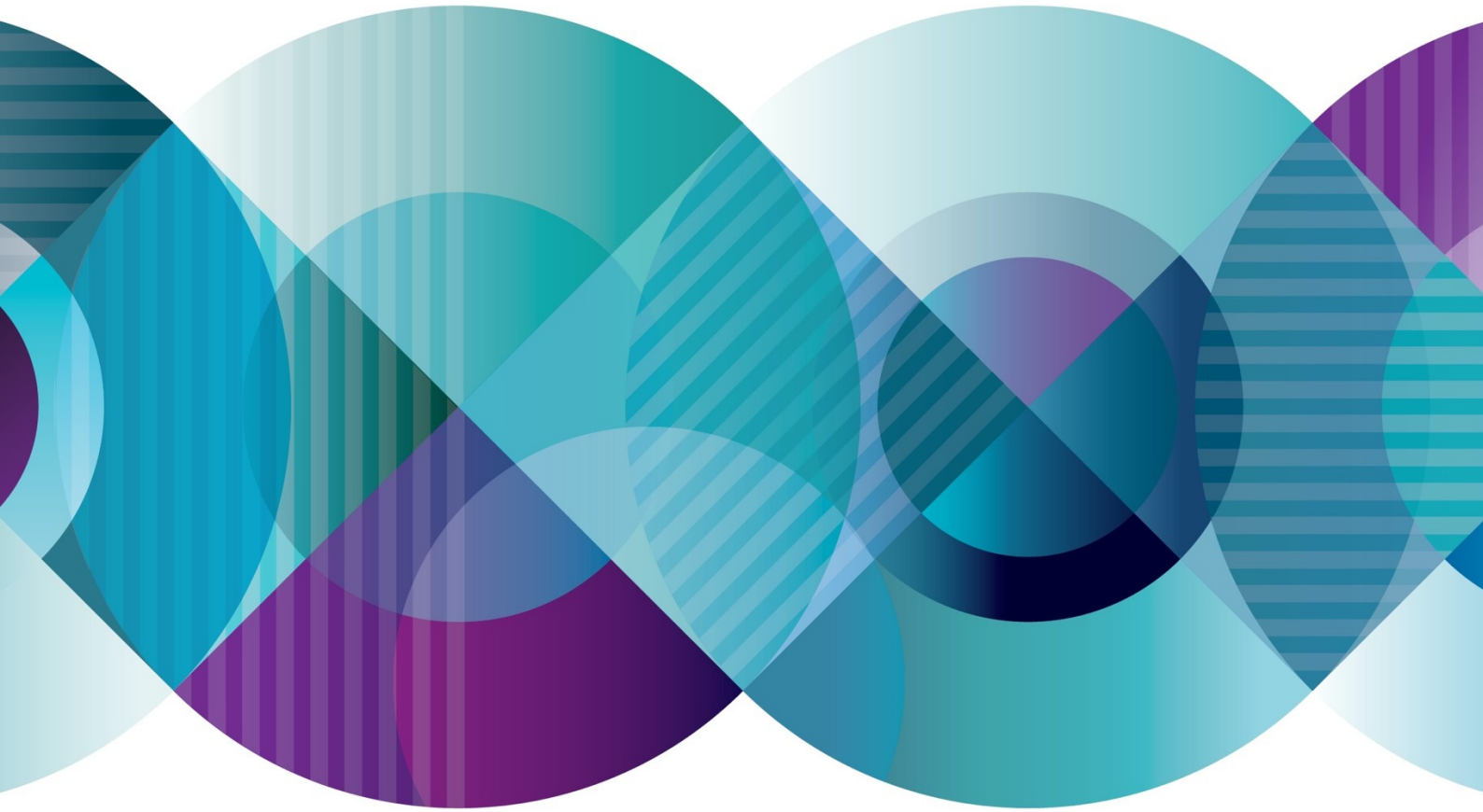
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE



National Safety and Quality Health Service Standards

Integrated Health and Aged Care Services Module and User Guide

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AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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Level 5, 255 Elizabeth Street, Sydney NSW 2000
Phone: (02) 9126 3600
Email: mail@safetyandquality.gov.au
Website: www.safetyandquality.gov.au

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Contents

Introduction

Integrated health and aged care services may include acute, emergency, sub-acute, community and primary care as well as residential, respite and home-based aged care services.

Health service organisations delivering acute, emergency and sub-acute health services must be accredited to the National Safety and Quality Health Service Standards (NSQHS Standards). Organisations delivering Commonwealth-funded aged care services must conform with the Aged Care Quality Standards (referred to in this document as the ACQ Standards), as applicable to their service type.

The Integrated Health and Aged Care Services Module (IHACS Module) supports approved Commonwealth-funded integrated health and aged care services to streamline the process of meeting the NSQHS Standards and the ACQ Standards in a single assessment process described under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.

The IHACS Module was developed by mapping the outcome statements in the ACQ Standards to the actions in the NSQHS Standards Second Edition to identify the elements unique to the ACQ Standards. These elements are consolidated into 14 Module Items, which when assessed alongside the actions in the NSQHS Standards, allow service providers to demonstrate meeting the ACQ Standards. The assessment outcomes against both the NSQHS Standards and the IHACS Module will be considered by the Aged Care Quality and Safety Commission to complete provider registration and re-registration decisions under the *Aged Care Act 2024*.

The IHACS Module replaces the *Multi-Purpose Services (MPS) Aged Care Module* that was published in February 2021. It is effective from 1 November 2025, upon commencement of the *Aged Care Act 2024.*

Applicability of the IHACS Module

The IHACS Module has been developed for approved Commonwealth-funded integrated health and aged care services.

At the time of publication, the IHACS Module applies to service providers delivering the Multi-Purpose Services Program (MPSP). Should additional aged care programs be included in the scope of the IHACS Module, this will be reflected on the websites of the Australian Government Department of Health, Disability and Ageing and the Aged Care Quality and Safety Commission.

Quality and safety in the aged care context

Service providers delivering integrated health and aged care services must ensure that relevant NSQHS Standards requirements are applied in the aged care service context. This includes considering aspects of aged care legislation, regulation, models of care, and workforce make-up that may differ from the healthcare context. Examples of these contextual differences are given below. This is a non-exhaustive list.

Aged Care Quality Standards

The strengthened ACQ Standards specify the expected level of safe, quality care that providers of residential, home and community-based aged care services are to meet. There are seven ACQ Standards:

1. The Individual
2. The Organisation
3. The Care and Services
4. The Environment
5. Clinical Care
6. Food and Nutrition
7. The Residential Community.

National Safety and Quality Health Service Standards

The NSQHS Standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with stakeholders to provide a nationally consistent statement about the standard of care consumers can expect from health service organisations.

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health services. Implementation is mandated in all hospitals, day procedure services and public dental services across Australia.

Legislation

To be registered to provide Commonwealth-funded aged care services, service providers delivering aged care services must conform with the conditions of registration and obligations of registered aged care providers specified in the *Aged Care Act 2024* and the *Aged Care Rules 2025*.

Philosophy of care

The *Aged Care Act 2024* and the ACQ Standards reflect a rights-based, person-centred model of aged care. The Aged Care Statement of Rights (contained in the *Aged Care Act 2024)* applies to all aged care services delivered. Person-centred aged care focusses on meeting the needs and preferences of people accessing aged care services including, but also beyond, their immediate clinical needs.

A core philosophy underpinning aged care provision is optimising quality of life, which can create priorities for care that may be different from those of acute health care. For example, promotion of autonomy and choice, dignity of risk, connections to identity and interests, social and personal relationships, and maintenance of physical and mental function (in line with a person's preferences) are important concepts in aged care.

Roles and responsibilities

Specific workforce considerations apply to the aged care context. Aged care services are commonly delivered by both health professionals and aged care workers who are not registered health professionals.

Where there are references to the workforce or to 'clinicians' in the NSQHS Standards, the delivery of aged care services has to consider the needs, roles and responsibilities of the aged care workforce including aged care workers.

The ongoing roles and responsibilities of supporters, families, friends, and other informal carers can be more substantial in the context of aged care delivery than in a healthcare context.

Integrated health and aged care services

Integrated health and aged care service providers generally deliver health and aged care services on or from the same site. State and territory government entities commonly supply infrastructure (such as buildings and information and communication technology) as well as shared services (such as human resources, records management, and food services). These factors may affect how integrated health and aged care service providers address related aspects of the IHACS Module.

Information and documentation

Systems for documenting, monitoring, reviewing, and communicating information need to be appropriate for the delivery of aged care services.

- Care may be delivered over a period of months or years, so up-to-date documentation should reflect the person's changing needs and preferences over time.
- Multiple parties from different organisations may be involved in meeting a person's needs, requiring clear delineation and communication of roles and responsibilities. Parties not employed by the provider may include supporters as well as outside health professionals such as general practitioners, oral health practitioners and specialist palliative care teams.
- Plans and strategies for optimising quality of life, as well as for preventing and managing issues with physical, mental or cognitive health, should be reflected in documentation.

Terminology

Some terminology differs between health and aged care contexts, and these differences are reflected in the NSQHS Standards and ACQ Standards. Key differences are explained below.

Service provider

In the context of the ACQ Standards, a 'service provider' refers to an organisation which delivers Commonwealth-funded aged care services and is registered to do so with the Aged Care Quality and Safety Commission. The Aged Care Quality and Safety Commission's Provider Registration Policy explains the processes and principles of the registration model.

Older person, supporter

The term 'older person' is used throughout this User Guide to refer to people using Commonwealth-funded aged care services. For the purposes of the IHACS Module, 'older person' has the same meaning as 'individual' in the *Aged Care Act 2024*.

The NSQHS Standards use the term 'patient' to refer to a person or group receiving healthcare services and the term 'consumer' to refer to a person who has used or may use a healthcare service, or a consumer representative or advocate. These terms are not used in the ACQ Standards.

A 'supporter' is a specific role defined in the *Aged Care Act 2024,* and service providers should check their legislated responsibilities with regard to this role.

Worker, health professional

The term 'aged care worker' in the *Aged Care Act 2024* means a person who is employed, hired, retained or contracted by, or is volunteering for, the service provider (whether directly or through an employment or recruiting agency) to provide care or other services.

The ACQ Standards refer to a range of health care workers such as 'health professional', 'allied health professional' and 'allied health assistant' which are defined terms under the *Aged Care Act 2024* Rules. These terms generally refer to workers who deliver health care services based on formal training and experience. The term 'clinician' is not used in the ACQ Standards.

Integrated Health and Aged Care Services Module

Module Item		
Person-centred care	**1**	The service provider delivers aged care services that: **a.** prioritise safety, health, wellbeing and quality of life **b.** tailor care based on needs, goals and preferences **c.** value identity, culture, ability, diversity, beliefs and life experiences.
Dignity, respect and privacy	**2**	The service provider delivers aged care services in a way that: **a.** is free from all forms of discrimination, abuse and neglect **b.** respects dignity and personal privacy **c.** upholds the rights set out in the Statement of Rights.
Choice, independence and quality of life	**3**	The service provider supports people accessing its aged care services to: **a.** exercise choice and make decisions about their care and services, with support when they want or need it **b.** exercise dignity of risk to achieve their goals and maintain independence and quality of life.
Agreements, fees, pricing, invoicing and statements	**4**	The service provider supports the autonomy of people accessing its aged care services to: **a.** take time and seek advice before entering into any agreements about their care and services **b.** understand agreements, fees and invoices so they can make informed decisions.
Workforce and human resource management	**5**	The service provider manages and plans for its current and future aged care workforce needs, ensuring that workers are suitably skilled, competent, qualified, experienced, supervised and trained to provide quality aged care and services.
Emergency and disaster management	**6**	In emergency and disaster management planning, the service provider considers and manages the risks to the health, safety and wellbeing of people and workers in its aged care services.

Module Item		
Assessment and planning	**7**	The service provider has comprehensive assessment and care planning processes for people accessing its aged care services that: **a.** incorporate risk management strategies and preventative care strategies **b.** support optimal quality of life, reablement and maintenance of function **c.** support early identification of changing needs and regular review of care plans.
Delivering comprehensive care and services	**8**	The service provider provides comprehensive care to people accessing its aged care services in a way that: **a.** optimises their quality of life and supports reablement and maintenance of function **b.** promotes use of their skills and strengths **c.** enables them to do the things they want to do **d.** supports them to feel safe in the place where care is delivered **e.** is culturally safe and appropriate **f.** is based on an understanding of situations and events that may lead to changed behaviours (for people with cognitive impairment).
Clinical safety	**9**	The service provider has processes to identify, reduce, monitor and manage the high impact and high prevalence clinical risks faced by people accessing its aged care services.
Care coordination and transition	**10**	The service provider has systems and processes to support coordinated care for people accessing its aged care services, including: **a.** where multiple health and aged care providers, and the support people of those accessing its aged care services, are involved in the delivery of care and services **b.** at transitions of care to or from the aged care service, including when transitions are unplanned **c.** clear responsibility and accountability for the delivery of care and services between aged care workers, health professionals and across organisations.

Module Item		
Environment	**11**	The service provider ensures that its aged care services: **a.** support people accessing home-based aged care services to mitigate environmental risks relevant to their care **b.** deliver a clean, safe and comfortable environment that optimises sense of belonging, interaction and function in residential care **c.** use or provide safe equipment that meets the needs of the person accessing its aged care services.
Infection prevention and control	**12**	The service provider uses an infection prevention and control system, processes and practices in its aged care services to minimise infection risks and, if they occur, to manage them effectively.
Food and nutrition	**13**	The service provider partners with people accessing its residential aged care service to provide a food, drinks and dining service that: **a.** supports service of appealing, flavoursome and varied food and drinks **b.** assesses and meets current nutritional needs, eating and drinking abilities, and preferences about what, how and how much they like to eat or drink **c.** assists with eating and drinking **d.** provides an enjoyable dining experience in a dining environment that promotes social engagement, function and quality of life.
Palliative and end-of-life care	**14**	The service provider has processes for people accessing its aged care services that: **a.** recognise and address their needs, goals and preferences for palliative care and end-of-life care and preserve their dignity **b.** actively manage pain and symptoms with access to specialist palliative and end-of-life care **c.** inform and support family and carers, including during the last days of life.

