of **restrictive practices*** (**Outcome 3.2**). • Put in place assessment **processes*** to respond to **changed behaviours*** that include: - making sure the immediate safety of the older person and others is maintained - identifying factors that could cause changes, including unmet needs, environmental, malnutrition, **delirium***, **pain***, eating, drinking, swallowing and medication changes - identifying each older person's psychosocial and support needs - involving carers and family, or others who know the person (when relevant) - referring to behavioural support specialists/ services and **allied health*** professionals when needed for residential and home services, as outlined in **Action 7.2.3**. • Make sure **person-centred***, accessible and effective **behaviour support plans***	**Behaviour Support Plans*** are mandatory requirement for older people in **residential services** that experience **changed behaviours*** and/ or require a **restrictive practice*.** It's also **evidence-based practice*** to use these in **home services** to effectively support the older person. **Home service providers** Some key tasks rely on the provider having control over their environment. These key tasks are more relevant to residential services but should still be considered by home services. At a minimum, all providers should have **systems*** and **processes*** to make sure workers know when and how to document or escalate any concerns or observations about changes to a person's behaviour, mental or cognitive status.

are in place (in the **care and services plan***) and effectively implemented for the older person with **changed behaviours***.

Monitor, review and improve processes* to prevent and manage changed behaviours*.

- Consider how to monitor the safety and quality of the organisation's **processes*** to prevent and support **changed behaviour***. Monitoring methods could include:
  - analysing trends in Mandatory Quality Improvement Program data against indicators for **restrictive practices*** and use of **psychotropic medicines*** for residential services
  - analysing trends against relevant indicators from the Psychotropic Medicine in Cognitive Disability or Impairment Clinical Care Standard
  - considering themes from **incident*** reports related to **changed behaviours*** and trends in **incident*** numbers and types
  - **feedback*** from workers about their knowledge of and confidence in strategies to prevent and support **changed behaviour***
  - **feedback*** from older people with **cognitive impairment***, their families and other supporters about whether they feel their needs and preferences inform the strategies used to prevent and reduce the impact of distress from **changed behaviour***. You should have **processes*** to review and revise the BSP regularly or when there is a change in the older person's circumstances.

- Consider how to use the information collected during monitoring to identify areas for **quality improvement***.
- Consider how to measure if quality has improved.
- Report the results of **quality improvement*** efforts to the **governing body***, older people and workers.

Outcome 5.7: Palliative and end-of-life care

What is the outcome you need to achieve?

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 a person receives in the last years, months and weeks of their life can reduce their distress and grief around death and dying. Safe and high-quality care at the **end-of-life*** is **comprehensive***, **coordinated care*** (**Outcome 5.4**). All older people have the right to dignity, comfort and privacy and to be cared for respectfully and with compassion. Preventing and giving relief from 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
- make choices and decisions about their care.

Workers and **health professionals*** recognise and respect older people's values, needs and wishes and provide care that responds to and meets their preferences. **Substitute decision-makers***,

family members and carers are involved in making decisions in line with the older person's wishes. This also needs to meet state or territory legislation (**Outcomes 1.1** to **1.3**).

An important part of **Outcome 5.7** is recognising when an older person has a condition that is life limiting or they're approaching the end of their life. Also, recognising when **palliative care*** can benefit them. **Health professionals*** need knowledge, sensitivity and skill to have conversations about advance care planning, palliative care and dying. The older person should be supported to have **end-of-life*** care conversations to the extent that they choose. Their choices must be respected. You should have **processes*** to review **advance care planning*** documents with the older person to ensure they are in line with their wishes and current **needs, goals and preferences***.

Effective communication and working together is important to make sure there is continuity of care. This also helps to coordinate care between teams, different settings and at transitions. Not all older people will need specialist **palliative care*** services. However, there should be processes to identify when an older person would benefit from specialist **palliative care*** and to facilitate **timely*** access to it.

Quickly recognising when an older person's is approaching the end of their life and their needs are changing is critical. Providers have **processes*** to monitor, manage and escalate changing needs and symptoms. The focus may be on the persons needs and identifying multidisciplinary team members to meet these needs which may include support **medication management*** and **timely*** access to medications when necessary.

Note: Outcome 5.7 includes principles from the:

- National Palliative Care Strategy, National Consensus Statement: Essential elements for safe and high-quality **end-of-life*** care
- National Palliative Care Standards for All Health Professionals and Aged Care Services**.**

Service context considerations

Residential service providers have 24-hour responsibility for the **clinical care*** needs of the people in their care. All the actions and key tasks in this outcome apply to residential service providers.

Home service providers have **systems*** to manage risks to people receiving care that is in proportion to:

- how complex the person's needs are
- the type of service they provide
- where they deliver the care.

They work with the older person, carers, **health professionals*** and specialist **palliative care*** services and others. This helps providers to understand what is needed and agree on the care they can provide and what is provided by others

Provider organisation		
Actions	**Key tasks**	**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.	**Put in place processes* for recognising and preparing for palliative care* and the end of life* needs.** • Put in place **person-centred***, **culturally safe* processes*** (**Standard 1**) to recognise older people who are approaching the end of their life. As well as those who could benefit from **palliative care***. These **processes*** can include: - supporting workers and **health professionals*** to use risk prediction tools, trigger tools and questions - communicating with the older person, their **carers*** and family to identify signs they may be approaching the end of their life (**Outcome 1.3**) - identifying and managing acute **deterioration*** that may be able to be reversed in line with the older person's wishes. - involving the older person's GP or nurse practitioner in discussions about diagnosis and prognosis as the older person approaches the end of their life. • **Facilitate access*** to **health professionals*** to review medication to look at whether the older person's medications should be **deprescribed*** or stopped. As well as looking at safe ways to administer medication. This is done is discussion with the older person and in	**Residential and home service providers** To recognise and get ready for a person's **end-of-life***, all providers need to build on their **systems*** and **processes*** for: • **person-centred care*** (**Outcome 1.1)** • assessment and planning (**Outcome 3.1**) • **comprehensive care*** (**Outcome 5.4**). **Home service providers** The role of home service providers is in proportion to: • the type of services • how complex the services are • where they deliver the services.

	line with their **goals of care***. • Plan for **anticipatory medicines*** and put in place **processes*** for safe use and administration (when needed). • Plan for and **facilitate access*** to equipment, aids and devices. Make sure that workers, **health professionals*** and **carers*** are trained and confident using them. • Make sure that workers have the knowledge and skills they need and can confidently recognise when an older person is approaching the end of their life. They also need to be able to perform their role within their scope of **clinical care*** and where they deliver care. **Monitor, review and continuously improve how your organisation recognises palliative care* and end-of-life*.** • Collect and analyse data from evaluation, reviews and **feedback***. Use this to improve how you and your workers recognise and respond to care needs at the **end-of-life***. • Look at **feedback*** about the experiences of older people, **substitute decision-makers*, carers*** and family about how you and your workers supported them to prepare for **end-of-life***.	They will also need to consider the needs and capacity of carers and family to support the older person.
5.7.2 The provider supports the older person, their family, carers and **substitute decision maker***, to: a) continue **end-of-life***	**Put in place processes* for end-of-life* planning.** • Build on the organisation's **systems*** and **processes*** for: - **person-centred care*** (**Outcome 1.1**) - dignity, choice, independence and	**Residential and home service providers** put in place **person-centred* processes*** for **end-of-life*** planning. These **processes***

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***.

quality of life* (**Outcomes 1.2** and **1.3**)
- assessment and planning (**Outcome 3.1**)
- **comprehensive care*** (**Outcome 5.4**).

- Put in place **processes*** for **end-of-life*** planning and making decisions that:
  - are **culturally*** and **psychologically safe***, **trauma aware and healing informed***
  - support the older person to have ongoing **end-of-life*** planning conversations with workers, **health professionals*** and others. The planning and conversations should be in line with the older person's preferences. For example, including **substitute decision-makers***, **carers*** and family in these conversations.
  - include reviewing **advance care planning*** documents with the older person in line with their preferences.
- Workers and **health professionals*** are trained and supported have **end-of-life*** conversations that are **person-centred***.
- **End-of-life*** planning conversations should seek to find out what is important to the older person at the end of their life, including the place the older person would wish to be at the end of their life.
- Include the older person's GP or nurse practitioner in discussions about diagnosis, prognosis and options for a **coordinated*** planning and delivery of

should be in proportion to the:
- type of services provided
- how complex they are.

end-of-life* care.