User Guide

Navigating the User Guide

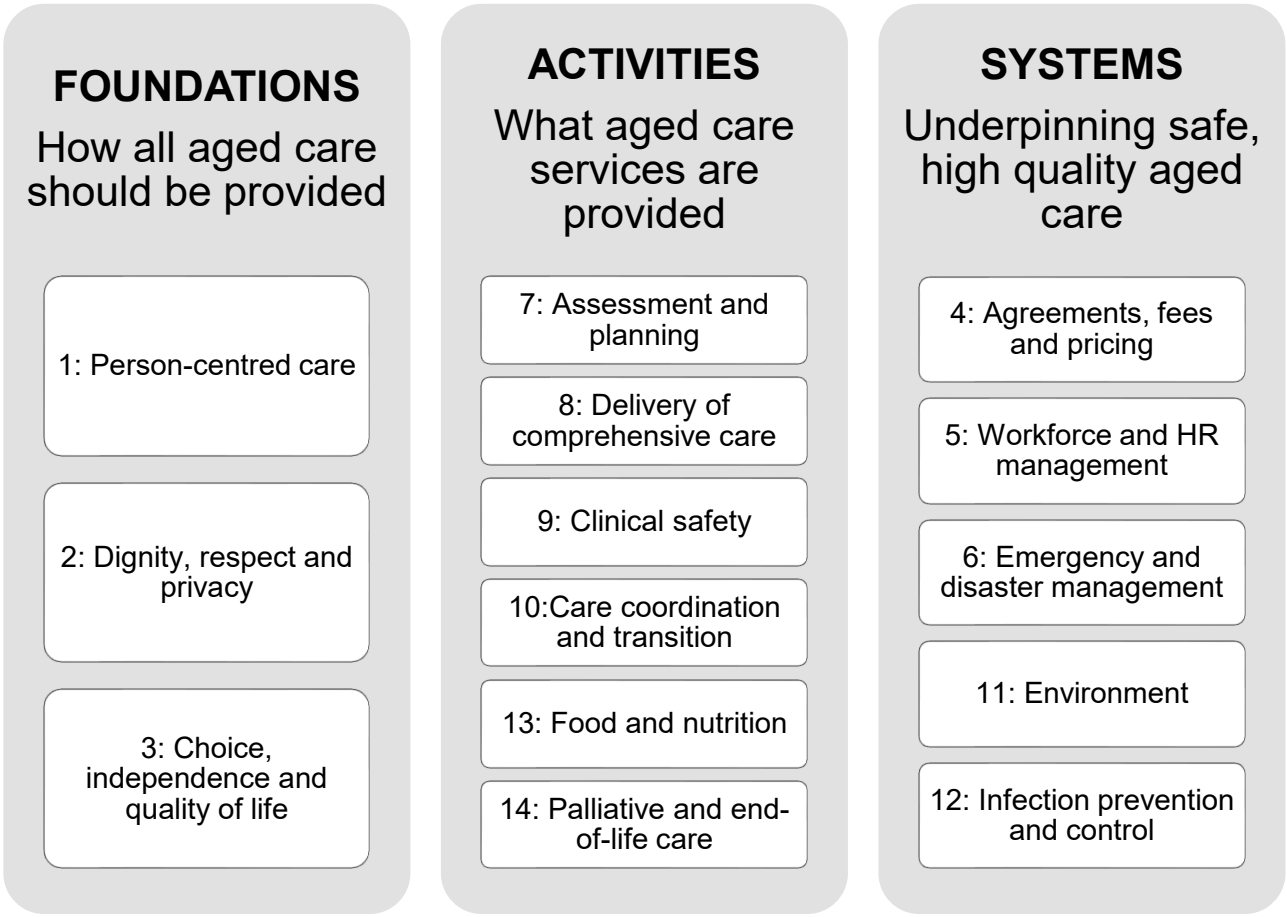
How the Module Items relate to each other

Module Items 1, 2 and 3 describe the **foundations** of the rights-based, person-centred approach to aged care provision that is articulated in the *Aged Care Act 2024*. This approach should be applied across all aged care activities carried out by the service provider and should underpin the way older people are treated by the aged care workforce.

Module Items 7, 8, 9, 10, 13 and 14 describe day-to-day **activities** that are carried out to achieve delivery of care and services to those accessing the aged care service. These relate to systems and processes that apply to:

- all types of aged care and services (that is, Assessment and planning (Module Item 7), Delivery of comprehensive care (Module Item 8), and Care coordination and transitions (Module Item 10))
- specific groups of older people based on their needs and on the type of service they are receiving (that is, Clinical safety (Module Item 9, for people receiving clinical care), Food and nutrition (Module Item 13, for people in residential care), and Palliative and end-of-life care (Module Item 14)).

Module Items 4, 5, 6, 11 and 12 describe aspects of strategic and operational **systems** of the service provider which create the conditions in which aged care activities can be consistently and safely carried out while upholding the foundational components.



Structure of guidance for each Module Item

Section	Explanation
Intent	Overview of the purpose of the item and why it is important for a service provider in the provision of integrated health and aged care services.
Key concepts	Concepts that are important for the governing body, management and workforce to understand when working towards achieving the intent of the item. Concepts are included that are specific to the aged care delivery context or that are differently applied in aged care when compared to health care.
Reflective questions	Starting point for the service provider to determine how it achieves the intent of the item and to start to identify gaps or improvements to be made.
Key tasks	Suggestions for actions and activities that can help the service provider address the intent of the item. Service providers may use other ways to demonstrate that they meet the intent of the item. Tasks undertaken to address the item should be relevant to the context of their service including the services delivered and the populations who accesses these services. There are two types of key tasks: 1. Tasks relevant to the delivery of healthcare that are extended to the provision of the aged care service 2. Tasks that are specific to the aged care service.
Examples of evidence	Suggestions of ways that a service provider can demonstrate that they meet the intent of the item. Service providers may also use other relevant forms of evidence relevant to its circumstances. There are three types of evidence listed in this section: 1. Documents and records 2. Feedback from parties involved in the governance, management and delivery of aged care services 3. Observations that can be made by assessors during assessment visits. Some feedback may be sought directly during assessment visits, while other feedback may be documented by the provider (e.g. through surveys, complaints, incidents).

Further resources

Please refer to the IHACS Module Resources List on the Commission's website for a curated list of further resources to support implementation of each Module Item.

Item 1: Person-centred care

1 **The service provider delivers aged care services that:**

a. **prioritise safety, health, wellbeing and quality of life**
b. **tailor care based on needs, goals and preferences**
c. **value identity, culture, ability, diversity, beliefs and life experiences.**

Intent

Module Item 1 explains the importance of person-centred care and how it can be achieved. It emphasises the need to understand each older person as a unique individual in order to deliver care that is respectful of, and responsive to, their individual needs and preferences.

Person-centred care means placing the older person at the centre of decision making about the planning and delivery of their care and ensuring that the service provider's systems and processes support people to shape how their care and services are delivered. This principle should underpin the way all older people using aged care services are treated in the context of professional and trusting partnerships with staff. This is important in fostering a sense of inclusion and safety.

This Module Item, along with Module Items 2 and 3, should form the foundation for how an integrated health and aged care service provider delivers its aged care services.

Key concepts

Person-centred care concepts described in the NSQHS Partnering with Consumers Standard are relevant to implementing Module Item 1. In addition, it is important for the service provider to focus on the following concepts in the aged care context.

- **Individuality and diversity** describe the varying social, economic, cultural and geographic circumstances of older people using the aged care service. The terms remind us that as members of society, older people come from a wide range of backgrounds and life experiences and that they identify with different communities, groups, beliefs, values and so on. Identifying, valuing and accommodating a person's individuality and diversity is an important part of understanding and treating them holistically as an individual.
- **Culturally safe care** 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.
- **Trauma aware and healing informed care** recognises that many people accessing aged care services 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 the workforce provide care that supports the person's emotional and psychological wellbeing.

Reflective questions

- How does the service provider identify, document and accommodate the identity, background and life experiences of people accessing its aged care services?
- How does the service provider work in partnership with each older person to identify and address their circumstances and needs?

Key tasks

Apply relevant actions from the NSQHS Standards

To meet Module Item 1, it is important that the service provider adequately extends relevant related actions from the NSQHS Standards into its delivery of aged care.

- Relevant actions in the **Clinical Governance Standard** include those related to safety and quality strategies for Aboriginal and Torres Strait Islander persons (1.04), quality improvement systems (1.08), diversity and high-risk groups (1.15), cultural safety (1.21) and creating welcoming environments for Aboriginal and Torres Strait Islander persons (1.33).
- Relevant actions in the **Partnering with Consumers Standard** include those related to sharing decisions in care planning (2.06-2.08) and communicating and partnering with older people (2.10-2.12).
- Relevant actions in the **Comprehensive Care Standard** include those related to planning for comprehensive care (5.07-5.08) and collaborating with older people, carers and families to tailor care for people with cognitive impairment (5.30).

Apply aged care-specific strategies

The service provider should ensure that its systems and processes for implementing and improving person-centred care are appropriate to the aged care context. A non-exhaustive list of strategies to help achieve this is given below.

Ensure systems and processes support individuality and diversity

- Ensure that the service provider's systems and processes for assessment and care planning enable the workforce to partner with the older person to understand their individuality and diversity and to plan care to meet their unique needs. This is closely linked to Module Item 7 (Assessment and planning).
- Identify, document and accommodate the aspects of the person's identity, community, connections and history that are meaningful and important to them. These might include:
  - identifying as an Aboriginal or Torres Strait Islander person
  - cultural and linguistic diversity
  - religious affiliation or spirituality
  - gender identity and expression
  - sexual orientation

  - life experiences such as:
    - work and career
    - hobbies and interest groups
    - living and working in remote or rural areas
    - serving in a defence force (being a veteran).

- Identify, document and accommodate the person's needs in relation to their social, physical, mental and cognitive health, such as:
  - living with disability
  - chronic physical or mental health conditions
  - cognitive impairment including dementia
  - experience of trauma
  - financial or social disadvantage
  - homelessness or being at risk of becoming homeless
  - spending time in care as a child (being a care leaver)
  - being a parent who has been separated from their children by forced adoption or removal.
- Identify if the older person is vulnerable. For example, an older person may be more at risk if they live alone, are socially isolated, depend on one carer, have cognitive impairment, have difficulty communicating or expressing themselves, have reduced mobility or are clinically frail.

Tailor care plans and care delivery to meet individual needs and preferences

- Ensure that the person's care plan explains how the service provider will meet their identified needs and preferences, such as:
  - tailoring care to the needs of people living with dementia
  - providing strategies and aids to meet communication needs and preferences
  - providing aids and equipment to meet sensory impairment needs
  - catering for cultural and linguistic needs including food preferences and preferred language for written and verbal communication
  - providing culturally safe care that supports ongoing connection to community, Country and Island Home, and cultural practices for Aboriginal or Torres Strait Islander persons
  - supporting a sense of belonging through ongoing connections with communities, groups, activities and events including those specific to religion, spirituality, culture, language, occupation, interests or hobbies
  - supporting maintenance of valued relationships with family and friends
  - ensuring recognition and respect for gender identity and expression and sexual orientation

- providing trauma aware and healing informed care.

Support professional and trusting relationships between older people and the workforce

- Ensure that systems for recruitment, training and supervision support and allow time for aged care workers and health professionals to maintain professional and trusting relationships with older people and to work in partnership with them when delivering care. This includes ensuring that members of the workforce, as appropriate to their role, know how to support older people by:
  - making them feel safe, welcomed, included and understood
  - encouraging them to cultivate and maintain relationships and connections to people and things that are important to them
  - helping them to stay engaged in meaningful activities and the community
  - recognising and engaging with people who are at risk of being socially isolated or feeling lonely
  - understanding, valuing and supporting their physical, emotional, cultural, spiritual and psychological wellbeing
  - encouraging them to use their skills and strengths to maintain or improve their physical, mental and cognitive function
  - providing culturally safe, trauma aware and healing informed care, including supporting connections to community, culture, country and Island Home for Aboriginal or Torres Strait Islander persons
  - identifying different types of trauma and how they can affect older people, including awareness of potential signs of trauma where these are not documented in the care plan or where the person does not want to share their experience
  - meeting the specific needs of people living with dementia
  - recognising the rights and respect the autonomy of older people, including their right to intimacy and sexual and gender expression.

Monitor, improve and review the approach to person-centred care

- Incorporate monitoring and improvement of the approach to person-centred care into the service provider's quality and safety improvement systems. For example, assessing the effectiveness of the service provider's approach to person-centred care could include reviewing complaints, feedback and incident reports for situations where:
  - an older person does not feel safe, welcomed, included or understood
  - an older person's communication or language needs and preferences are not met
  - services are not delivered in a culturally safe, trauma aware or healing informed way.

- Regularly talking with older people and their supporters about their care and services to identify where individual needs and preferences are not being met is also an important part of continuous improvement.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Strategies, policies or processes for assessment, care planning and service delivery that clearly detail requirements for person-centred, inclusive, culturally safe, trauma aware and healing informed care (including for Aboriginal and Torres Strait Islander persons and people living with dementia).
- Documented roles and responsibilities for management, aged care workers and health professionals in ensuring person-centred care, including requirements to collaborate with older people and develop professional, trusting relationships.
- Continuous improvement plans and/or Reconciliation Action Plans demonstrating how the service provider is monitoring, reviewing and improving its strategies for planning and delivering person-centred care and improving its approach to inclusion and diversity.
- Records of management and/or governing body meetings that demonstrate discussions of, and/or actions for, developing, implementing, monitoring and improving person-centred, inclusive, culturally safe, trauma aware and healing informed care.
- Samples of intake assessments and care planning documents that:
  - reflect engagement of the older person in a partnership approach
  - capture and value the older person's individual background, culture, diversity, beliefs, life experiences, communication needs and preferences, and choices for care
  - show that aged care workers and health professionals use inclusive and respectful language
  - indicate how care and services are tailored to the individual needs and background of the older person.
- Training documents and records related to this Module Item.