- Assist the older person to make their own decisions with **supported decision making***, when needed.
- Communicate with the person's **substitute decision-maker*** when an older person lacks capacity to take part in making decisions.
- Make sure **policies*** and **processes*** for **advance care planning documents*** and substitute decision-making are in line with your state or territory legislation. Workers and **health professionals*** also need to understand these.
- Store and manage **advance care planning documents*** securely (including appointments of a **substitute decision-maker***). This makes sure they can be easily accessed and **regularly*** reviewed, while maintaining privacy.
- Share current **advance care planning documents*** when needed with the older person's consent, particularly:
  - at **transitions of care***
  - with paramedics on transfer to hospital.
- Explain to older people that , with their consent, their **advance care planning documents*** can be uploaded to **My Health Record***.

Monitor, review and improve processes* to support older people at the end of life*.

- Monitor how well your organisation is supporting **advance care planning*** into everyday practice. This includes **advance care planning*** reviews and assessment

	on: - how you receive, store and manage **advance care** planning documents* - how you review, follow and share with **health professionals'*** **advance care planning documents*** - how you manage and share **advance care planning documents*** to ensure relevant health professionals and services have access when needed, such as during **transitions of care***. • Analyse **feedback*** from older people about the quality of **end-of-life*** planning conversations. • Consider how effective your **processes*** are for **supported decision-making*** when an older person's capacity to make decisions about their own care is reduced.	
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	**Put in place systems* and processes* for comprehensive palliative* and end-of-life* care.** • Plan and provide **person-centred***, **culturally safe***, **trauma aware and healing informed care***. Make sure care meets an older person's goals, preferences and wishes (**Outcome 1.1**). • Plan and provide comprehensive assessment that looks at the whole person. Assessment that focuses on comfort, dignity and effective **pain management*** to prevent and relieve suffering (**Outcome 3.1 and 5.4**). **Comprehensive care*** at the end of a person's life responds and adapts to changes in their clinical needs. These	**All residential and home service providers** put in place **processes*** for comprehensive **end-of-life*** care. These p**rocesses*** should be in proportion to the: • type of services provided • how complex they are. **Residential service providers**

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***

changes can include periods where the person **deteriorates***, stabilises and sometimes improves.

- Review the older person's preferences about who they want involved in their care and how they want them involved. This might include **substitute decision-makers***, **carers***, family, spiritual leaders and others (**Outcome 1.1**).
- Partner with the older person to identify their cultural, spiritual and psychological needs on commencement of services and on an ongoing basis. These needs can be as important to them as their physical needs (**Outcome 1.1**). This can include considering the older person's beliefs and practices around death and dying.
- Identify where the older person prefers to receive **palliative care*** and where they prefer to die. Strategies and interventions should support the older person to stay at home, or where they prefer to be at the end of their life.
- Aboriginal and Torres Strait Islander people may want 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***.
- Make sure that workers and **health professionals*** understand their role in providing **comprehensive care*** for older people with **palliative care*** needs and at the end of their life. They also need the knowledge and skills to provide high-

Residential service providers need to put in place **processes*** to support fair access to community and inpatient services. These are available to older people living in their own homes. This includes access to specialist **palliative care*** services when needed.

Home service providers

Home service providers should consider assessing the person's **carer*** if they have one. The assessment should look at the carer's needs, what they're able to do and if they can keep supporting the older person long term.

to family and **carers***.	quality care. • Put in place and maintain relationships and referral pathways with **health professionals***, and specialist palliative care services. • Make sure workers quickly identify, monitor and escalate a change or **deterioration*** in an older person's health. • Make sure your organisation and workers communicate early with **health professionals***, **substitute decision-makers***, **carers*** and family as needed. Follow the older person's preferences. • Facilitate **timely*** access to specialist **palliative care*** and other services when needed. • Facilitate **timely*** access to **medicines***. **Medicine reviews*** should optimise symptom control and include **anticipatory*** prescribing and **deprescribing*** to optimise symptom control (**Outcome 5.3**). • Facilitate **timely*** access to specialist equipment for an older person with **palliative care*** needs and at the end of their life. **Monitor, review and improve systems* and processes* for comprehensive palliative* and end-of-life* care.** • Analyse your clinical data on how effectively you're treating symptoms, including the use of **pain*** relief. • Review **feedback*** from older people, **substitute decision-makers***, family, **carers*** and **health professionals*** to make your **processes*** for

	comprehensive care* at the **end-of-life*** more effective. • Monitor how and when workers refer and escalate care **palliative care*** needs to **health professionals*** and specialist **palliative care*** services. Work to improve access and reduce barriers where needed.	
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	**Put in place 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**), put in place **processes*** to: - identify when an older people is in the **last days of their 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 can include decisions about transfer to hospital, stopping interventions that are not beneficial and avoiding futile interventions like CPR (**Outcome 1.1**). - focus on maintaining comfort and dignity. Plan for and manage distress, discomfort and the possibility of severe symptoms. - make sure you have **systems*** for communicating with older people, **carers***, family, **substitute decision-makers*** and escalating to **health professionals*** in the **last days of life*** (**Outcome 3.4**)	**Residential and home service providers** **Residential and home service providers** put in place **processes*** for care at the end of a person's life that are in proportion to the: • type of services provided • how complex they are. **Home service providers** **Home service providers** need to make sure each older person has a plan in place for the safe use of **medicines*** to manage **pain*** and symptoms, including **anticipatory medicines*** in line with their service context and the

hospital, where this is in line with the older person's preferences	- monitor, manage and escalate quickly changing needs and unresolved symptoms for medical review. This might include a specialist **palliative care*** service. - address the increased risk of **delirium***, **pressure injury*** and the need for more oral, eye, bowel, bladder and pressure area care. • Make sure that **anticipatory medicines*** to manage **pain*** and symptoms are: - available - appropriately prescribed, administered, monitored and reviewed - available 24-hours a day (**Outcome 5.3**). • Make sure workers are trained, skilled and supported to identify when an older person is in the **last days of their life***. Also, being able 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 processes* for the last days of life*.** • Analyse **feedback*** from **substitute decision-makers***, family and **carers*** of people who received care in the **last days of life***. 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***.	services being delivered. Everyone involved should understand the **roles and responsibilities*** of: • the provider • **carer*** • family • **substitute decision-maker*** • **health professionals***. Ensure that roles and responsibilities for care and escalation are clearly documented to support the older person during the last days of their life. Make sure escalation **processes*** are available 24-hours a day in line with the service context and the services being delivered.

Standard 6: Food and nutrition

What is the intent?

Access to nutritionally adequate food is a fundamental human right. Food, drink and the dining experience can have a huge impact on a person's quality of life. As people age, they may lose their appetite or experience conditions that impact on their ability to eat and drink. As such, it is particularly important that providers engage with older people about what and how they like to eat and drink, deliver choice and meals that are full of flavour, appetising and nutritious (including for older people with texture modified diets), and support older people to consume as much as they want and exercise dignity of risk.

In many cultures, food also plays a large role in fostering feelings of inclusion and belonging. The experience of sharing food and drink with other older people, friends, family and carers is important for many older people.

Providers must draw on Standard 3 in delivering food services to ensure this is informed by robust assessment and planning, and services are delivered in line with the needs, goals and preferences of older people. It is also critical for providers to monitor older people for malnutrition and dehydration and respond appropriately where concerns are identified – this is addressed as part of Standard 5.

Standard 6 is intended to apply only to residential care services.

Outcome 6.1

What is the outcome that you need to achieve?

The **provider*** partners with older people to provide a quality food service, which includes appealing and varied food and drinks and an enjoyable **dining experience***.

Why is this outcome important?

Outcome 6.1 explains providers' obligations to partner with older people in residential care homes to make sure the food and drink they provide is:

- appealing

- varied
- nutritious
- meets their needs and preferences.

Enjoyable food, drink and **dining experiences*** contribute to a quality food service that supports older people's **quality of life***.

It's important that providers actively seek and incorporate feedback from older people, their family and carers to continuously improve the food service. Providers should use **contemporary, evidence-based practices*** to inform **continuous improvement***. For example, providers can organise a food and dining focus group to get feedback from older people on their preferences. They can then make changes to the menu based on this feedback.

Outcome 6.1 highlights how important it is to understand each older person's different cultural, nutritional and personal needs and preferences. For example, an older person's cultural background may influence specific food, drink and dining choices and preferences. Partnering with older people on food and nutrition can help providers understand and meet the older person's individual needs and preferences.

You need to give focus to**:**

- partnering with older people to create an enjoyable food, drink and **dining experience***
- continuously improving the food service in line with **contemporary, evidence-based practices***.

Key tasks:

Put in place a system* for partnering with older people to make food, drink and dining experiences* enjoyable.

Make sure this **system*** focuses on older people's **needs, goals and preferences*** (**Outcome 1.1**). It should give older people choice and control over their food, drink and **dining experiences***. Consider how your broader **processes***, when partnering with older people, support them to exercise **dignity of risk*** and **eating and drinking with acknowledged risk***. These should be in line with **contemporary, evidence-based practice*** (**Outcomes 1.2, 1.3 and 2.1**).

Also, talk with older people about their eating, drinking and dining preferences. This can include:

- asking them about their food and drink likes, dislikes, intolerances and allergies. For example, find out if the older person has any specific cultural or religious beliefs that may influence what they want to eat and drink (**Outcome 1.1**). This should include considering:
  - culturally significant, local or native foods
  - shared meals
  - gatherings of cultural significance.

- having formal **processes*** for consulting with older people about food, drink and the **dining experience***. For example, through a consumer advisory body or focus group (**Outcome 2.1**).

Use available resources to make sure you're considering all the older person's preferences. For example, the Commission has a food and dining preference sheet. You can use this to record each person's preferences.

It's important to partner with older people who need extra support. This makes sure you understand and can meet their eating, drinking and dining preferences. Some older people may have **communication barriers*** and may need individualised and extra support. This can include older people who:

- are living with:
  - **mental illness***
  - **cognitive impairment*** including **dementia***
  - disability.
- come from cultural and linguistically diverse (CALD) backgrounds
- identify as Aboriginal and Torres Strait Islander.

Also, make sure older people with **communication barriers*** and who need extra support are represented and partnered with appropriately.

Your strategies to support enjoyable food, drink and **dining experiences*** should be in line with **contemporary, evidence-based practice*** and guidelines. For example, making sure **allied health*** recommendations, like using adaptive equipment prescribed by an occupational therapist, are available (**Outcome 6.2**).

Include **processes*** to identify risks associated with eating and drinking (**Outcome 2.4**). You also need **processes*** to control the risks you find. For example, you may need to refer an older person to an **allied health*** professional if they're more likely to aspirate (accidentally breathe food or liquid into the lungs) (**Outcomes 3.2** and **5.5**). This should be done in partnership with older people to support their food, drink and dining needs and preferences (**Outcome 2.1**) while also managing risk where possible. Consider the older person's right to exercise **eating and drinking with acknowledged risk (EDAR)*** (**Outcome 1.3**).

Document the older person's nutritional needs and preferences in their **care and services plan***s following assessments (**Outcomes 3.1, 5.4** and **6.2**). **Regularly*** review plans to make sure their nutritional needs and preferences are documented accurately. Make sure you communicate their needs and preferences with all relevant workers (**Outcome 3.3**). For example, catering and care workers who provide mealtime support with eating and drinking.

To make sure you're meeting older people's food, drink, and dining preferences, include **processes*** to monitor:

- how satisfied they are with food, drinks and the **dining experience***. This can include food satisfaction surveys, **feedback*** forums and other monitoring strategies such as considering plate wastage (served food that remains uneaten).
- that they're consuming enough food and drink to meet their nutritional needs (**Outcomes 5.4**, **5.5** and **6.3**).

Share information about older people's food, drink and nutrition through a confidential **process*** between your organisation, hospitals and external services. This is to make sure you provide continuity of care during **transitions of care*** (**Outcomes 2.7, 3.3, 3.4** and **7.2**). For example, changes to dietary requirements recommendations by an **allied health*** professional. For older people transitioning back into your care, review this information and update their **care and services plans*** if their dietary needs have changed (**Outcome 3.1, 3.4** and **7.2**). This includes you referring an older person to an **allied health*** professional for assessment, if appropriate (**Outcomes 3.2** and **5.5**).

Make sure workers have the time, support, resources and skills to partner with older people on their food, drink, and dining experiences.

Provide workers with guidance and training on how to partner with older people on their food, nutrition and dining **experiences***. This needs to be in line with:

- the organisation's **policies*** and **procedures*.** These should be in line with **contemporary, evidence-based practice***.
- workers' **roles and responsibilities***.

Make sure workers are in line with, understand and provide appropriate assistance when:

- partnering with older people on their food, nutrition and dining needs
- delivering and improving food, nutrition and hydration services
- recognising clinical change that impacts food intake and nutrition (**Outcome 5.5**)
- supporting older people with modified diets and thickened fluids (**Outcome 6.4**)
- helping older people with eating and drinking
- using the communication **system*** (**Outcome 3.3**) to:
  - make sure nutrition and hydration information is up-to-date
  - escalate any risks, changes, **deterioration*** or **incidents*** affecting the older person's nutrition, hydration or ability to eat and drink.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how well you partner with older people to create enjoyable food, drink and dining experiences.

To check if you are partnering with older people effectively on food, nutrition and **dining needs***, you can review:

- older people's care and service documents (**Outcome 3.1**). For example, making sure care provided in the progress notes aligns with the older person's needs outlined in their **care and services plan***.
- data on malnutrition, diet-related diseases and unplanned weight loss. This includes malnutrition screening (**Outcome 5.5**).
- **complaints*** and **feedback*** for trends (**Outcome 2.6**)
- **incident*** information for trends (**Outcome 2.5**).

Look for situations where:

- there have been **incidents*** involving the older person while eating and drinking (**Outcomes 2.5** and **5.5**). For example, coughing, aspiration, **choking*** or an allergic reaction
- an older person has become malnourished, dehydrated or lost weight unexpectedly
- the organisation has not partnered with the older person to provide enjoyable food, drinks and **dining experiences*** tailored to the person's **needs, goals and preferences***. You may be able to find this information by speaking with older people and analysing feedback trends.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). For example, ask them if their provider partners with them to provide food, drinks and **dining experiences*** they enjoy. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- have strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

The guidance for **Outcome 5.5** has more information on managing unplanned weight loss and malnutrition.

Outcome 6.2

What is the outcome you need to achieve?

The **provider*** understands the specific nutritional needs of older people and assesses each older person's current needs, abilities, and preferences in relation to what and how they eat and drink.

Why is this outcome important?

Outcome 6.2 explains providers' obligations to assess each older person's specific nutritional **needs, goals and preferences*** in residential care. This makes sure you can provide a quality food service that meets **person-centred*** and **culturally safe care*** principles. It makes sure that you reflect each older person's nutritional needs and preferences in their **care and services plan***. **Person-centred care*** makes sure you address individual dietary requirements, cultural needs and preferences.

Outcome 6.2 highlights how important it is to make sure assessments consider the specific nutritional needs of older people. This includes focusing on protein and calcium rich foods. This should also consider that nutrition needs change as older people age. It also encourages a **dining experience*** that supports how independent and satisfied older people are. **Outcome 6.2** highlights how important it is to make sure food services meet each older person's **goals of care***. All areas of nutrition, hydration and dining should be personalised to optimise each older person's health, wellbeing and dignity. **Outcome 6.2** helps to prevent and minimise malnutrition, dehydration and other identified clinical risks and contributes to how satisfied older people are generally with their meals.