Feedback

- Feedback from the governing body showing how members assure themselves that care planning and delivery is person-centred. This could be through review and analysis of trends in care experiences, quality of life indicators or provider-nominated performance indicators.
- Examples from management showing how incidents, complaints and feedback are used to support continuous improvement on this Module Item.

- Feedback from aged care workers and health professionals (as relevant to their role) about their confidence and understanding about how to:
  - identify aspects of individuality and diversity (including cultural and life experiences)
  - recognise and respect the right of older people to autonomy, including intimacy and sexual and gender expression
  - implement trauma aware and healing informed care practices.
- Examples from aged care workers and health professionals (as relevant to their role) showing how they identify and meet the communication needs of older people (e.g. older people with diverse backgrounds, people living with dementia, people with vision or hearing impairment).
- Feedback from older people about the extent to which they feel:
  - safe, welcome and included
  - understood and valued by aged care staff as an individual
  - supported to maintain relationships, interests and connections that are important to them
  - supported to connect to community, culture, country and Island Home (for Aboriginal and Torres Strait Islander persons).

Item 2: Dignity, respect and privacy

2 **The service provider delivers aged care services in a way that:**

a. is free from all forms of discrimination, abuse and neglect
b. respects dignity and personal privacy
c. upholds the rights set out in the Statement of Rights.

Intent

This Module Item explains three foundational aspects of quality aged care - dignity, respect and privacy - and how these can be strengthened. It highlights the importance of ensuring that a rights-based approach underpins all aged care service provision, as described in the Statement of Rights in the *Aged Care Act 2024*.

Delivering rights-based aged care services supports older people to be empowered to decide how they receive care and to retain a sense of autonomy and control over their lives.

Key concepts

Important concepts for implementing dignity, respect and privacy in the aged care context include the following.

- Every older person has a right to be treated with **dignity and respect**, including supporting choice about when and how physical care or treatment occurs.
- **Personal privacy** in the aged care context is a right that includes privacy during intimate care and protection of personal spaces and belongings.
- **Older person's rights:** service providers have a positive duty to deliver care and services in a way that upholds the rights of older people as specified in the Statement of Rights in the *Aged Care Act 2024*. This includes the rights to:
  - safe, fair, equitable and non-discriminatory treatment
  - freedom from all forms of violence, degrading or inhumane treatment, exploitation, neglect, coercion, abuse or sexual misconduct
  - choice, decision making, taking risks, dignity, language preferences, and security of tenure.

Reflective questions

- How does the service provider prevent, identify and respond to the risk of individuals being subject to violence, abuse, racism, neglect, exploitation and discrimination?
- How does the service provider ensure the workforce understands their roles and responsibilities for preventing and reporting abuse?

- How does the service provider ensure that an older person's needs and preferences around personal privacy are identified, recorded and addressed?
- How does the service provider support its workforce to understand, value and uphold the rights of older people as set out in the Statement of Rights?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS Standards into its delivery of aged care. For Module Item 2, relevant related actions include those from the NSQHS **Clinical Governance Standard** on open disclosure, incident management and feedback and complaints management systems (actions 1.11-1.14) and the **Partnering with Consumers Standard**.

Apply aged care-specific strategies

The service provider needs to identify how it can embed the Statement of Rights into the planning, delivery and improvement of its aged care services. The following is a non-exhaustive list of suggested strategies to support achievement of Module Item 2 in the context of the aged care service.

Prevent, identify and manage violence, abuse, neglect and discrimination

- Implement a system (policies, processes, training) to prevent, identify, respond to and report violence, abuse, racism, neglect, exploitation and discrimination. This can be integrated into systems and processes for risk management, incident management and complaints management.
- Policies, processes and training materials should make clear how the service provider:
  - follows processes to prevent abuse and discrimination
  - proactively identifies instances of abuse and discrimination
  - investigates and addresses these situations including practising open disclosure
  - encourages older people to provide feedback and complaints
  - involves older people, family and carers in processes of preventing, recognising, responding and reporting abuse
  - complies with relevant national, state and territory legislation.
- Ensure workers understand their role in and responsibility for:
  - identifying, reporting and escalating concerns about abuse and discrimination
  - reporting serious incidents in line with the Serious Incident Response Scheme (SIRS)
  - obtaining informed consent when responding to situations involving abuse or discrimination

  - protecting the older person's right to privacy.

Protect personal privacy

- Implement processes to ensure that the personal privacy of older people is respected, that older people have choice about how and when they receive intimate personal care or treatment, and that this is carried out sensitively and in private. This can include:
  - documenting the service provider's usual process for providing intimate personal care or treatment
  - deciding with the older person how and under which circumstances they receive intimate physical care (such as showering assistance) or treatment, based on their needs and preferences, and documenting any differences to the service provider's usual process.

Ensure workers uphold the legislated rights of older people

- Ensure that the workforce understand their responsibilities under the *Aged Care Act 2024* to uphold the rights of older people accessing aged care services, as described in the Statement of Rights. This includes providing guidance and training on:
  - upholding the Statement of Rights
  - adhering to the Code of Conduct
  - treating older people with kindness, dignity and respect
  - recognising and respecting the relationship between older people and their supporters
  - respecting the privacy of older people, including their home, the things they own, their information and the things they discuss during care.

Monitor, improve and review the approach to upholding older people's rights

- Implement monitoring and improvement processes to understand when an older person is not being treated with kindness, dignity and respect or their privacy is being breached. This may include:
  - regularly reviewing complaints, feedback and incident reports
  - being open about what has gone wrong with older people, family and carers (open disclosure)
  - implementing strategies to mitigate the risk of things going wrong again.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Strategies, policies or processes detailing the approach to recognising, preventing and responding to violence, abuse, racism, neglect, exploitation and discrimination.
- Strategies, policies or processes showing how the service provider ensures that care and services uphold the rights of older people as outlined in the Statement of Rights, and that care delivery respects these rights.
- Documented roles and responsibilities for management and the workforce for recognising and reporting discrimination and abuse and for practising open disclosure when things have gone wrong.
- Continuous improvement plans showing how the service provider monitors, reviews and improves its systems and processes to ensure older people are treated with dignity, respect and their privacy protected.
- Samples of intake assessments and care planning documents that detail strategies for respecting the personal privacy of the older person, including their preferences for receiving intimate physical care or treatment.
- Evidence from the incident management and/or complaint management systems showing how incidents or complaints involving disrespect, breaches of personal privacy, abuse or discrimination are responded to appropriately and in a timely manner.
- Training documents related to this Module Item.

Feedback

- Feedback from members of the governing body about how they know whether the service provider's system for recognising and responding to violence, abuse, racism, neglect, exploitation and discrimination is implemented and effective.
- Examples from management showing how systems and processes have been applied to specific risks, situations or incidents related to abuse or discrimination, and how improvements to these systems and processes have been identified.
- Survey responses or other feedback from aged care workers and health professionals (as relevant to their role) about their knowledge of how to recognise, prevent and respond to violence, abuse, racism, neglect, exploitation and discrimination, including their knowledge of processes for reporting instances of these.
- Survey responses or other feedback from older people and their supporters about the extent to which they:
    - feel they are treated with kindness, dignity and respect

  - are able to let workers know their preferences for intimate physical care such as showering assistance and continence care, and whether their wishes are consistently respected
  - feel their preferences for personal privacy (e.g. staff knocking before entering their room) are respected.

Observations

- Aged care workers, health professionals and management are observed to be treating people and speaking to and about them with kindness, dignity and respect.
- Aged care workers and health professionals are observed maintaining the personal privacy of older people when they are receiving intimate care and treatment (for example, personal care is delivered within bathrooms, or behind closed doors or curtains, and workers knock on the older person's door before entering their room).

Item 3: Choice, independence and quality of life

3 **The service provider supports people accessing its aged care services to:**

a. **exercise choice and make decisions about their care and services, with support when they want or need it**
b. **exercise dignity of risk to achieve their goals and maintain independence and quality of life.**

Intent

This Module Item explains the importance of the older person's right to exercise choice and to make decisions about their life, care and services, even when these choices carry risk (known as dignity of risk). The exercise of choice is essential to ensure the person can live the best life they can and that quality-of-life considerations are prioritised. Along with Module Items 1 and 2, Module Item 3 should underpin the approach to delivering all aged care services.

To support choice, the service provider needs to make appropriate support available for informed decision making, when the person wants or needs it, including access to information the person can understand, advocates, and decision-making supporters when requested or needed. The roles and responsibilities of supporters and the right to access advocates are specified in the *Aged Care Act 2024.*

Key concepts

Important concepts for implementing choice, independence and quality of life in the aged care context include the following.

- An **advocate** is an impartial person who can support older people in a variety of situations – from understanding aged care services or fees through to understanding their rights and managing their aged care
- **Dignity of risk**. All adults have the right to make decisions that affect their lives and to have those decisions respected, even if there is some risk to them. Dignity of risk means respecting this right. Care and services need to strike a balance between respect for the older person's autonomy and the protection of their other rights (such as safety, shelter), unless it is unlawful or unreasonably impinges on the rights of others.
- **Supporting independence** means more than respecting older people's rights to make decisions about their own care. It means that the service providers should make sure that the systems and processes implemented as part of NSQHS Partnering with Consumers Standard support older people, their families and carers to shape how their care and services are delivered.
- **Quality of life** is an older person's perception of their position in life taking into consideration their environment and their goals, expectations, standards, and concerns. It includes their emotional, physical, material, and social wellbeing.

- **Supported decision making** is the process of enabling a person who requires support to make, and/or communicate, decisions about their own life. The decision-making process is supported, but the decision is theirs.
- **A registered supporter** is a trusted person of the older person's choosing. They are registered with My Aged Care to help the older person to make and communicate their own decisions about aged care services and needs. A registered supporter can request, access or receive information about the older person but does not have decision-making authority.
- **A substitute decision-maker is** a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of an older person whose decision-making ability is impaired. A substitute decision-maker may be appointed by the older person, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.

Reflective questions

- How are people accessing aged care services supported to plan, make decisions about the way they live, and understand the care and service options available to them? Where is this documented?
- How are supporters (as defined in the *Aged Care Act 2024*), family and friends involved in the planning, decisions and lives of people accessing aged care services if this is what a person wants?
- How are people accessing aged care services supported to make informed choices, including when their choice may include risks to themselves or others?

Key tasks

Apply relevant actions from the NSQHS Standards

In addressing Module Item 3, it is important that the service provider adequately extends relevant related actions from the **NSQHS Partnering with Consumers Standard** into its aged care services. Relevant actions include those on informed consent (2.04), identifying capacity to make decisions (2.05a), identifying substitute decision makers (2.05b), supporting shared decision making (2.06- 2.07), and providing appropriate information (2.10).

Apply aged care-specific strategies

The extent and types of decision making by older people in the aged care context can be more wide-ranging and have greater implications for the way a person lives their life than may be the case in acute health care.

Service providers need to ensure that policies, processes and training for supporting decision making include the principle of dignity of risk and the goals of optimising quality of life and maximising autonomy and independence.

Embed support for decision making into care planning and care delivery systems

- Ensure systems and processes for planning and delivering care:
  - define what is meant by a decision, and when a process for making decisions should be followed – such as processes for informed consent, supported decision making, or using a substitute decision-maker
  - identify situations requiring informed consent, including financial consent, consent to collection and use of information, clinical treatments and interventions, use of restrictive practices or escalation to medical or emergency services.
- Ensure systems and processes for planning and delivering care and services prompt workers to:
  - identify when informed consent is required and carry out the steps to support and record it
  - discuss with the older person who they want to be involved in decision making and to document and review this over time
  - identify and document the need for support to make decisions and review this over time
  - help the older person to access needed support, including advocates of their choosing
  - use substitute decision-makers only if the older person loses their decision-making capacity and after all other options to support an older person to make their own decisions are exhausted.

Embed the principle of dignity of risk into decision-making support

- Ensure systems for assessment, planning and delivery of care support older people to live the best life they can, including by enabling positive risk-taking where this promotes the person's autonomy and quality of life. This may involve:
  - partnering with older people in assessment and care planning processes to identify goals of care and to ensure they can identify and access activities that are meaningful and enjoyable to them
  - monitoring and recording signs of change in the older person's quality of life, and partnering with them to identify strategies to respond to the change
  - educating the workforce to assess and communicate risks to older people in a way they can easily understand, to make informed decisions involving dignity of risk
  - ensuring risks and communication processes about risk are documented.

Monitor, improve and review the approach to choice, independence and quality of life

- Check if workers are helping older people to engage in decision making about their care and services, through reviewing care and services plans and progress notes, complaints and feedback, and information about incidents and near misses.

- Talk to older people, their families and carers about how workers have supported them to make choices, including giving them information that they can understand.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Formal agreements or other evidence that the service provider maintains connections with and, where an older person requests or requires it, facilitates access to advocacy services and other forms of decision-making support. These services should represent the diversity of older people accessing the aged care service.
- Policies and procedures for identifying decision-making capacity, for supporting and documenting informed consent, and for using substitute decision-makers only as a last resort.
- Continuous improvement plans showing how the service provider monitors, reviews and improves its systems and processes to support choice, independence and quality of life.
- Sample of care plans for older people that include:
  - evidence of informed consent being given for particular care or treatment
  - details of their decision-making capacity, those that support them with decision making, and names and contact details of supporters
  - where relevant, information on activities for positive risk taking, accompanied by appropriate risk assessments that balance the independence and choice of the older person against risk of harm and impact on others
  - evidence of monitoring and responding to signs of change in the person's quality of life.
- Training documents and records related to this Module Item.

Feedback

- Feedback from the governing body showing how members assure themselves that older people are supported to make decisions that affect their quality of life. This could include monitoring trends in quality-of-life measures.
- Examples from aged care workers and health professionals (as relevant to their role) of how an older person's goals and preferences are used to identify meaningful and enjoyable activities to help maintain their quality of life.
- Feedback from aged care workers and health professionals (as relevant to their role) about their confidence in:
  - identifying an older person's need for support in decision making

  - discussing positive risk-taking and dignity of risk with the older person
  - understanding when informed consent is required from the older person.
- Feedback from older people about:
  - whether and how they feel the service supports them to live the best life they can
  - whether the service supports them to include the people they want to be involved in decision making.

Item 4: Agreements, fees, pricing, invoicing and statements

4 **The service provider supports the autonomy of people accessing its aged care services to:**

a. **take time and seek advice before entering into any agreements about their care and services**
b. **understand agreements, fees and invoices so they can make informed decisions.**

Intent

This Module Item emphasises the importance of transparency and informed decision making in the context of financial agreements, fees, charges, invoicing and statements for aged care services.

This includes the requirement to provide timely, accurate and understandable information to support the older person's autonomy to make decisions about their care and services.

Key concepts

Important concepts for implementing this item in the aged care context include the following.

- **Autonomy** to make informed financial decisions. Older people have the right to make decisions about their care and services and to be provided with the information, time and support they need to do this.
- **Service agreements** are agreements between a service provider and a person who is accessing funded aged care services, containing information about the services that will be delivered to that person and other information as required by the *Aged Care Rules 2025*.

Reflective questions

- How does the service provider ensure that older people are able to take time and seek advice (if wanted) to make informed decisions about service agreements?
- What steps does the service provider take to ensure that all information related to service agreements and financial arrangements is provided in a clear, accurate and easily understood way?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS **Partnering with Consumers Standard** into its aged care services. Relevant actions include those on informed consent (2.04) and providing appropriate information (2.10).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested strategies to support achievement of Module Item 4 in the context of the service provider's aged care service.

Information and communication about service agreements

- Implement policies and processes for communicating with older people to help them understand the service agreements they are entering into, including:
    - the fees and charges for care and services
    - their right to decline services due to financial concerns.
- Ensure the communication system enables the workforce to give information to older people and supporters about service agreements:
    - before entering into the agreement or before care commences, whichever happens first
    - when there are changes to prices, fees or payments
    - with sufficient time and support to understand the information and to seek external advice
    - in a way that supports the older person to give informed consent.
- Older people and supporters should be informed 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
    - terms and conditions about their rights and responsibilities
    - the care and services to be provided
    - fees and other charges they need to pay.
- Information about service agreements should be provided in a way that:
    - meets each person's language and communication needs and preferences
    - uses plain language, large text or verbal explanation.

Billing systems

- Use the service provider's system for managing fees, invoices and payments to make sure that:
    - billing is accurate at all times and checks are routinely performed to monitor this
    - older people know how to give feedback or make complaints about incorrect charges
    - older people are told when there are issues in invoices, including giving refunds in a timely way

  - fees and chargeable items specified in agreements and shown on invoices are consistent, accurate and transparent
  - invoices are provided in a format that is easy to understand and in a timely way.

Monitoring complaints and feedback

- Monitor complaints and feedback from older people to:
  - identify issues with agreements and billing and resolve them with changes to the communication and billing systems when required
  - check that workers are supporting older people to understand their agreements, invoicing and payments.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies and processes detailing the method, timing and content of communications with older people about service agreements and other financial documents.
- Policies for managing invoicing and payments that address:
  - processes for setting, reviewing and updating fees and charges
  - timeliness and accuracy of communications about agreements, fees and charges
  - processes to give advance notice and gain informed consent from an older person for changes to fees and charges
  - processes for monitoring, identifying and addressing over- or under-charging.
- Samples of agreements with older people showing that sufficient information is presented, in an appropriate way, for the person to make informed decisions about their care and services.
- Written communication with older people showing they were informed in advance and consented to any changes to fees.

Feedback

- Feedback from older people and their supporters about:
  - whether service agreements and other financial documents are easy to understand, accurate and appropriate for making decisions about care and services
  - whether they are given enough time and support to understand and consider written information about agreements, fees and charges
  - how any issues with agreements, fees and charges were addressed.

Item 5: Workforce and human resource management

5 **The service provider manages and plans for its current and future aged care workforce needs, ensuring that workers:**

a. **are suitably skilled, competent, qualified, experienced, supervised and trained to provide quality aged care and services**
b. **experience a workplace culture that prioritises their safety, health and wellbeing, and encourages and acts on their complaints and feedback.**

Intent

This Module Item explains the central importance of strategic workforce planning for safe and quality aged care provision. It also outlines human resource management considerations that are especially relevant to the aged care context.

An appropriate workforce strategy makes sure that there are enough workers with the right skills, qualifications and competencies to deliver quality and safe aged care and services. This includes conducting pre-employment screening and providing the training and supervision that workers need to effectively perform their roles. It also means creating a workplace culture that promotes the safety, health and wellbeing of workers through active engagement and encouragement of feedback.

Key concepts

Important concepts for implementing effective workforce and human resource management practices in the aged care context include the following.

- **Psychological safety** is a feeling or mental state that influences proactive behaviours such as asking questions, reporting errors and open communication. Psychological safety is also associated with strong interpersonal relationships and an effective organisational culture that includes collaboration, trust, and innovation, which ensures an older person's safety.

Reflective questions

- How is the workforce education and training system used to develop, enhance and maintain skills of the aged care workforce?
- How does the service provider ensure its workforce mix comprises the right number and skills to consistently deliver safe, quality care and services to meet the care needs of older people?
- What active steps does the service provider take to promote the physical and psychological safety of its aged care workforce?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS Standards into its aged care services.

- Relevant actions from the **Clinical Governance Standard** include those related to seeking feedback from the workforce (1.13), training systems (1.19-1.21), performance management (1.22), validation, qualifications and scope of practice (1.23-1.24), roles and responsibilities (1.25), supervision (1.26) and providing the workforce with access to guidelines, tools and resources for evidence-based practice (1.27).
- Relevant actions from other Standards include identifying training requirements for the workforce to ensure they can fulfil their safety and quality responsibilities across all Standards (e.g. actions 2.01c, 8.01c).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 5 in the context of the aged care service.

Workforce strategy and management

- Document and implement a workforce strategy and processes to:
  - match the skills and competencies of workers to the needs and preferences of older people using the service (including clinical, psychological, social and cultural needs)
  - ensure the number and mix of workers in the aged care service enable the delivery of safe quality care
  - screen and hire suitably qualified and competent workers
  - maximise worker continuity, by prioritising direct employment and planning for workforce shortages, absences or vacancies
  - monitor staff turnover and reasons for leaving and use this information to improve workforce strategy and processes.
- Use the service provider's human resource management system to:
  - conduct and document pre-employment screening checks as well as processes to validate education, qualifications and employment history
  - assess skills, competencies and training needs during recruitment processes and as part of ongoing performance monitoring and management
  - roster workers to meet the requirements of safe and quality care in each shift, including at times where more support is required (mornings, bedtime, mealtimes)
  - meet workforce needs, including supporting diverse workers and flexible working arrangements.

Physical and psychological safety of workers

- Support the physical and psychological safety of workers by:
  - understanding workers' psychological and physical needs
  - promoting a workplace culture where workers feel safe to raise concerns
  - actively engaging and consulting with workers on issues that affect them, including as part of strategic and business planning
  - supporting workers to provide feedback and make complaints without reprisal
  - identifying and supporting workers in distress (e.g. through fatigue, bullying, harassment)
  - including guidance in training about responding to traumatic and emergency events and dealing with hazardous situations
  - identifying and monitoring risks to workers through risk and incident management systems
  - completing risk assessments for situations or environments that can cause harm to workers and managing these on a case-by-case basis
  - supporting workers providing care at the end of life and managing grief and loss.

Training systems

- Ensure that the service provider's training system provides for all workers delivering aged care services to receive competency-based training relevant to their role, such as in:
  - person-centred, rights-based care
  - their responsibilities for identifying and escalating any concerns they have about an older person
  - culturally safe, trauma aware and healing informed care
  - caring for people living with dementia (such as through Dementia Training Australia)
  - caring for people who need palliative care or who are nearing the end of life
  - their obligations and responsibilities under the *Aged Care Act 2024*, including the Code of Conduct, the Serious Incident Response Scheme, and the Aged Care Quality Standards.
- Keep training records and regularly review and improve the effectiveness of the training system as part of continuous improvement.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Strategic planning documents and evidence such as meeting minutes showing that the service provider actively engages with, listens to and consults with the aged care workforce and leverages their expertise.
- Policies and processes that reflect the workforce strategy for the aged care service and:
  - describe how the service provider plans and manages its aged care workforce to meet its service needs
  - detail how staffing levels and training approaches are adapted based on the changing needs and situations of people accessing the aged care service
  - show how aged care workers are supported to fulfil their roles and responsibilities and meet quality standards including through supervision, assessment, monitoring and review, and competency-based training.
- Continuous improvement plans showing actions to improve human resource management and training systems and evidence of monitoring the effectiveness of these actions.
- Evidence of compliance with legislative requirements for aged care worker screening and validation of qualifications and competency.
- Up-to-date employment records detailing pre-employment checks, contact details, qualifications and experience.
- Work schedules or rosters showing the skill mix and numbers of the workforce used to provide safe quality care on every shift.
- Reports from the incident management system documenting adverse events associated with inadequate staffing numbers or skills.
- Evidence of induction and other training and supervision programs for the aged care workforce that detail their roles and responsibilities in meeting the requirements of this Module.
- Evidence that workforce survey results and other feedback including workforce complaints have been used to improve the service provider's approach to staff wellbeing, and that the identity of those who want to give anonymous or confidential feedback is protected.
- Training records showing that aged care workers and health professionals have received required training based on an assessment of their competencies, skills and responsibilities.

Feedback

- Feedback from members of the governing body about how they prioritise the safety, health and wellbeing of the aged care workforce in strategic and business planning.
- Feedback from management about how improvements have been made in response to workforce feedback, complaints, and incidents related to staffing levels and skill mix.
- Feedback from aged care workers and health professionals about:
  - the extent to which they feel informed and supported to be healthy and safe at work

  - how comfortable they feel raising concerns or making complaints
  - their confidence that they have the capabilities, supervision, support and resources they need to perform their role.
- Feedback from older people and their supporters about whether they believe there are sufficient staff with the right skills in the aged care service.

Item 6: Emergency and disaster management

6 **In emergency and disaster management planning, the service provider considers and manages the risks to the health, safety and wellbeing of people and workers in its aged care services.**

Intent

This Module Item explains how planning and testing for emergency and disaster situations in the aged care context requires engagement and partnership with older people, families, carers and workers. Emergency and disaster management plans should be based on risk assessments and should cover natural disasters, medical emergencies, pandemics and outbreaks.

Reflective questions

- How does the service provider integrate emergency and disaster planning and management into its risk management system?
- How are older people, their families, carers and workers involved in planning for emergencies and disasters?

Key tasks

Apply relevant actions from the NSQHS Standards

Emergency and disaster management in aged care should be part of the risk management system. It is important that the service provider adequately extends relevant related actions from the NSQHS Standards into its aged care services.

- Relevant actions from the **Preventing and Controlling Infections Standard** include those related to planning and governance for infection and pandemic risks (3.01-3.02), clean and safe environment (3.13-3.14), and planning for workforce impact of outbreaks and pandemics (3.16).
- Other relevant NSQHS actions include those on risk management systems (1.10) and on partnering with consumers in service planning and governance (2.11).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 6 in the context of the aged care service.

- Engage with older people, supporters, workers and local emergency response partners about the emergency and disaster management plans, so that:
  - Risk assessments for both residential care and home-based care incorporate locally relevant risks that arise with different types of natural or environmental disasters

  - Older people, supporters and workers are aware of and can contribute to emergency and disaster planning and procedures
  - The processes to meet each person's needs during an emergency are included in their care plan where required, including extra supports they may need, for example:
    - due to physical health conditions or disability
    - to meet cultural, language or communication needs
  - Workers are aware of their role in an emergency or disaster situation, including how to continue providing care and services (for example, equipment to take during an evacuation)
  - Strategies and processes for alerting and communicating with older people during an emergency or disaster are appropriate and effective.
- Regularly test and review the emergency and disaster management plans in partnership with older people, supporters, workers and other emergency response partners.
- Ensure that experiences and issues identified during drills and training inform improvements to the emergency management system.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Emergency and disaster management plans that include evidence of:
  - input from older people, their supporters and emergency response partners
  - specific consideration of the aged care context and the specific additional needs of older people using the service, including residential care and (where relevant) home-based care
  - periodic review to identify improvements.
- Records of emergency and disaster procedure testing (e.g. drills in fire evacuation).
- Records of emergency management training for relevant workers.
- Records of regular checks of emergency equipment by external parties.

Feedback

- Feedback from aged care workers and health professionals about their confidence in knowing how to respond during an emergency or disaster situation, including how to continue to provide care and services.

- Feedback from older people and their supporters about their involvement in planning, testing or reviewing what would happen in the case of an emergency or a disaster such as a bushfire or flood.

Observations

- In a service environment (residential or community-based service):
  - emergency exits are signed, well-lit and clear
  - emergency evacuation diagram(s) are in appropriate locations with assembly point clearly noted
  - emergency management workers (first aiders and wardens) are identified and their contact numbers listed
  - fire blankets and extinguishers are in date.