Contemporary, evidence-based practices* are a key element in guiding the assessment and planning of older people's nutrition and hydration, and dining needs and preferences. You need to work with **allied health*** and **health professionals***, such as Accredited Practising Dieticians and Certified Practising Speech Pathologists, to make sure you provide **quality care***. This multidisciplinary approach supports the effective assessment of each older person's specific needs and preferences and informs how you provide food and drink. This needs to be in line with **contemporary, evidence-based practices***. You should **regularly*** reassess the older person's nutritional needs, preferences and **dining experiences*** to make sure that the food, drink and **dining experience*** stays safe, appropriate and tailored to them.

You need to give focus to:

- reassessing older people's nutritional needs. This includes their:
  - **dining needs*** and preferences
  - **dining experience***
  - ability to eat and drink.

Key tasks:

Assess older people's nutrition, hydration and dining needs* and preferences as part of your assessment and planning processes*.

Assess each older person's individual nutrition, hydration and **dining needs*** and preferences. Do this **regularly*** and in **partnership*** with the older person (**Outcome 2.1**) and include anyone else the older person wants to involve (**Outcome 3.1**). For example, their family, carers and **health professionals***.

When you assess the older person's individual nutrition, hydration and **dining needs*** and preferences, consider:

- including a clinical assessment of specific food and nutritional needs (**Outcome 5.4**). This assessment must be performed by an appropriate **allied health*** professional such as an Accredited Practising Dietitian. Assessment of nutritional needs should consider each older person's requirements, particularly for protein, energy and calcium. They should base this on **contemporary, evidence-based practice*** recommendations and guidelines (**Outcome 6.1**).
- the older person's therapeutic, cultural and religious dietary needs and preferences. This may also require considerations relating to how you prepare food (**Outcome 6.1**). There are resources available to help you assess older people's food and dining needs and preferences. For example, we have a food and dining preference sheet you can use.
- clinical, physical and cognitive issues that may affect the older person's ability to eat, drink and swallow. For example, poor **oral health*** or the effects of medication on appetite.
- adopting **trauma aware and healing informed practices*** relating to nutrition, food and dining. The guidance for **Outcome 3.2** has more information on delivering **trauma aware and healing informed care***.

Make sure you record the **outcomes*** of the assessment in the older person's **care and services plan***. Review and update these plans **regularly***. This is to make sure their plan stays effective and meets their needs and preferences (**Outcome 3.1**). Communicate these **outcomes*** to the older person, their family, workers, carers and others involved in their care. Include what and when the older person likes to eat and drink. Do this to support workers to understand what:

- is a positive **dining experience*** for each older person (**Outcomes 1.1** and **6.4**)
- is culturally and spiritually safe for each older person (**Outcome 1.1**)
- optimises older people's independence, **reablement*** and **quality of life*** (**Outcomes 3.1**). This means helping older people regain and keep their physical, mental and cognitive functions (**Outcomes 1.1** and **6.4**). You can do this by promoting use their skills and strengths.

Make sure you have **processes*** to support older people to eat and drink independently, when it's safe to. For example, an **allied health*** professional such as a speech pathologist may recommend

individualised safe swallowing strategies. This is to reduce risk and encourage older people to eat safely and independently (**Outcomes 3.1** and **5.5**).

Put in place strategies to manage **deterioration*** or changes in the older person that relate to them eating and drinking (**Outcome 5.4**). For example, when **deterioration*** and changes affect the older person's ability to:

- eat, drink and swallow
- meet their specific nutritional needs
- meet their hydration needs
- access food and drink when they want it (**Outcome 3.2**).

Make sure you refer and **facilitate access*** to Accredited Practising Dietitians, Certified Practising Speech Pathologists and other **allied health* professionals*** to help mitigate instances of **deterioration***. Severe and immediate **deterioration*** of older people in your care should be seen by a medical professional. This is in line with comprehensive **multidisciplinary care*** (**Outcome 5.4**).

The guidance for **Outcomes 5.4** and **5.5** has more information on managing **deterioration*** and clinical safety relating to **choking***, swallowing, nutrition and hydration.

Make sure workers who are part of the assessment and planning process* have the time, support, resources, and skills to assess nutritional needs and preferences.

Provide workers with guidance and training on how to assess older people's individual nutritional needs and preferences. This needs to follow:

- the organisation's **policies*** and **procedures*.** These should reflect **contemporary, evidence-based practice***.
- workers' **roles and responsibilities***.

Relevant to their role, make sure workers understand how to:

- assess each older person's nutrition, hydration and dining needs and preferences as a part of their **care and services plan*** (**Outcome 3.1**)
- use this information to plan and provide satisfactory food, drink and dining experiences each older person enjoys
- refer to appropriate **health professionals*** for specialist advice and reviews. For example, a speech pathologist for an eating, drinking and swallowing assessment (**Outcome 5.4**).
- undertake relevant screening using validated tools (**Outcome 5.5**).

Workers who assess nutritional needs may need specific training. Use the **system*** for managing human resources to identify specific training needs (**Outcome 2.9**). For example, a Registered Nurse may need more training on how to complete a malnutrition screening using a validated tool.

You may not expect a care worker to learn how to use this tool, but they may need more training on how to identify and escalate malnutrition concerns to clinical workers.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how well you're assessing and planning for older people's nutritional needs and preferences.

To check if you're assessing older people's nutritional needs and preferences effectively, you can review:

- the older person's care and service documents (**Outcome 3.1**). For example, making sure care provided in the progress notes meets the older person's needs outlined in their **care and services plan***.
- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- there have been **incidents*** involving the older person during eating and drinking (**Outcome 5.5**). For example, coughing, aspiration, **choking*** or an allergic reaction.
- the older person's nutritional needs and preferences haven't been considered or properly assessed.

Assess if workers are following your **evidence-based*** **policies*** and frameworks which outline your assessment and planning **process*** (**Outcome 2.9**). You can do this through quality assurance reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- have strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Outcome 6.3

What is the outcome you need to achieve?

Older people receive food and drinks that meet their nutritional needs, are appetising and flavoursome, have variation and choice about what they eat and drink and are able to eat and drink as much as they want.

Why is this outcome important?

Outcome 6.3 explains providers' obligations to make sure that older people in residential care homes receive appetising, nutritious and flavourful meals that meet their individual needs and preferences. This includes all areas of food services. For example:

- making sure nutritious snacks and drinks are always available
- serving food at the correct temperature
- presentation that is appealing, including for texture modified meals.

You must support each older person's right to choose what, when, where and how they eat and drink.

Key aspects of **Outcome 6.3** include the development and regular review of menus. Menus should offer variety and choice, making sure older people not only receive the nutrients they need but also enjoy their meals, enhancing their satisfaction and **wellbeing***. You need to partner with older people and relevant **allied health*** and **health professionals***, such as Accredited Practising Dietitians, to make sure you design menus to meet the older person's nutritional needs and preferences. This collaborative approach makes sure that meals are interesting, varied and enjoyable for older people, while addressing any specialised dietary needs in line with **contemporary, evidence-based practices***.

You need to give focus to:

- development and review of menus
- partnering with older people and relevant **health professionals***
- giving older people's choice about what, when, where and how they eat and drink
- access to snacks and drinks.

Key tasks:

Put in place strategies to provide food and drink to older people that meets their needs and preferences.

Include **processes*** to:

- partner with older people (**Outcomes 6.1** and **2.1**). This is to enable older people to provide input into the service's menu. For example, ask older people what their food preferences are and consider partnering with local communities to include traditional foods and cooking methods. Strategies need to be flexible and provide choice to support each older person's needs and preferences. It's important to acknowledge that older people's needs and preferences can change daily.
- support older people to exercise **dignity of risk*** and **eating and drinking with acknowledged risk (EDAR)** (**Outcomes 1.2** and **1.3**). For example, if an older person can't eat gluten and they still want to eat bread, you should give them the opportunity to choose whether they eat it or not. Provide the older person with the information they need to make this decision. For example, talk with them about the risks involved and explore strategies to mitigate risk (**Outcome 2.6**). This is so they can make an informed decision about their food and drink choices.
- make sure all older people can access **nutritious*** snacks and drinks at all times. This includes always providing water, as well as snacks and drinks that meet specific dietary requirements.
- get expert input from chefs, cooks and Accredited Practising Dietitians when menu planning. This makes sure the needs of any older people with specialised dietary requirements are being met. They can review recipes, ingredients, cooking methods, serving sizes, menu changes and the **dining experience***. Accredited Practising Dietitians will also help make sure older people are given food and drink that meets their specific nutritional needs.
- have a menu and mealtime assessment completed by an Accredited Practising Dietitian at least once a year. Menu and mealtime assessments should include a review of the menu against relevant nutritional standards, guidelines and frameworks (such as texture modification) based on **contemporary, evidence-based practice***. This is to help make sure food and fluids, nutritional care, mealtimes and **dining experiences*** you provide support the **needs, goals and preferences*** of older people at your service.
- design and review food service **processes***, including menus and the **dining experience***, to support each older person's needs and preferences. This will help to make sure that you tailor food, drink and the **dining experience*** to each older person's needs and preferences (**Outcomes 1.1 and 3.1**). You can do this by partnering with older people and discussing menu options with them (**Outcome 6.1**). Make sure you document how you're providing a variety and choice of food and drink to older people as listed in your menus. For example, having seasonal or quarterly menu changes.

- make sure you base menu options on **contemporary, evidence-based practices*** and guidelines (**Outcome 6.1**)
  - enable choice about what, where and when older people can eat and drink

- seek and implement feedback from older people to make sure that the food you serve is appetising, appealing, flavourful and well presented, including for texture modified foods. For example, using different plating techniques and serving equipment. Make sure that a trained professional with knowledge in texture modification and skill in your dietary framework reviews your texture modified diet menus. This is to help make sure you prepare meals correctly and consistently.
- consider:
  - contrasting coloured vegetables
  - different textures (where appropriate for the older person)
  - fresh foods
  - seasonal foods
  - food aromas, as the way older people taste and smell can reduce with age.
- prepare and handle food safely while managing dignity of choice and risk. You need to:
  - show that you comply with your approved food safety program in line with the relevant state or territory food safety legislation
  - work with older people and the relevant food safety body to enable choice when they want to eat foods that are risky for vulnerable people
  - serve food and crockery in a way that is safe. For example, at a temperature that is not too hot or cold.
  - have strategies to give opportunities to older people to be safely involved in preparing food and drink (**Outcome 7.1**). For example, through daily living and leisure activities.

Make sure the workers who provide food and drinks have the time, support, resources and skills to do this in line with older people's needs and preferences.

Provide workers with guidance and training on how to prepare and provide food and drink in line with older people's needs and preferences. This needs to be in line with:

- the organisation's **policies*** and **procedures*.** These should reflect **contemporary, evidence-based practice***.
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- provide meals, drinks and snacks that:
  - are varied, appetising, flavourful and appealing
  - meet each older person's nutritional needs and preferences
  - they prepare, store and serve safely, including to the correct consistency as needed for each older person
- support older people to choose what, when, where and how they eat and drink.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

The guidance for **Outcome 3.2** has more information on delivering care and services.

Monitor that food and drinks provided to older people are in line with their needs and preferences.

To check if the food and drinks you provide to older people meet their needs and preferences, you can review:

- the older person's care and service documents (**Outcome 3.1**). For example, making sure care provided in the progress notes is in line with the older person's needs outlined in their **care and services plan***.
- **complaints*** and **feedback*** for trends (**Outcome 2.6**)
- **incident*** information for trends (**Outcome 2.5**).

Look for situations where:

- an older person has experienced food related illness or allergies when provided food and drinks
- your organisation has used unsafe food practices
- older people haven't been able to access food or drink
- you haven't met older people's assessed needs or documented preferences with food and drink.

Also, talk with older people, their families and **carers*** to understand if there are ways to improve the way you serve food and drink at the service (**Outcomes 6.1, 5.4** and **2.1**). Workers may also be able to provide **feedback*** about the way food and drink is served and enjoyed. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and **carers*.**
- have strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Outcome 6.4

What is the outcome that you need to achieve?

Older people are supported to eat and drink. The **dining experience*** meets the needs and preferences of older people to support social engagement, function, and **quality of life***.

Why is this outcome important?

Outcome 6.4 explains providers' obligations to make sure older people receive a positive **dining experience*** in residential care homes. The **dining environment*** should promote a sense of belonging, social engagement, **reablement***, **quality of life*** and enjoyment. For example, you should speak to older people to understand how you dining areas could be inviting, homely and accessible.

You can further support **reablement***, **quality of life*** and **maintaining function*** with a meaningful **dining experience*** that encourages older people to join in social activities, share meals with visitors and engage with their community. By partnering with **allied health*** and **health professionals***, such as Occupational Therapists and Physiotherapists, you can support older people with individualised strategies to safely eat, socialise, and enjoy their meals in settings that are comfortable and tailored to their preferences.

A positive **dining environment*** also contributes to helping older people achieve their **goals of care***. Providing older people autonomy to eat and drink in line with their preferences supports their right to exercise choice and make decisions about their **activities of daily living***.

You need to give focus to:

- having enough workers to prompt and support older people to eat and drink
- making sure the dining environment supports:
  - a sense of belonging
  - social engagement
  - **reablement***
  - enjoyment
- sharing food and drinks with visitors.

Key tasks:

Put in place strategies to make sure the dining experience* meets the needs and preferences of older people and supports social engagement, function and quality of life*.

Integrate these strategies with your:

- broader strategies for daily living (**Outcome 7.1**). This is to include older people in dining activities that:
  - promote older people's **quality of life***
  - enable them to share food and drinks with their visitors if they want
  - help older people maintain social connections and contribute to their community. For example, by having older people take part in meaningful and engaging activities, such

as themed dining events for special occasions, and cultural and religious holidays that older people have chosen to celebrate or take part in.

- **workforce*** strategy (**Outcome 2.8**). You need to determine and arrange for the number and mix of workers that makes sure you support older people to eat and drink safely (**Outcome 2.9**). At a minimum, you need to consider skills and qualifications workers need to make sure they safely prepare and serve food (**Outcome 6.3**).
- strategies to support older people who need physical assistance to consume their meals safely. This may be because of visual, dexterity (skill in performing tasks) or **sensory impairments***, as well as swallowing difficulties (**Outcomes 5.4** and **5.5**)
- strategies to supervise older people with eating, drinking or swallowing difficulties as identified by a speech pathologist. This must follow recommendations made in their assessment (**Outcomes 5.4** and **5.5**)
- strategies to manage people's assessed needs in relation to mealtimes. For example:
  - workers are aware of signs and symptoms of eating, drinking and swallowing difficulties and escalate concerns as soon as possible (**Outcomes 5.4** and **5.5**). Document this information in their **care and services plan***s (**Outcome 3.1**). These plans should also include information on individualised strategies as assessed and prescribed by a Speech Pathologist.
  - monitor and assess the skills of workers on an ongoing basis to make sure they are providing appropriate texture modified foods and thickened fluids, as assessed and prescribed by speech pathologist (**Outcomes 6.3** and **5.5**). This includes being able to identify appropriate consistencies in line with older people's assessed needs (**Outcomes 6.2**).
  - you have **processes*** to investigate, document, respond to and manage **incidents*** to do with eating, drinking and swallowing (**Outcome 2.5**).
- broader strategies to create and maintain a **service environment*** that is clean, safe, welcoming, comfortable and accessible (**Outcome 4.1b**). Make sure the **dining environment*** supports **reablement***, social engagement, cultural safety and promotes a sense of belonging and enjoyment. Also, partner with older people to find ways to improve the **dining environment*** so it's enjoyable and tailored to their individual needs and preferences at mealtimes (**Outcome 6.1**). For example, you can do this by:
  - supporting older people to eat where they want. Older people should be encouraged to eat in the communal space but supported to eat where they wish. For example, to sit at the table of their choice whether indoors or outdoors, or in their room.
  - ensure dining room is free of clutter and furniture doesn't block pathways
  - installing handrails between older people's rooms and the dining room (where practical) to make sure they can move safely as prescribed by an occupational therapist.
  - asking older people what their favourite condiments are and offering these on their tables during mealtimes.