Item 7: Assessment and planning

7 **The service provider has comprehensive assessment and care planning processes for people accessing its aged care services that:**

a. **incorporate risk management strategies and preventative care strategies**

b. **support optimal quality of life, reablement and maintenance of function**

c. **support early identification of changing needs and regular review of care plans.**

Intent

This Module Item describes a comprehensive approach to assessment and care planning in the aged care context. The approach is based on the rights-based principles of person-centred care described in Module Items 1 and 2, and the promotion of autonomy, independence and quality of life described in Module Item 3.

Comprehensive assessment and planning should cover all aspects of care a person requires or requests and should address both clinical and non-clinical needs and preferences. It is done in partnership with the older person to optimise their quality of life and support their goals of care.

As an older person may use the aged care service for a period of months or years, review and reassessment are important to ensure they continue to receive safe and quality care that meets their changing needs over time.

Key concepts

Important concepts for implementing effective assessment and planning systems in the aged care context include the following.

- **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.
- **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, supporters 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.
- **Preferences** are the things the older person chooses, likes or dislikes when it comes to their care, services and lifestyle. 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.
- **Quality of life** is an older person’s perception of their position in life taking into consideration their environment and their goals, expectations, standards, and concerns (see Module Item 3).

- **Reablement** is a person-centred care process to support an older person to regain physical, mental or cognitive function, to prevent or slow down loss of function, to adapt to some loss of day-to-day function, or to adjust to changing capabilities. It helps people regain confidence and capacity for daily activities. It may promote a person's independence, building capacity or social and community connections. Supports could include training in a new skill, modification to a person's home environment or having access to equipment or assistive technology.

Reflective questions

- How does the service provider ensure that its workforce is able to carry out or provide access to comprehensive assessment of both clinical and non-clinical needs and preferences of the older people accessing its aged care services?
- How do comprehensive assessments consider a person's needs and preferences related to quality of life, reablement and maintenance of function?
- How does the service provider ensure that care plan documents are accessible to workers and are used by them to direct the care provided to each older person?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS Standards into the delivery of aged care.

- Relevant actions in the **Partnering with Consumers Standard** include those on substitute decision makers (2.05c) and providing information (2.10)
- Relevant actions in the **Comprehensive Care Standard** include those on developing the comprehensive care plan (5.07-5.14 inclusive) and advance care planning (5.17)
- Relevant actions from the **Communicating for Safety Standard** include processes for effective communication (6.04), handover processes (6.07, 6.08) and documentation of information (6.11).

Apply aged care-specific strategies

The assessment and planning processes for aged care services should incorporate the principles of person-centred care, rights-based care, and promotion of autonomy, independence and choice, as described in Module Items 1, 2 and 3.

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 7 in the context of the aged care service.

Assessment and planning systems

- Ensure that the assessment and planning processes used in aged care:

  - support preventative care and aim to optimise quality of life, reablement and maintenance of physical, mental and cognitive functions
  - enable workers, within their scope of practice, to identify the older person's needs, preferences and goals of care, plan for care that meets these, and review the effectiveness of this care
  - support the workforce to identify risks to the older person's health, safety and wellbeing in partnership with the older person, supporters and health professionals involved in their care
  - include clinical assessments, by qualified health professionals, to identify, document and plan for clinical risks, acute conditions, exacerbations of chronic conditions, and clinical frailty.

Care plan documentation and review

- Ensure that care plans:
  - are individualised and tailored, considering the elements of individuality and diversity highlighted in Module Item 1
  - are comprehensive and include information about the person's needs, goals and preferences and how the service provider will acknowledge, respect and address these
  - include information about how workers can support the older person to manage identified risks
  - are accessible and available to workers to guide how they deliver care
  - are offered to, and can be accessed by, the older person and others they want involved in their care and services
  - include clear timelines for review.
- Review care plans at regular intervals and when there are changes in the person's preferences, condition or circumstances, including when:
  - care that can be provided by an older person's family or carer changes
  - there are changes in the health professionals or services providing care to the older person (such as when a GP retires)
  - transitions occur between services (such as discharge from hospital)
  - risks emerge, are assessed, and strategies developed to manage them
  - there are changes in mental health, cognitive or physical function or capacity
  - there are changes in ability to perform activities of daily living
  - an incident impacts the older person (such as a fall)
  - care responsibility changes between others involved in the older person's care.

Comprehensive clinical assessment

Conduct a comprehensive clinical assessment at commencement of care, at regular intervals and when needs change. This includes:

- a comprehensive medical assessment with a general practitioner
- identifying an older person's level of clinical frailty and communication barriers
- identifying the health professionals and other support services that need to be involved in the person's care, such as:
  - a mental health professional if the person has psychological deterioration
  - dementia support specialists if the person has cognitive deterioration
  - a dietitian to provide nutrition care in response to identified weight loss
  - a speech pathologist to assess swallowing ability.
- planning clinical care that optimises the older person's quality of life, reablement and maintenance of function
- identifying and providing access to the equipment, aids, devices and products required by the older person.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies and procedures documenting the roles and responsibilities of aged care management and workforce in comprehensive assessment, clinical assessment, care planning and advance care planning.
- Policies showing how assessment and planning systems and processes:
  - support preventative care, quality of life, reablement and maintenance of function
  - involve relevant health professionals, including in a comprehensive clinical assessment at the start of care and on review of the care plan
  - lead to individualised care plans for each older person
  - support timely communication of the outcomes of assessment and planning to the older person and those involved in their care.
- Continuous improvement plans showing how the service provider monitors and identifies areas for improvement in assessment and planning of aged care and services, any improvement actions taken, and evaluation of the impact of those actions.
- Sample of care plans for older people showing:

  - how the older person and others they want involved in their care have been involved in assessment and planning
  - how the person's needs, goals, preferences, pre-existing conditions and risks have been incorporated to ensure individualised care
  - documentation of the person's clinical risks, acute conditions, exacerbations of chronic conditions and frailty
  - that reassessment and review of the plan has been conducted when the person's needs, preferences, condition, diagnosis, function or circumstances change
  - that there has been timely referral to health professionals or other services where required, such as to medical, rehabilitation, allied health, specialist nursing and advisory services.
- Training documents and records related to this Module Item.

Feedback

- Feedback from members of the governing body about how they assure themselves that assessment and planning systems and processes are effective and that they are used by the workforce (including agency workers) to direct the delivery of individualised care.
- Feedback from management about how they monitor that assessment and planning systems and processes support the workforce to partner with older people to identify needs and preferences and plan care that will meet these.
- Examples from management about improvements made to assessment and planning processes in the aged care service.
- Feedback from aged care workers and health professionals (as relevant to their role) about:
  - their knowledge about their responsibilities for assessment, planning, documentation and review
  - how they communicate with and involve the older person and others involved in the older person's care in developing and reviewing the care plan
  - whether they feel supported and able to recognise risks to the person's health, safety and wellbeing and to identify changes to an older person's physical, mental and cognitive function, capacity or condition.
- Feedback from older people and their supporters about their level of involvement in assessment and planning for their care and services, and whether their needs, goals and preferences have been understood and considered in their care plan and advance care planning.

Item 8: Delivering comprehensive care and services

8 **The service provider provides comprehensive care to people accessing its aged care services in a way that:**

a. **optimises their quality of life and supports reablement and maintenance of function**

b. **promotes use of their skills and strengths**

c. **enables them to do the things they want to do**

d. **supports them to feel safe in the place where care is delivered**

e. **is culturally safe and appropriate**

f. **is based on an understanding of situations and events that may lead to changed behaviours (for people with cognitive impairment).**

Intent

This Module Item explains the importance of delivering comprehensive care and services in line with the outcomes of assessment and the care plan, in a way that is appropriate and safe for the older person's specific needs, background and preferences. In the aged care context, it is important to consider the impact of clinical conditions on the older person's quality of life and wellbeing, and to ensure the risks of harm from care are prevented and managed. A comprehensive care approach should underpin all care through to the end of life.

The older person's autonomy and right to exercise choice and to be supported to make informed decisions should be respected when delivering care and services, as should the principle of dignity of risk. Care and services should aim to optimise the person's quality of life, supporting them to use their skills and strengths to do the things they want to do in an environment that feels safe and comfortable to them.

In the context of delivery of care to people living with cognitive impairment or conditions such as dementia, the service provider must have regard to its legislated responsibilities under the *Aged Care Act 2024* for the minimisation of, and conditions of use for, restrictive practices.

Key concepts

Important concepts for effective delivery of comprehensive care in the aged care context include those listed under Module Items 1 to 3, as well as those listed below.

- **Comprehensive care** is based on identified goals of care that align with the older person's expressed preferences and personal and clinical care needs. It considers the impact of the person's health issues on their life and wellbeing, and is informed by contemporary evidence-based practice.

- **Activities of daily living** include the fundamental skills typically needed to manage basic physical needs in the following areas: grooming/ personal hygiene including oral care, dressing, toileting/continence, transferring/ambulating and eating.
- **Cognitive impairment** refers to deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment.
- **Changed behaviours** are defined by Dementia Support Australia as 'any behaviour which causes stress, worry, risk of or actual harm to the person, carers, family members or those around them.' There are many reasons why the behaviour of a person with cognitive impairment can change, including physical changes in the brain. Changes may also be related to a person's environment, health or medication. Cognitive impairment can affect a person's ability to control how they respond to situations. Changed behaviours are often the result of distress and can be a signal that an older person needs something or that their medical condition is changing.
- **Restrictive practices** are any practices or interventions that have the effect of restricting the rights or freedom of movement of the older person. These include chemical restraint, environmental restraint, mechanical restraint, physical restraint and seclusion. Requirements for the use of restrictive practices, including that they are used only as a last resort and with informed consent, are described in the *Aged Care Act 2024.*

Reflective questions

- How does the service provider meet its obligations to minimise the use of restrictive practices and to adhere to legislated conditions for their use?
- How does the service provider ensure that its systems and processes for care delivery support comprehensive care for older people living with conditions associated with cognitive impairment such as dementia?
- How does the service provider ensure that an older person using their residential care service has access to services and supports for daily living that meet their needs, goals and preferences?

Key tasks

Apply relevant actions from the NSQHS Standards

To meet Module Item 8, it is important that the service provider adequately extends relevant related actions from the NSQHS Standards into the delivery of aged care.

- Relevant actions in the **Comprehensive Care Standard** include those on designing systems to deliver comprehensive care (5.04), developing and using the comprehensive care plan (5.13-5.14), preventing delirium and managing cognitive impairment (5.29-5.30),

preventing and managing aggression and violence (5.33-5.34) and minimising restrictive practices (5.35-5.36).

- Relevant actions from the **Communicating for Safety Standard** include governance systems and processes to support effective communication (6.01, 6.04, 6.06), handover (6.07-6.08), and communication of critical information (6.09-6.10).
- Other relevant NSQHS actions include those about providing a safe environment for care delivery (1.29-1.33), partnering with people in their own care (2.03-2.10), and detecting and recognising acute deterioration and escalating care (8.04-8.09).

Apply aged care-specific strategies

The assessment and planning processes for aged care services should incorporate the principles of person-centred care, rights-based care, and promotion of autonomy, independence and choice, as described in Module Items 1, 2 and 3.

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 8 in the context of the aged care service.

Deliver comprehensive care to meet each older person's identified needs and preferences

- Ensure that the service provider's systems, processes and resources for care delivery enable the workforce to provide care and services that are:
  - aimed at optimising the older person's quality of life, maintaining function and supporting reablement, where this is consistent with their preferences
  - culturally safe, trauma aware and healing informed
  - aligned with contemporary, evidence-based practice
  - guided by each older person's current needs, goals and preferences.
- Each service provider should tailor care delivery systems and processes to ensure that they can meet the specific needs of the population of older people accessing their aged care services. Specific actions include:
  - routinely monitoring, identifying and documenting changes in an older person's physical health and functioning, cognitive functioning, mental health, quality of life, and ability to maintain activities of daily living and to do the things they want to do
  - implementing referral processes that support early intervention when changes are identified, including referral to health professionals and to My Aged Care for reassessment as required
  - making reasonable efforts to involve the older person in selecting their workers (including the gender of, and language spoken by, workers providing care) and maximising worker continuity where possible
  - supporting older people to use equipment, aids, devices and products safely and effectively to optimise their quality of life and maintain function.
- Ensure that the workforce (as appropriate to role) is supported to:

  - assess risk and identify deterioration and respond to or escalate risks in a timely way
  - recognise and address the need for palliative and end-of-life care (see Module Item 14).

Deliver comprehensive care for people with cognitive impairment

- Ensure that systems and processes for care delivery support comprehensive care for older people living with cognitive impairment and conditions such as dementia. As each person's experience is different, understanding the individual is important to communicate effectively and provide the right care.
- Ensure that the workforce is trained and supported to understand their role in meeting the specific care needs of people living with cognitive impairment, including:
  - being aware of the range of physical, social, psychological and behaviour support needs, including palliative needs and needs at the end of life
  - understanding the potential contributing factors to cognitive and behaviour changes, such as clinical, environmental and medication-related factors, including factors that may be modifiable and require regular review
  - monitoring and mitigating clinical risks associated with cognitive impairment, including increasing risk of falls, pain, pressure injuries, oral deterioration, medication errors and delirium
  - knowing when and how to complete or review a behaviour support plan, in accordance with legislation
  - understanding non-pharmacological strategies to prevent or manage changes in behaviour.
- Policies, procedures and processes for the clinical care of a person living with cognitive impairment should ensure that the workforce prioritise:
  - learning about the person as an individual and partnering with them and their supporters to identify needs and preferences
  - understanding and documenting the person's preferred strategies for minimising situations that may lead to changed behaviours and for supporting them if changed behaviours occur
  - identifying strengths and skills and encouraging the use of these in day-to-day activities
  - identifying communication needs and strategies to meet these.
- In line with legislation, minimise the use of restrictive practices, and where restrictive practices are used, ensure these are:
  - used as a last resort, in the least restrictive form and for the shortest time needed
  - used with the informed consent of the person or (if they lack capacity) their restrictive practices substitute decision maker

  - monitored and regularly reviewed.