Put in place strategies in partnership with older people that are in line with their needs and preferences (**Outcomes 6.1** and **2.1**). Consider:

- the needs of older people living with **cognitive impairment***, including **dementia*** (**Outcomes 3.2** and **5.6**). For example, they may need modified cutlery or colour contrast of

utensils and plates as assessed and prescribed by an Occupational Therapist. Identify when to escalate concerns to an appropriate **allied health*** professional such as an occupational therapist. They can assess their needs and inform how workers can provide support to the older person during eating times.
- the older person's cultural and social needs and preferences in their **dining experiences*** (**Outcome 1.1**).

Make sure older people have choice and preferences for their ideal dining environment. You need to acknowledge the older person's right to exercise choice and **dignity of risk*** when considering their requests (**Outcome 1.3**).

Make sure the workers who provide dining experiences* have the time, support, resources and skills to do this in line with older people's needs and preferences.

Make sure you consider older people's individual needs when you plan for workers' rosters (**Outcome 2.8**). This is to make sure there are enough qualified workers available when providing **dining experiences*** (**Outcome 3.1**). This needs to consider each older person's individual needs in line with their **care and services plan***. Based on this, make sure you have enough qualified workers to:

- support older people to eat at the times they want to and at their own pace
- promote older people's **reablement***. Workers can do this by rebuilding older people's skills and confidence to eat or drink by themselves (**Outcome 3.2**).
- support people living with **cognitive impairment***, including **dementia*** (**Outcomes 3.2** and **5.6**). Some older people may have individualised mealtime support strategies recommended by an **allied health*** **professional*** that you should follow. For example:
  - modified cutlery and colour contrast of utensils and plates
  - verbal prompts to slow down the pace of eating
  - equipment to ensure safe positioning.
- identify:
  - when the older person may be having difficulty eating, drinking or swallowing
  - the correct consistencies of texture modified diets and thickened fluids (**Outcomes 6.2** and **5.5**).
- monitor older people's food and drink intake. This will help you identify older people who require a further nutritional assessment.
- support older people who eat in their rooms to experience a positive **dining experience***
- support older people to eat and drink when there is an infectious disease risk or outbreak (**Outcome 4.2**). For example, make sure additional staff are available to support older people to eat and drink during mealtimes.

Provide workers with guidance and training on how to provide positive **dining experiences*** to older people. This needs to be in line with:

- the organisation's **policies*** and **procedures*.** These should reflect **contemporary, evidence-based practice***.
- workers' **roles and responsibilities***.

Make sure workers understand how to:

- support older people to eat and drink. This includes identifying older people who need extra assistance to safely eat and drink
- provide a **dining experience*** that supports **reablement***, social engagement and a sense of belonging and enjoyment
- provide opportunities for older people to share food and drinks with their visitors.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

The guidance for **Outcome 3.2** has more information on delivering care and services.

Monitor how well you provide a positive dining experience* in line with older people's needs and preferences.

To check if you're providing a positive **dining experience*** in line with older people needs and preferences, you can review:

- older people's care and service documents (**Outcome 3.1**). For example, making sure care provided in the progress notes aligns with the older person's needs outlined in their **care and services plan***.
- **complaints*** on the **dining experience*** (**Outcome 2.6**)
- **feedback*** (**Outcome 2.6**) on how to improve the **dining experience***. This is to optimise older people's **quality of life***.
- workers' ideas to support each older person's **dining experience***. This can help you find opportunities to improve the **dining experience*** and make it more enjoyable. For example, by supporting or encouraging older people to pick fresh flowers from the garden to place on tables.
- **incident*** information (**Outcome 2.5**).

Look for situations where older people haven't had:

- support to safely eat and drink
- a positive **dining experience***.

Also, talk with older people, their families and carers about their **dining experiences*** (**Outcome 2.1**). Partner with older people to get their feedback and include this in **continuous improvement*** plans for **dining experiences*** (**Outcomes 2.1, 2.6** and **6.1**). You may need to think about other ways to get feedback from older people with **communication barriers***, such as using visual supports.

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- have strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Standard 7: The residential community

What is the intent?

When people move into a residential service, the residential community becomes a central feature of their lives. It is critical that older people feel safe and at home in the residential community, have opportunities to do things that are meaningful to them and are supported to maintain connections with people important to them. Meaningful activities can include participating in hobbies or community groups, seeing friends and family or activities that contribute to the residential community such as gardening, cooking and setting tables.

A residential community can involve diverse members from different cultures and backgrounds. It is important that each older person's culture is respected, and their diversity valued so they feel included, safe and at home in the service.

Given the scope of responsibility in residential care, providers also have increased requirements to ensure that older people have access to other services and to coordinate a planned transition to or from the service to maximise continuity of care for older people.

Standard 7 is intended to apply only to residential care services.

Outcome 7.1

What is the outcome you need to achieve?

Older people receive services and supports for daily living that optimise their **quality of life***, promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their **service environment***.

Why is this outcome important?

Outcome 7.1 explains providers' obligations to deliver care and services that support older people's daily living needs in their residential care home. As a provider, the care you provide directly affects the physical and psychological wellbeing of older people.

Outcome 7.1 highlights the older person's right to make choices and have access to the things they want to do in relation to their daily living activities. This is important for their overall **quality of life*** and wellbeing. This helps older people to:

- maintain their independence
- take part in activities that are meaningful to them
- maintain social connections in and outside the residential community
- live life in line with their preferences**.**

It's important to support older people's **activities of daily living*** and help them to take part in lifestyle activities. These activities, when tailored to each person's abilities and preferences:

- support independence
- build confidence
- help maintain their physical, mental and cognitive functions
- provide opportunities for **reablement***.

Outcome 7.1 recognises the older person's right to do the things they want to do. This includes maintaining their own social and personal relationships, having control of their own room and activities of their own interests. This supports older people's sense of freedom and control over their lives. Providers should support older people's rights to make informed decisions about their care and activities. To do this, providers need to balance older people's right to **dignity of risk*** with considerations for their physical and **psychological safety***. This can include working with the older person on safety measures to support their choices. A safe, respectful and supportive environment creates trust, and makes sure older people feel comfortable and respected in their daily activities.

You need to give focus to:

- minimising boredom and loneliness
- monitoring older people's function in relation to **activities of daily living***
- strategies to protect the physical and **psychological safety*** of older people
- entertaining visitors in private
- making sure older people can engage in sexual activity without judgement.

Key tasks:

Put in place strategies to support a community experience that meets the needs and preferences of older people (Outcomes 1.1, 3.1 and 3.2).

Make sure you deliver care and services that support a community experience that meets the needs and preferences of older people (**Outcomes 1.1, 3.1** and **3.2**).

Any strategies, activities or supports for older people need to be documented in their **care and services plan***. This should be part of your assessment and planning **process*** (**Outcome 3.1**). Review and improve these plans in partnership with older people (**Outcome 2.1**). Make sure you

support the older person's right to **dignity of risk*** when they want to take part in activities of their choosing (**Outcome 1.3**). These strategies, activities and supports should:

- meet older people's **needs, goals and preferences*** (**Outcomes 1.1, 3.1** and **3.2**)
- provide opportunities for them to take part in lifestyle activities and **activities of daily living** in a way that is meaningful to them. Meaningful means the older person feels valued for their role in the residential community. For example, being responsible for setting the table or taking care of the vegetable garden. Consider ways to provide older people with social purpose. For example, if an older person enjoys writing, ask them to write a welcome letter to a new resident.
- optimise the older person's **quality of life***. For example, if an older person is happier spending time outside, provide them with opportunities to do activities outdoors, such as gardening or reading.
- help older people do what they want to do. For example, workers need to be able to support an older person to go for a walk if this is something they enjoy.
- support older people to regain and maintain their physical, cognitive and mental functions by encouraging them to use their skills and strengths (**Outcome 3.2**). This supports their **quality of life***, gives them opportunities to take part in activities that would be part of their life at home, and helps them to maintain independence. For example, if an older person enjoys:
  - reading – you can support them with audiobooks or large print books
  - food and cooking – you can give them opportunities to take part in preparing meals.
- be **culturally safe***, **trauma aware, healing informed*** and appropriate for people with diverse backgrounds (**Outcome 1.1**). This helps older people to maintain connections to their cultures and communities. This includes recognising how important it is for older people who identify as Aboriginal and Torres Strait Islander to maintain connection to community, culture and Country.