Deliver comprehensive care to support quality of life in residential care

- Support and enable all older people accessing residential care to do the things they want to do, including to:
  - participate in lifestyle activities that reflect the diverse nature of the residential community
  - minimise boredom and loneliness
  - maintain connections (including with pets) and participate in activities that occur outside the residential community
  - have social and personal relationships
  - contribute to their wider community through participating in meaningful activities that engage them in normal life.
- Implement strategies to protect the older person's physical and psychological safety, including ensuring that they:
  - have control over who goes into their room and when this happens
  - can entertain visitors in private
  - can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies and procedures documenting the roles and responsibilities of aged care management and workforce in the delivery of comprehensive care that:
  - is tailored to the needs, goals and preferences of the older person
  - is culturally safe, trauma aware and healing informed
  - supports and optimises quality of life, maintenance of function and reablement
  - supports the use of equipment, aids and devices
  - supports worker continuity and involvement of the older person in selecting their workers where possible.
- Policies and processes for caring for people with cognitive impairment including dementia and delirium that support:
  - understanding of the range of underlying contributing factors

  - timely recognition of cognitive impairment and delivery of best practice care.
- Evidence that the use of restrictive practices is aligned with contemporary evidence-based practice and with legislative requirements.
- Evidence that behaviour support plans are in place where required and are used and regularly reviewed for people living with cognitive impairment who have changed behaviours.
- Activities programs or similar showing that there are activities available to people using residential aged care services that reflect the diversity of the residential community, promote quality of life, aim to reduce boredom and loneliness and support involvement in the wider community.
- Quality improvement documents showing how the service provider monitors and identifies areas for improvement in the delivery of aged care and services, any improvement actions taken, and evaluation of the impact of those actions.
- Documented referral processes, including to My Aged Care for reassessment where required, and evidence of liaison with health professionals and other services to meet the identified clinical and non-clinical needs and preferences of older people.
- Documentation such as training records, handover notes and progress notes demonstrating that aged care workers and health professionals:
  - recognise risks or concerns related to an older person's health, safety and wellbeing, and escalate these in a timely manner
  - assess and monitor capacity for daily activities such as hygiene, oral care, dressing, toileting, continence, transferring and eating
  - 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
  - communicate effectively verbally and non-verbally with different older people
  - collaborate with older people with cognitive impairment and their supporters to understand the person and optimise outcomes
  - identify situations that may precipitate changes in behaviour
  - implement strategies to address clinical and other causes of changes in behaviour.

Feedback

- Feedback from members of the governing body about how they assure themselves that the service provider is minimising the use of restrictive practices and only using these as a last resort, according to conditions set out in the *Aged Care Act 2024.*
- Feedback from management about how they ensure that comprehensive care is delivered in line with evidence-based practice, with particular attention to meeting the needs of people with cognitive impairment and of those living in residential care.
- Feedback from aged care workers and health professionals (as relevant to their role) about:

  - whether they feel supported to deliver culturally safe, trauma aware and healing informed care
  - whether they know what to do when they have concerns related to an older person's health, safety or wellbeing, including noticing deterioration
  - confidence in supporting or assisting older people in activities of daily living
  - confidence in identifying and responding to the complex care needs of people with cognitive impairment and conditions such as dementia, including understanding their individual needs, factors contributing to changes in their behaviour, and strategies that are effective in supporting them to manage distress
  - understanding of their legal responsibilities in relation to restrictive practices
  - ability to communicate verbally and non-verbally with older people according to communication needs and preferences.
- Feedback from older people and their supporters about:
  - the extent to which the care and services they receive meet their individual needs, including supporting selection of their workers where possible
  - whether the service provider adequately and appropriately identifies and responds to needs related to cognitive impairment and conditions such as dementia and delirium
  - whether those accessing residential aged care feel:
    - supported to do the things they want to do to promote their quality of life and minimise boredom and loneliness
    - safe physically and psychologically at all times, including having control over who goes into their room and when
    - able to maintain relationships of choice free from judgement.

Item 9: Clinical safety

9 **The service provider has processes to identify, reduce, monitor and manage the high impact and high prevalence clinical risks faced by older people accessing its aged care services.**

Intent

This Module Item explains the processes the service provider needs to incorporate into its quality and safety systems to ensure that clinical risks to older people are identified, reduced, monitored and managed. As with all components of clinical care, improving clinical safety in the aged care context should be seen within the context of shared decision making and respecting a person's choice to make decisions that may involve risk to their health.

Several high prevalence, high impact clinical risks to older people were highlighted by the Royal Commission into Aged Care Quality and Safety. These are choking and swallowing, continence, falls and mobility, nutrition and hydration, mental health, oral health, pain, pressure injuries and wounds, and sensory impairment. In addition, quality use of medicines involves managing specific risks in the aged care context. Plans to minimise risk of harm should be documented and communicated to the older person, workers and others involved in their care.

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

Key concepts

Important concepts for implementing safe clinical care in the aged care context include the following.

- **Eating and drinking with acknowledged risk** (EDAR) is when the older person chooses to eat and drink things that have a health risk, where these are informed choices that have been discussed and documented in an EDAR plan in the person's care record.
- **Incontinence-associated dermatitis** is skin irritation or damage due to prolonged contact with urine or faeces. It is often characterised by redness, inflammation and/or skin breakdown.
- **Medication assistance** is a different task to medication administration. The two tasks have different legal conditions for who can perform them and when. Medication assistance is when a worker supports a person to self-administer their medicines. Assistance does **not** include giving, measuring or dispensing a medicine, but can include prompting or assisting a person to open packaging.
- **Mental health** relates to the psychological, social, and emotional wellbeing of individuals. Being mentally healthy is 'more than just the absence of an illness, rather a state of overall

wellbeing' (Mindframe Australia). Promoting positive mental health in older adults means creating environments and supports that enable social connection, occupation in meaningful or enjoyed activities, and a sense of coping with the stressors of everyday life (World Health Organization).

- **Oral health** is the condition of a person's teeth and gums, as well as the health of the muscles and bones in their mouth. Oral hygiene is the maintenance or oral cleanliness for the preservation of health.
- **Pain management** involves pain identification, pain assessment, pain treatment and monitoring and evaluation of effectiveness. Accurate and timely identification of pain requires ongoing vigilance for signs of pain in an older person by those involved in their care. (Pain Management Guide Toolkit for Aged Care, 2nd Edition)
- **Pain-related communication barriers** prevent an older person from understanding the information they receive or the ability for others to understand them. Language, cognitive impairment and physical conditions can all create barriers to communication that can be addressed with appropriate supports.
- **Sensory impairment** is an impairment or deficit in one or more senses. This includes vision, hearing, touch, smell, spatial awareness, balance and taste. Common sensory impairments include deafness and hearing loss, blindness, low vision and balance disorders.
- **Wellbeing** is a positive state experienced by an older person in which there is a sense of meaning and purpose. It encompasses the person's physical, spiritual, emotional and mental health and is strongly linked to quality of life.

Reflective questions

- How does the service provider ensure a focus on the high prevalence, high impact risks that were identified by the Royal Commission into Aged Care Quality and Safety?
- How does the service provider ensure that those working in its aged care service understand the clinical risks facing older people, including how to recognise, prevent and mitigate them (as relevant to their roles)?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant actions from the NSQHS Medication Safety Standard, Comprehensive Care Standard, and Recognising and Responding to Acute Deterioration Standard into its aged care services.

- Relevant actions from the **Medication Safety Standard** include those on clinical governance for medication management (4.01-4.04), medication reconciliation, documentation of allergies and adverse drug reactions (4.05-4.09), medication review and medicines lists (4.10-4.12), and medication management processes including for high-risk medicines (4.13-4.15).

- Relevant actions from the **Comprehensive Care Standard** include those related to screening and planning for clinical risks (5.07 and 5.10), preventing and managing pressure injuries (5.21-5.23), preventing fall and harm from falls (5.24-5.26), nutrition and hydration (5.27-5.28), and responding to distress related to self-harm or suicidal thoughts (5.31-5.32).
- Relevant actions from the **Recognising and Responding to Acute Deterioration Standard** include those related to training requirements (8.01c) and processes to enable staff to detect acute physiological or mental deterioration (8.04-8.05) and protocols for escalating care (8.06-8.09).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 9 in the context of the aged care service.

Ensure medication management is appropriate to the aged care context

- In the context of the **medication management** system, there are specific considerations for best practice in the aged care context. These considerations are fully explained in the Department of Health, Disability and Ageing's *Guiding Principles for Medication Management* in residential aged care, in the community and at transitions of care. For example, the service provider should ensure:
  - safe administration including assessing the older person's swallowing ability, determining suitability of crushing medicines and providing alternative safe formulations when required in consultation with the prescriber and pharmacist
  - 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
  - support for remote access for prescribing.
- In the aged care context where unregulated aged care workers (as well as regulated health professionals) are involved in providing care, the service provider must clearly define roles and responsibilities for managing medicines, communicate these to aged care workers and health professionals, and monitor that these are being followed. Roles and responsibilities must be in line with national and state or territory legislation, regulations and professional standards. They need to make clear:
  - 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 them.
- It is important to note that medication administration and medication assistance are different tasks. They have different legal conditions for who can perform them and when. Processes for safe medication administration should ensure:
  - the difference between medication assistance and medication administration is clear

  - health professionals understand their roles and responsibilities for medication administration under legislation, regulations and professional standards
  - nurses are supported to uphold the obligations of their professional registration, including through clear delegation and supervision arrangements
  - regulated health professionals carry out administration (registered nurses or enrolled nurses with relevant training and supervision)
  - where an appropriately trained and competent delegate, such as a care worker, can legally perform some medication administration tasks, these are carried out under appropriate supervision.
- In the residential care context, the service provider should consider whether aged care-specific medication management tools and strategies should be used to support quality use of medicines, such as:
  - the National Residential Medication Chart
  - pharmacist services including review and reconciliation of a resident's medicines (using available Medicare Benefits Schedule items where appropriate), to help identify opportunities to:
    - provide more optimal therapies
    - identify side effects and interactions
    - encourage adherence
    - make sure medicine is optimally administered
    - deprescribe and reduce the risk of harm from inappropriate polypharmacy.
- Other considerations for the quality use of medicines in the aged care context include:
  - managing the particular risks for older people when using certain medicines (such as the risk of falls or risk of choking)
  - managing high-risk medicines (such as opioids, anticoagulants, insulin and psychotropic medicines) which can pose a greater risk to older people
  - supporting and facilitating the use of non-pharmacological strategies as a first line approach when appropriate, such as when responding to changed behaviours and minimising the use of restrictive practices for people with cognitive impairment (see Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard).

Implement systems and processes to manage clinical risks and to prevent and minimise harm to older people

Chewing and swallowing

- Implement processes to support safe chewing and swallowing when the older person is eating, drinking, taking oral medicines and during oral care, including:
  - assessing for eating, drinking and swallowing difficulties, needs and preferences with input from a speech pathologist if risks are identified

  - implementing evidence-based processes for safe eating, drinking and swallowing, including input from relevant health professionals
  - partnering with the older person to make informed decisions on strategies to manage risks (such as using a plan for eating and drinking with acknowledged risk (EDAR))
  - training workers in identifying risks and responding to choking incidents in an emergency, including documentation in the incident management system
  - ensuring food and fluids are provided according to best practice for preparing and providing texture modified foods, in line with health professionals' recommendations
  - ensuring that oral medicines are supplied in suitable forms, with appropriate substitutions or alternative routes of administration discussed with the prescriber and pharmacist and documented in the care record.

Continence care

- Implement processes for continence care by:
  - assessing continence symptoms and needs including a health professional's review of factors potentially affecting continence (such as diet and medicines)
  - monitoring, identifying and managing changes in a person's continence, constipation, urinary tract infections or decline in skin integrity
  - protecting the older person's skin integrity and minimising incontinence-associated dermatitis
  - optimising the older person's dignity, comfort, function and mobility
  - ensuring safe and responsive assistance with toileting
  - facilitating access to a continence nurse when needed to support continence assessment or care
  - monitoring use of continence products to ensure that adequate products are available and provided.

Nutrition and hydration

- Develop policies, procedures and processes for nutrition and hydration in consultation with a dietitian to:
  - maintain an older person's nutrition and hydration, prevent malnutrition and dehydration, and to respond to malnutrition and dehydration in a timely way
  - (for residential care) make sure that appropriate and varied foods and fluids with adequate nutrients are available that provide the opportunity to meet nutrition and hydration needs.
- Involve the older person in discussions about needs and preferences for preventing and managing dehydration and malnutrition including ensuring cultural safety and trauma aware care.

- Identify and manage factors that increase risk of malnutrition and dehydration, by:
  - considering and monitoring the impact of chronic conditions on nutrition and hydration
  - 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 relevant professionals when clinically indicated.
- Identify dehydration and malnutrition early by:
  - ensuring workers are supported to monitor nutrition and hydration and escalate concerns early, where this is within their scope of practice or role description
  - carrying out regular screening using a tool validated in aged care
  - involving health professionals early to clinically assess, review and manage risks and concerns related to nutrition and hydration, and to review whether an intervention is effective.
- Implement management strategies in line with health professionals' recommendations and the older person's preferences.
- Monitor, review and improve processes for managing nutrition and hydration, including reviewing data on unplanned weight loss or gain, involving dietitians in reviewing outcomes of care and acting on the findings of clinical incident reports.

Mental health

Implement processes to optimise mental health and respond supportively to mental illness.