Make sure your strategies to support a community experience are tailored to each older person's assessed needs. This supports their sense of purpose and engagement. This is so they can:

- do the things they want to do, both inside and outside the residential community. This includes facilitating access to the community for activities outside the residential community.
- take part in meaningful activities they are interested in. Activities can be individual, group or partnered. Have **processes*** to provide a range of regular and diverse activities that older people can choose to take part in. These can include:
  - social activities like bingo, book clubs or movie nights. This helps to minimise boredom and loneliness, and maintain social and personal relationships.
  - cultural, spiritual and religious activities they want to take part in. For example, taking part in cultural and holiday celebrations, cultural gatherings or days of significance, services at places of worship, or prayer and meditation sessions. Also, support older people to take part in culturally appropriate routines and practices, if they want to.
  - a range of planned, mentally engaging activities like trivia and quiz sessions, or games like sudoku, crosswords and jigsaw puzzles. This helps to maintain cognitive function and supports better mental health.

  - creative activities like arts and crafts, painting, knitting clubs or music therapy sessions. This helps to maintain cognitive function and support emotional wellbeing through creative expression. This can also provide opportunities for social engagement.
  - cooking activities. This can help to stimulate the senses, improve self-esteem, and build and maintain motor skills.
  - activities to stay physically active like walking groups, exercise classes, dancing or gardening. This helps to maintain and improve physical health, such as mobility and dexterity.
  - outings and excursions. For example, going on day trips in the community or bus tours. This helps to maintain connections inside and outside the residential community.
- take part in activities that would be a normal part of an older person's life at home. For example, helping with meal service, setting tables, doing laundry or arranging flowers.
- contribute to the community in ways they want to. This can be by organising activities related to their diverse cultural backgrounds. For example, taking part in cultural events and activities, pride celebrations and disability advocacy group events. This helps to support emotional, spiritual and psychological **wellbeing***.

Your strategies also need to consider ways you can support the older person's:

- physical and **psychological safety*** (**Outcomes 4.1b** and **5.4**). Involve older people in making decisions about strategies to protect their physical and **psychological safety***. Make sure these strategies are **culturally safe***, **trauma aware and healing informed*** and documented in their **care and services plan*** (**Outcomes 1.1, 3.1** and **3.2**). This includes respecting each older person's diverse backgrounds and life experiences such as past trauma. Strategies also need to meet each person's **needs, goals and preferences*** (**Outcome 1.1**). The guidance for **Outcome 3.2** has more information on delivering **culturally safe***, **trauma aware and healing informed care***.
- comfort, physical and psychological wellbeing. For example, consider ways to make sure you support the older person to overcome any anxiety about their mobility or continence issues. This helps them do the things they want to do, particularly activities that are outside the residential community.
- right to make choices about the **activities of daily living*** and lifestyle activities they want to do. For example, you shouldn't force older people to go for a walk or take part in group activities if they don't want to.
- rights and autonomy of older people (**Outcomes 1.1** and **1.2**). This includes their right to intimacy, sexual and gender expression. For example, make sure you support older people to spend time with whoever they want with their mutual consent.
- privacy. Make sure everyone involved in an older person's care respects their personal privacy (**Outcome 1.2**). Make sure you support older people to entertain visitors privately when they want to. Make sure you understand who can enter the older person's room and when, without them feeling unsafe.
- right to **dignity of risk*** (**Outcome 1.3**). Make sure you provide the older person with the information they need to make these decisions. For example, talk with them about the benefits, risks and consequences involved so they can make informed decisions about the activities they do.

Put in place **processes*** to identify, monitor and record older people's physical, cognitive and mental functions in relation to **activities of daily living***. You need to do this with older people, and with their **informed consent*** where relevant. This can help you to identify **deterioration*** or changes to an older person's:

- ability to perform **activities of daily living***
- mental health
- cognitive or physical function
- capacity or condition (**Outcome 3.2**).

Consider whether you need referrals or specialist advice from **allied health*** or other **health professionals*** when supporting older people with their **activities of daily living*** (**Outcomes 3.2** and **5.4**).

Make sure workers have the time, support, resources and skills to encourage and support older people to take part in community experiences.

Consider ways to make sure workers have the skills to encourage and support older people to take part in community experiences and do the things they want to do. For example, provide workers with guidance and training (**Outcome 2.9**). This needs to be in line with:

- your organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities***.

Make sure workers understand how to support and encourage older people to:

- do the things they want to do in line with their **needs, goals and preferences***
- take part in activities that are meaningful to them
- perform **activities of daily living***
- make choices with their daily living that support their independence and **quality of life***.

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how you support older people to take part in community experiences.

To check if you are supporting older people to take part in community experiences and perform **activities of daily living***, you can review:

- older people's care and service documents, such as **care and services plans*** and progress notes (**Outcome 3.1**)

- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where:

- older people haven't received adequate services and support for daily living
- older people haven't been able to take part in activities that meet their **needs, goals and preferences*** (**Outcome 1.1**)
- community activities and the **service environment*** (**Outcome 4.1b**) were culturally, spiritually, psychologically and physically unsafe. For example, if an older person is encouraged to take part in a cultural activity that they find offensive or upsetting based on their past experiences, trauma or personal beliefs.
- older people have reported feeling bored or lonely
- older people's family and friends have felt uncomfortable visiting the residential home
- older people haven't been able to have a level of privacy in their rooms that make them feel safe.

Also, talk with older people, their families and carers about the care and services they receive (**Outcome 2.1**). For example, ask them if they're supported to take part in activities that are meaningful to them and perform **activities of daily living*** in line with their **needs, goals and preferences***. Ask older people with specific needs and diverse backgrounds if their daily living needs have been considered and met. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** when delivering services and support for daily living (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Outcome 7.2

What is the outcome you need to achieve?

Older people experience a well-coordinated transition to or from the **provider*** for planned and unplanned transitions. There is clear responsibility and accountability for an older person's care and services between workers, **health professionals*** and across organisations.

Why is this outcome important?

Outcome 7.2 explains providers' obligations to make sure older people experience safe and well-coordinated **transitions of care***. **Transitions of care*** happen when the older person's care is transferred between residential care, hospitals, other services and community settings. Getting an older person's **informed consent*** and making sure there is effective communication between older people, their families, carers, workers and **health professionals*** is important during these transitions. Transitions usually happen when an older person's condition and care needs change. Coordinating care effectively during transitions supports **continuity of care*** and minimises the risk of older people experiencing **adverse events***. It's important that you maintain **continuity of care*** during transitions to support the delivery of safe and **quality care*** and services.

Outcome 7.2 highlights how important it is to protect older people's privacy and manage their personal information as they transition from one service to another. Providers should closely with the older person, their family, carers, **health professionals*** and specialist health services. This makes sure information about the older person, like their **care and services plan***, is current, complete and given on time during transitions. You should review and update **care and services plans*** to meet the older person's changing **needs, goals and preferences*.** This informs their care and services when transitioning back to their provider. Coordination and communication across care settings during **transitions of care*** makes sure this information is up-to-date and effective.

You need to give focus to:

- **continuity of care***
- facilitating access to other services if needed
- maintaining connections with specialist services.

Key tasks:

Put in place processes* to support coordinated transitions for older people.

Transitions can happen between:

- locations
- **provider*** organisations
- providers of care and services. This includes hospital and emergency care and services.
- levels of care in the same location. For example, as the older person's condition and care needs change.