- Actively promote an older person's mental health and wellbeing using evidence-based strategies such as:
  - 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
  - serving and encouraging the eating and drinking of nutritious foods and drinks
  - 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 a sense of coping with stress.
- Respond supportively and quickly to distress and symptoms of mental illness (including thoughts of harm or suicide) by implementing processes to:
  - partner with each older person, and with their supporters to the extent the older person wants, to use their knowledge about their own mental health (such as 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 in planning a response to any deterioration
- identify signs of deteriorating mental health in a timely way
- ensure 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 quickly escalate observations and concerns about deterioration to appropriate health professionals
- monitor and document changes in mental health, strategies used to respond to changes, and observations of how effective interventions and strategies are
- record in the care and services plan the outcomes of any mental health assessments, recommended care strategies, and responsibilities for implementing the strategies and reviewing progress.

Oral health

- Implement processes to maintain oral health and prevent decline.
- Complete oral health assessments using a validated oral health assessment tool by a trained health professional such as a registered nurse. Higher needs may be seen in older people who:
  - are living with cognitive impairment
  - are at the end of life
  - have eating, drinking or swallowing issues
  - have dry mouth or altered salivation
  - are nil by mouth
  - take certain medicines.
- Monitor and respond to deterioration in oral health. If change or deterioration is identified, facilitate referral or access to a dentist or other oral health practitioner for oral health assessments at the commencement of care, regularly and when required.
- Assist with daily oral hygiene needs, including encouraging and assisting older people with natural teeth to brush them, and those with dentures to keep their dentures clean.

Pain management

- Implement processes for managing pain.
- Assess the older person's pain including where they experience challenges in communicating their pain. 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.

- Plan for, monitor and respond to the older person's need for pain relief. Evidence-based pain management includes both non-pharmacological and pharmacological approaches. In many cases, non-pharmacological strategies can be highly effective, including:
  - psychological
  - educational
  - physical activity and movement
  - nutritional
  - complementary approaches (see Pain Management Guide Toolkit for Aged Care).
- Making pain management available 24-hours a day.

Sensory impairment

- Implement processes to minimise and manage sensory impairment from hearing loss, vision loss and balance disorders by providing access to and supporting the use of assistive devices and aids to maximise the older person's independence, function and quality of life. These can include:
  - identifying changes and decline in sensory function in a timely way
  - regularly monitoring the older person's hearing, vision and balance to identify changes in sensory function and to make sure aids and devices are appropriate
  - referring to specialist health professionals for management including diagnosis, treatment and management of devices and aids
  - accessing assistive devices and aids for the older person and regularly monitoring their use, cleanliness and effectiveness
  - improving the care environment using strategies such as noise management, lighting, colour contrast, signage, textures and design.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies and processes describing requirements for the safe and quality use of medicines in the aged care context, including clear definitions of roles and responsibilities for aged care workers and health professionals, and protocols for delegation and supervision of medicines tasks.
- Policies and processes for the management of high prevalence and high impact clinical risks in older people.

- Sample care documentation showing evidence of continuity of access for an older person to their medication regime including where there is a transfer of care, where there is acute illness, and when a new medicine is prescribed or the dose changed.
- Sample care documentation showing assessments of an older person's clinical risks, planned strategies for care, and progress notes recording and reviewing use of these strategies, such as:
  - assessment documentation for specific risks, using validated tools where available (e.g. continence and skin integrity assessment, nutrition and hydration assessment)
  - monitoring documents to identify changes or deterioration (such as weight charts, bowel charts)
  - evidence of consultation with relevant health professionals for specialist assessment or treatment where clinically indicated
  - recommendations from health professionals and evidence that these have been followed in the delivery of care
  - evidence of review of the effectiveness of interventions and strategies used and of changes made to these as required.
- Training documents and records related to this Module Item.

Feedback

- Feedback from the governing body and management about how they monitor the effectiveness of the processes for preventing, identifying and managing high prevalence, high impact clinical risks. This could include routinely using the findings of clinical audits and analysis of trends in clinical incident data to identify areas for improvement.
- Feedback from management demonstrating actions taken towards improving processes for preventing, identifying and managing high prevalence, high impact clinical risks among people accessing the aged care service.
- Feedback from aged care workers and health professionals (as relevant to their role) about their:
  - understanding of their roles and responsibilities for medication management
  - confidence in preventing, identifying and managing clinical risks and needs of older people including continence, falls and mobility, nutrition and hydration, mental health, oral health, pain, pressure injury and wounds or sensory impairment.
- Feedback from older people about whether they are supported to self-administer their medicines or are given their medications, whether any medication errors have occurred and how the service provider dealt with the error, and whether there have been times when their medicines were not available.
- Feedback from older people and their supporters regarding access to relevant health professionals to support management of clinical care needs, risks or safety (e.g. a speech pathologist conducting a swallowing assessment).

Item 10: Care coordination and transition

10 **The service provider has systems and processes to support coordinated care for people accessing its aged care services, including:**

a. **where multiple health and aged care providers, family and carers are involved in the delivery of care and services**

b. **at transitions of care to or from the aged care service, including when transitions are unplanned**

c. **clear responsibility and accountability for a person's care and services between aged care workers, health professionals and across organisations.**

Intent

Meeting an older person's needs in a comprehensive way can involve referral to or input from multiple health and aged care professionals and services as well as community organisations and supporters.

Given the scope of responsibility in residential care, a service provider delivering residential care is required to ensure that older people have access to other services as needed and to coordinate a planned transition to or from the other service to maximise continuity of care.

This Module Item explains how the service provider can effectively coordinate transitions of older people between care providers, between aged care and hospital, and on visits to the community. This requires the service provider to identify and consistently communicate with the other parties involved, and the roles and responsibilities of each party should be clear and documented.

Key concepts

Important concepts for effective care coordination and transition in the aged care context include:

- **Coordination of care** means the deliberate organisation of aged care activities, interventions and services that are delivered by different parties, as well as routine sharing of information between the parties. Care coordination has the aim of achieving consistency of approach to a person's care and avoiding the need for care recipients to repeat their story.
- **Continuity of care** is the experience of the older person when they have an ongoing relationship with a care professional or care team over time. It needs to be maintained when the responsibility for care is transferred between individuals or teams or between organisations. This includes maintaining effective communication and documentation processes.
- **Transitions of care** are situations where all or part of an older person's care is transferred between locations, organisations, providers or levels of care within the same location. For those accessing residential care, this can include temporary transitions to visit the community or family.

Reflective questions

- How does the service provider ensure continuity of care when an older person needs to be transferred to or from hospital?
- How does the service provider maintain connections with external health and community-based professionals, services or organisations to facilitate care coordination and safe transfers of care?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS Standards into its aged care services.

- Relevant actions from the **Partnering with Consumers Standard** include those on sharing decisions to plan care (2.06-2.07)
- Relevant actions from the **Comprehensive Care Standard** include those on referral and accountability (5.04b and c), collaboration and teamwork (5.05-5.06), and working in partnership to plan and deliver comprehensive care (5.13-5.14)
- Relevant actions from the **Communicating for Safety** and **Recognising and Responding to Acute Deterioration Standards** include those on effective clinical communication processes during transfers of care, for handover and for time-critical information (6.04, 6.07-6.10) and on timely clinical response to acute deterioration (8.10).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 10 in the context of the aged care service.

Ensure that parties external to the aged care service are involved and informed

- Implement processes to ensure the older person, their supporters and external health professionals such as GPs are involved as partners in the coordination of care and services, where this is what the older person wants. This helps to maintain continuity of care and make sure everyone involved knows about any transfers of responsibility or other changes. It can also help reduce adverse events, harm and disruption to the older person.
- Identify those the older person wants to be involved in coordinating their care and involve them in planning transitions of care such as visits to the community or to family members' homes.
- Document and communicate the respective roles and responsibilities of those involved in the older person's care in the care plan, and review these regularly.
- Provide timely notification to the person's general practitioner when clinical incidents or changes occur.

- Put in place strategies for planned and unplanned transitions in situations where an older person:
  - is going to or being discharged 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.

Manage transitions between residential care and hospital or other health care settings

- Implement processes for coordination of care for older people in the residential aged care service which ensure that:
  - access to services offered by health professionals or other individuals or organisations is facilitated when the service provider is unable to meet the older person's needs
  - connections with specialist health services, including rehabilitation, allied health, palliative care, specialist nursing and specialist dementia care services, are maintained and accessed as required
  - use of hospitals or emergency departments is recorded and monitored
  - older people and their supporters are engaged in decisions regarding transfers
  - receiving supporters, health professionals or organisations are given timely, current and complete information about the older person as required
  - when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies and processes for transitioning older people between the residential aged care service and the hospital, other care services and stays in the community.
- Processes and protocols for ensuring timely communication of relevant up-to-date information at transitions of care, with due attention to protecting the older person's privacy and personal information and ensuring informed consent to share information. Such information may include the older person's:
  - needs, goals and preferences (including language, communication, cultural, food and drink)
  - advance care planning documents

  - medication history, medicines list and information about allergies and adverse drug reactions
  - clinical assessments, care plans and notes about changes in the person's condition
  - details of others involved in their care including health professionals, supporters and substitute decision makers
  - equipment, aids and products used
  - risks of harm or clinical concerns including infection risks
  - behaviour support plan, for those who experience changed behaviours or may require the use of restrictive practices.
- Processes and protocols for notifying relevant people about clinical incidents or changes, including GPs, other health professionals, and supporters.
- Evidence of continuing relationships (including formal agreements, referral pathways etc) between the service provider and external organisations, including specialist health services, health professionals and relevant community organisations to facilitate coordinated comprehensive care.
- Care plans and other documents showing clear roles and responsibilities for aged care workers, health professionals and external services, as well as clear accountability for care, including during transitions of care.
- Training documents and records related to this Module Item.

Feedback

- Feedback from aged care workers and health professionals (as relevant to their role) about their confidence in:
  - planning and coordinating older people's transitions between services, organisations and levels of care
  - knowing how to facilitate access to health professionals and specialist health services
  - obtaining informed consent to, and knowing the mechanisms for, communicating relevant information to others on transitions of care.
- Feedback from older people and their supporters about:
  - experiences of transitions of care and whether they were included in planning and informed about changes
  - whether they feel the different providers, workers and services involved in their care communicate with each other and work together to meet the older person's needs
  - whether they feel they have adequate access to health professionals outside of the aged care service when they need it.

Item 11: Environment

11 **The service provider ensures that its aged care services:**

a. **support people accessing home-based aged care services to mitigate environmental risks relevant to their care**

b. **deliver a clean, safe and comfortable environment that optimises sense of belonging, interaction and function in residential care**

c. **use or provide safe equipment that meets the needs of the person accessing its aged care services.**

Intent

This Module Item explains the importance of providing care and services in a physical environment that is safe, supportive and meets the needs of older people. It covers assessing and managing environmental risks both in home-based aged care and in residential care. It also highlights the role of a comfortable, safe, accessible and inclusive residential care environment, with outdoor and indoor spaces, in optimising a person's quality of life. The provision and use of safe, clean and appropriate equipment and assistive devices can also support an older person's daily functioning and independence.

Key concepts

Important concepts related to environment and equipment in the aged care context include:

- **Environmental risks** include poor lighting and slip, trip and fall hazards as well as risks related to equipment and to the delivery of services. Through a risk management system, providers can identify and address environmental risks. This helps to mitigate the risk of harm to older people and workers.
- **Equipment management** ensures that equipment and aids are safe, clean and appropriate to a person's needs. It includes inventory management to keep track of equipment, a maintenance plan, and cleaning schedules and processes.

Reflective questions

- What does the service provider do to make the residential care environment welcoming and to promote social engagement and a sense of belonging?
- How does the service provider assess and mitigate environmental risks if providing care in an older person's home?
- How does the service provider ensure the residential care environment is suitable for older people with sensory or cognitive impairment?

Key tasks

Apply relevant actions from the NSQHS Standards

It is important that the service provider adequately extends relevant related actions from the NSQHS **Clinical Governance Standard,** about creating and maintaining a clean and safe environment (1.29-1.31, 1.33), into its aged care services.

Apply aged care-specific strategies

A residential aged care environment is an older person's home for a period of months or years and it can have positive or negative impacts on their ability to do the things they want to do and on their quality of life. Important considerations for aged care include creating dementia-friendly environments, personalisation of private space, collaborative input to elements of public space (such as music or temperature) and provision of accessible garden and outside space.

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 11 in the context of the aged care service.

Manage environmental risks in home-based care

If delivering home-based care, service providers should discuss with the older person any identified environmental risks and options to mitigate them. 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.

- Use risk management and communication systems to:
  - identify, assess, document, manage and review any environmental risks that may affect the safety of the older person and workers, including from equipment or aids and broader environmental risks such as overheating
  - complete an equipment and aids assessment when the person starts receiving care to assess the appropriateness of current equipment, the need for other equipment or for a referral to a health professional
  - include other people, such as workers and supporters in these discussions, with the older person's consent
  - enable workers to share information with each other to help identify risks, where the older person receives care and services in their home from different providers.
- Ensure that workers delivering home-based care know how to:
  - identify and manage risks using the risk management system
  - use the communication and information management systems to share critical information about identified risks
  - 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
  - record incidents and near misses using the incident management system.

Provide inclusive and comfortable internal and external environments for residential care

- Ensure that residential care environments:
  - are welcoming, comfortable and provide older people with a sense of belonging
  - give space to allow older people privacy when they want it, or to enable them to host visitors
  - follow dementia-friendly design principles
  - are accessible, including for older people with a disability
  - promote movement, engagement and inclusion through design
  - enable older people to move freely both indoors and outdoors
  - unobtrusively reduce safety risks and optimise useful stimulation.
- Ensure that residential care environments are culturally safe and inclusive to meet the diverse needs of older people, by:
  - involving Aboriginal and Torres Strait Islander persons, their families and the wider community in designing a culturally safe, respectful environment
  - enabling increased presence of an older person's loved ones towards the end of life, including allowing them to stay overnight if needed to follow cultural practices
  - providing space for prayer or practice of spiritual, cultural or religious rituals.