Find, document, and share all current information when an older person is transferred. Make sure the older person has given their **informed consent*** for you to share this information. You can do this by using your communication (**Outcome 3.3**) and **information management systems*** (**Outcome 2.7**). The information you share might include the older person's:

- **needs, goals and preferences*** (**Outcome 1.1**), including:
  - language and communication needs and preferences (**Outcomes 1.1** and **5.4**)
  - specific needs for older people with diverse backgrounds (**Outcome 1.1**)
  - food, drink and dining needs and preferences (**Outcome 6.2**).
- **advance care planning documents*** (**Outcome 3.1**)
- clinical assessment, priorities and **goals of care*** (**Outcome 5.4**)
- relevant **allied health*** and **health professionals*** involved in their care (**Outcome 5.4**)
- family, carers, their **substitute-decision maker*** (if they have one) and other people the older person wants involved in their care.
- equipment, aids and products they need (**Outcome 5.4**)
- risks of harm or clinical concerns (**Outcomes 2.4, 5.4** and **5.5**)
- information about changes in the older person's condition (**Outcomes 3.3** and **5.4**)
- infection risks (if there are any) (**Outcomes 4.2** and **5.2**)
- medication history and current medicines list. Including, for example, information about adverse drug reactions (**Outcome 5.3**).
- **behaviour support plan***, for those who experience changed behaviours or may require the use of **restrictive practices*** (**Outcomes 3.2** and **5.6**).

It's important to make sure you maintain continuity of care during transitions. Make sure your transition **processes***:

- include using your communication **system*** (**Outcome 3.3**)
- include **processes*** to plan and coordinate transition of care and services before a decision is made (**Outcomes 3.4** and **5.4**). This should happen in partnership with the older person, their family, carers and other providers of care and services. It also applies to whichever setting or service the older person is transitioning to and back. Make sure everyone involved is clear about their responsibilities and accountabilities.
- consider each older person's identity, culture, ability, **diversity***, beliefs and life experiences (**Outcome 1.1**). Make sure this information is documented in their **care and services plan*** and discussed with the older person (**Outcome 3.1**). For example, an older person may need to transition to a health service of their choice to access specialist services.
- help workers and others caring for an older person to have access to the older person's current medication, medical equipment (if needed) and other supporting information (**Outcomes 5.3** and **5.4**). This also includes any infection risks, so measures can be put in place to protect the health and safety of everyone involved in **transitions of care*** (**Outcome 4.2**). You need to review this information before the transition. It also needs to be current, complete and provided in a **timely*** way. Your **information management system*** and **clinical information system*** need to make sure the privacy of older people is in line with data security requirements (**Outcomes 2.7 and 5.1**).
- record and monitor older people's hospital or emergency department visits. This includes monitoring the reasons why the older person has been admitted to hospital and using this information to improve **clinical care*** (**Outcome 5.4**). You also need to review if their **care and service plan*** has been updated with any changes in their discharge plan. Make sure you assess and apply any changes to older people's **care and services plans*** when they transition back to your care.
- are in line with **comprehensive care*** needs (**Outcome 5.4**). Make sure:

  - you check and review hospital discharge and transfer summary information. This informs changes to older people's care and services in a **timely*** way. Make sure this information is correct and check clinical information with external services if needed. You can do this by actively partnering with people who provide care and services to the older person.
  - medications are up to date at the time of transition (**Outcome 5.3**). Also, make sure current and complete medication information is available throughout the transition **process***. This includes a record of reasons for any changes to medications.
  - you monitor clinical conditions. For example, increase your observation of an older person in the days after their transition from hospital. This may be included in their discharge summary or return from hospital monitoring **process***.
  - you review **goals of care*** with the older person while considering their **reablement***. This means, trying to help the older person to regain their physical, mental and cognitive functions.
  - you review the older person's **care and services plan*** when the transition happens (**Outcome 3.1**) and update it as needed. This includes monitoring and evaluating how effective their **care and services plan*** is.
  - you store, manage, use and share **advance care planning documents*** with relevant people (**Outcome 3.1**).
- use your risk management **system*** to address challenges and risks when planning transitions (**Outcome 2.4**). Make sure you consider:
  - transitions at night. For example, risks with low-light situations, impact on sleeping patterns, and less resources available at night.
  - additional resources you need that should be available to provide continuity of care, such as equipment, supplies and medication
  - circumstances that mean the older person has a higher risk of harm when their care is transferred. This can include those who:
    - identify as Aboriginal and Torres Strait Islander
    - have a disability
    - have experienced trauma, particularly chronic or complex trauma
    - have cognitive or physical impairment
    - live with **dementia***
    - have mental illness
    - are culturally and linguistically diverse
    - need **palliative care*** and **end-of-life care***
    - have co-morbidities. This means, having more than one health condition or illness at the same time.

Put in place strategies to help older people access specialist care and services when they need or want to.

As part of **comprehensive care***, there are services that a person needs to address their clinical needs (**Outcome 5.4**). These can be:

- medical

- rehabilitation
- **allied health***
- **palliative care***
- specialist nursing
- advisory services.

For example, a person might need specialist **dementia*** care services.

You need to provide **comprehensive care*** once you understand each older person's needs (**Outcome 5.4**). This means, you need to address these needs and minimise the risk of harm (**Outcome 5.5**). Your strategies need to make sure that you help older people receive the specialist care and services they need. For example, specialist services can be accessed to:

- maintain and improve a person's **oral health***
- manage **pain***
- manage wounds
- access **palliative care*** and **end-of-life care*** (**Outcome 5.7**)
- support **mental health***
- optimise mobility
- manage sensory impairment
- manage **cognitive impairment*** and support **changed behaviours*** associated with **dementia*** (**Outcome 5.6**)
- make sure people feel **culturally safe*** (**Outcome 1.1**). For example, access to interpreters and translators, translated resources or culturally appropriate healthcare and community supports.

For regional and remote providers, limited resourcing may affect **timely*** access to **multidisciplinary care*** and specialist services. These providers should consider strategies to make sure older people are appropriately referred to specialist services, **allied health*** and **health professionals*** to support continuity of care and effective coordination during **transitions of care***.

Where needed, you need to maintain connections with specialist services so that older people can get **timely*** support when they need it.

Make sure workers who provide care and services have the time, support, resources and skills to use your processes* for transitions.

Provide workers with guidance and training on how to use your **processes*** for transitions and support an older person's transition to and from their provider (**Outcome 2.9**). This needs to be in line with:

- your organisation's **policies*** and **procedures***
- **contemporary, evidence-based practice***
- workers' **roles and responsibilities*** (**Outcome 2.9**).

Make sure workers understand how to:

- plan and coordinate older people's transitions between services, provider organisations and levels of care
- facilitate access to **health professionals*** and specialist health services when needed
- share and access information about the older person during **transitions of care***. You can do this using the communication (**Outcome 3.3**) and **information management systems*** (**Outcome 2.7**). For example, this can include information about their:
  - **needs, goals and preferences***
  - **care and services plan***
  - clinical needs (**Outcome 5.4**).

The guidance for **Outcomes 2.8** and **2.9** has more information on workforce planning and worker training.

Monitor how well your processes* for transitions of care* are working.

To check if you're managing **transitions of care*** well, you can review:

- older people's care and service documents, such as their **care and service plans*** and progress notes (**Outcome 3.1**)

- **complaints*** and **feedback*** (**Outcome 2.6**)
- **incident*** information (**Outcome 2.5**).

Look for situations where you haven't:

- coordinated **transitions of care*** effectively
- communicated information effectively during transitions
- facilitated access to specialist health services and **health professionals*** when an older person needed them.

Also, talk with older people, their families and carers about their experiences during **transitions of care*** (**Outcome 2.1**). For example, ask them if they feel their transitions to and from the provider have been well-coordinated. These conversations can then inform **continuous improvement*** actions and planning (**Outcome 2.1**).

Assess if workers are following your quality **system*** (**Outcome 2.9**). You can do this through quality assurance and **system*** reviews.

If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to:

- practise **open disclosure*** (**Outcome 2.3**). This means being open about what has gone wrong. Share what went wrong with older people, their family and carers.
- put in place strategies to mitigate the risk of things going wrong again.

The guidance for **Outcome 2.3** has more information on monitoring the quality **system*.**

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city