Maintain clean and safe equipment and aids

- Ensure equipment and aids used or provided in the delivery of care and services are safe, clean, well-maintained and meet the needs of older people.
- Put in place a process and documentation to keep track of equipment and when it requires cleaning, maintenance or replacement.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Sample of risk assessment records for environmental or equipment risks at an older person's home (for in-home aged care).
- Evidence of timely servicing, maintenance, renewal and replacement of indoor and outdoor furniture, fittings and equipment (for residential care).
- Cleaning and maintenance records for equipment and aids provided to older people or used with older people.

- Evidence of referrals to relevant health professionals to review an older person's environment, equipment and/or aids and that their recommendations have been followed.

Feedback

- Evidence from management that relevant feedback, complaints and incident reports have been identified and used to improve the service environment.
- Feedback from aged care workers and health professionals (as relevant to their role) about their confidence in identifying environmental risks to themselves and to older people and their knowledge about how to communicate or escalate their concerns.
- Feedback from older people about whether they have the equipment and aids they need and whether these are clean and safely working (as relevant to their needs).

Item 12: Infection prevention and control

12 **The service provider uses an infection prevention and control system, processes and practices in its aged care services to minimise infection risks and, if they occur, to manage them effectively.**

Intent

The NSQHS Preventing and Controlling Infections Standard comprehensively addresses this topic and should be extended to the service provider's aged care service. This Module Item draws attention to additional aspects of infection prevention and control (IPC) that are specific to, or differently implemented in, the aged care context.

There is a known complexity to implementing IPC practices in aged care, especially when care is delivered in a communal or home environment. While the overarching aim is always to make the risk of infection as low as possible, other social and wellbeing factors must be considered so that IPC interventions and restrictions are not overly severe for older people and their family and carers. Local risk assessment is essential to inform appropriate management, reduce infection risks and achieve a balanced approach to IPC.

Service providers should refer to the Aged Care Infection Prevention and Control Guide for evidence-based, aged care-specific infection prevention and control advice.

Key concepts

Important concepts for implementing infection prevention and control in the aged care context include the following.

- **Person-centred care and wellbeing**: In aged care settings, the focus of minimising infection-related risks in aged care requires careful consideration of the quality of life of the older people to whom services are provided as part of the approach for risk assessment. These considerations should be balanced with maintaining an environment where care can be delivered in a manner that minimises the spread of infection and the impact on others receiving and providing care.

Reflective questions

- How does the service provider ensure that infection prevention and control systems and processes are extended into its aged care service?
- How does the service provider consider the quality of life, physical and mental wellbeing needs of older people within its infection prevention and control practices in aged care?

Key tasks

Apply relevant actions from the NSQHS Standards

To meet Module Item 12, it is important that the service provider adequately extends the **NSQHS Preventing and Controlling Infections Standard** into its aged care services, alongside careful consideration of the quality-of-life impacts of infection prevention and control measures for older people.

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested strategies to support achievement of Module Item 12 in the context of the aged care service.

- Ensure the service provider's system for infection prevention and control is appropriate to the aged care context including by:
  - identifying an appropriately qualified and trained infection prevention and control lead in residential care
  - prioritising the rights and wellbeing of older people
  - ensuring personal protective equipment is available to older people
  - supporting older people to correctly use personal protective equipment
  - being informed by worker and older person immunisation rates
  - undertaking risk-based vaccine-preventable diseases screening and immunisation for older people in residential care
  - implementing disease screening and immunisation requirements (in line with jurisdictional and public health unit requirements) for visitors.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- IPC policies for the aged care setting that support consideration of the quality-of-life impacts of IPC measures on older people.
- Role description for an infection prevention and control lead for the aged care service.
- Training documents and records related to this Module Item.
- Immunisation records for aged care residents and workers showing that they are up to-date with required vaccinations and immunisations (where applicable).
- Reports or data used to monitor infections and assess the effectiveness of IPC practices in aged care, and evidence of these being used to improve.

Item 13: Food and nutrition

13 **The service provider partners with people accessing its residential aged care service to provide a food, drinks and dining service that:**

a. **supports service of appealing, flavoursome and varied food and drinks**

b. **assesses and meets current nutritional needs, eating and drinking abilities, and preferences about what, how and how much they like to eat or drink**

c. **assists eating and drinking**

d. **provides an enjoyable dining experience in a dining environment that promotes social engagement, function and quality of life.**

Intent

This Module Item explains how older people's food, drink and dining experience and outcomes can be improved within a residential care service. The service provider must be aware of the specific nutritional needs of older people and should apply this understanding when assessing and meeting individual needs and preferences for food, drinks and dining. It is important to partner with older people and relevant health and food professionals to design and plan menus and create an enjoyable dining experience, and to use older people's feedback in continuous improvement of the food service.

It is recognised that service providers may have various arrangements with regard to the supply of food and drinks and the design of menus. In such cases, the service provider is expected to take reasonable steps and consider innovative mechanisms to meet the requirements of this Module Item.

Key concepts

Important concepts for implementing quality food, nutrition and dining services in the aged care context include:

- **Menu and mealtime assessments or reviews** are conducted by an Accredited Practising Dietitian and are designed to assess the meals, drinks and dining experience to determine if they are meeting individual needs for nutrition, enjoyment and safety.
- **Dining experience** is the way in which food and drink is provided to satisfy needs and preferences and support the choice of those served. It includes the environment, setting, service and atmosphere in which food and drink are served.

Reflective questions

- How does the service provider ensure that systems and processes for food and nutrition are based on an understanding of the specific nutritional needs of older people?

- How does the service provider ensure that the individual food, drink and dining needs and preferences of older people are assessed and met?
- What does the service provider do to partner with older people in designing menus, creating an enjoyable dining experience, and making improvements to the provision of food and drink?

Key tasks

Apply relevant actions from the NSQHS Standards

To meet Module Item 13, it is important that the service provider adequately extends relevant related actions on partnering with older people in the design and evaluation of services from the NSQHS **Partnering with Consumers Standard** (2.11) and on nutrition and hydration from the **Comprehensive Care Standard** (5.02, 5.03, 5.27, 5.28) into its aged care services.

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 13 in the context of the aged care service.

Partner with older people to provide enjoyable food, drinks and dining experiences

- Partner with older people on how to create enjoyable food, drinks and dining experiences at the service. This includes talking with each older person about their food and drink likes and dislikes, as well as cultural or religious needs and preferences.
- Partner with older people on designing menus (including for texture modified diets) that:
  - are developed with the input of chefs, cooks and an Accredited Practising Dietitian, including for older people with specialised dietary needs
  - are regularly changed, include variety and enable older people to make choices about what they eat and drink
  - are reviewed at least annually through a menu and mealtime assessment by an Accredited Practising Dietitian.
- Implement a system to monitor and continuously improve the food service in response to:
  - older people's intake of food and drink to ensure it meets their nutritional needs (including review of identified unplanned weight loss and malnutrition)
  - the impact of food and drink on the health outcomes of older people.

Assess, document, communicate and review individual needs and preferences

- Put in place strategies to monitor for and recognise signs of deterioration in the person that affect their eating and drinking. Facilitate access to allied health professionals to help mitigate the effects of deterioration on nutrition and hydration and ensure severe or rapid deterioration is assessed by a medical professional.

- As part of assessment and planning, regularly assess and review each older person's nutrition, hydration and dining needs and preferences. Document these in the person's care plan and make sure they are communicated with all relevant workers and at transitions of care. The assessment should consider:
  - allergies and intolerances
  - the specific nutritional needs of older people, including a focus on protein, energy and calcium rich foods
  - the older person's dining needs and preferences
  - clinical and other physical issues identified that impact the older person's ability to eat and drink (such as swallowing difficulties, lack of appetite or poor oral health), including health professionals' recommendations
  - impact of cognitive impairment on eating, drinking and dining needs
  - support needed to eat and drink, including adaptive equipment (where indicated) and physical assistance
- As relevant to their role, make sure workers understand how to:
  - assess nutrition, hydration and dining needs and preferences as part of care planning
  - use this information to plan and provide satisfactory food, drink and dining experiences
  - refer to appropriate health professionals for specialist advice and reviews
  - undertake relevant screening using validated tools (health professionals with relevant training)
  - identify and escalate malnutrition concerns.

Provide food and drinks in a way that meets individual needs and preferences

- For each meal, ensure that older people can exercise choice about what, when, where and how they eat and drink.
- Ensure sufficient qualified workers are available at mealtimes to meet residents' needs for support to eat and drink, including to:
  - encourage, prompt, and physically assist to safely eat and drink as much as the person wants, at their own pace
  - promote reablement by rebuilding a person's skills and confidence to eat or drink by themselves
  - support individualised mealtime strategies for people with cognitive impairment, as recommended by an allied health professional
  - monitor food and drink intake
  - identify any difficulties with eating, drinking or swallowing and to ensure the correct consistency of texture modified foods and thickened fluids.

- Provide meals, drinks and snacks (including where older people have specialised dietary needs) that:
  - are appetising and flavourful
  - are prepared safely and served at the correct temperature and in an appealing way, including the presentation of texture modified foods using tools such as moulds
  - are accessible at all times (for nutritious snacks and drinks including water).
- Provide a dining environment that:
  - supports reablement, social engagement and a sense of belonging and enjoyment
  - provides opportunities for older people to share food and drinks with their visitors.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Food and nutrition policies and processes incorporating:
  - strategies for meeting the specific nutritional needs of older people such as the need for protein and calcium-rich foods
  - consultation with older people about design of menus and service of food and drinks, such as through a consumer advisory body or group discussion
  - facilitation of choice for older people in what and when they eat and drink
  - documented roles and responsibilities for management and the workforce in the planning, preparation and service of meals.
- Care documentation for a sample of older people showing evidence of:
  - individual assessments and reassessments of nutritional and dining needs and preferences
  - recording of how needs are met and adequacy of intake monitored
  - consideration of clinical and physical issues, such as oral health, chewing and swallowing ability, medication impact on appetite, seating and positioning requirements for eating and drinking, dexterity
  - an individual and flexible approach to preparing and delivering meals for people living with cognitive impairment or receiving palliative care
  - recording of physical assistance required to eat and drink
  - collaboration with other parties such as chefs, dietitians or speech pathologists to optimise nutrition and hydration.

- Evidence that management and the governing body monitor and act on evidence of nutrition and hydration concerns, such as indicators of malnutrition and unexpected weight loss or gain or complaints from older people.
- Incident reports related to eating and drinking such as aspiration, choking or allergic reactions and evidence of action taken to improve.
- Continuous improvement plans showing how improvements in food, drink and the dining experience are identified, monitored and reviewed for effectiveness.
- Training documents and records related to this Module Item.

Feedback

- Feedback from members of the governing body and management about how they assure themselves that the nutrition and hydration needs of older people are being met and that they would know if and when this is not the case.
- Feedback from aged care workers and health professionals (as relevant to their role) about whether they have the time, support and resources to provide appropriate eating and drinking assistance to older people, in line with their needs and preferences.
- Feedback from older people about their satisfaction with food, drinks and the dining experience (such as from complaints, survey results, monitoring of food left uneaten).
- Feedback, including complaints, from older people and their supporters showing the extent to which they feel consulted about food, drinks and dining experience.

Item 14: Palliative and end-of-life care

14 **The service provider has processes for the people accessing its aged care services that:**

a. **recognise and address needs, goals and preferences for palliative care and end-of-life care and preserve their dignity**

b. **actively manage pain and symptoms with access to specialist palliative and end-of-life care**

c. **inform and support family and carers, including during the last days of life.**

Intent

This Module Item identifies how the service provider can provide safe and quality care towards the end of life in a way that prevents and relieves suffering and reduces distress. It explores how the service provider can support the older person's right to dignity, comfort and privacy and to respectful and compassionate care.

Key concepts

Important concepts for implementing palliative and end-of-life care in the aged care context include:

- **Palliative care** helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness. A palliative approach aims to prevent and relieve suffering by means of early identification and correct assessment, treatment or support for symptoms such as pain as well as other physical, psychological, social or spiritual problems.
- **End-of-life** is the period when an older person is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of older people with chronic or malignant disease, or very brief in the case of older people who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.
- **End-of-life planning conversations** may include talking to the older person, their loved ones and health professionals about their beliefs, values, goals and preferences for the care and treatment in the last days, weeks or months of their life.
- **Anticipatory medicines** are prescribed and dispensed in preparation for a time when a person needs them. They are used to manage symptoms in the home with the goals of rapid relief and avoiding unplanned or unwarranted admission to a hospital.
- **Bereavement support** includes the emotional, psychosocial and spiritual support provided to families and loved ones before and after the death of a person. It is designed to help people cope with grief, loss and adjustment.
- **Spiritual care** involves caring for the whole person, incorporating the needs of mind, body and spirit. This holistic approach can enhance spiritual wellbeing and improve health and

quality of life. Spiritual care recognises and responds to a person's spiritual needs by supporting them to find meaning, purpose, hope and transcend loss, grief, disability, illness and pain.

Reflective questions

- How does the service provider work with others outside of the service (such as palliative care teams) to improve the older person's end-of-life care?
- How does the service provider identify the need for a palliative approach to care and recognise that a person is nearing the end of their life? How is this communicated to the older person, their supporters and relevant health professionals?
- How does the provider ensure that workers are competent to respond quickly and appropriately to the older person's rapidly changing needs (including recognising and responding to delirium)?
- How does the service provider ensure that older people are provided culturally safe and supportive opportunities to talk about dying so they can make their wishes known?

Key tasks

Apply relevant actions from the NSQHS Standards

To meet Module Item 14, it is important that the service provider adequately extends relevant related actions from the NSQHS **Comprehensive Care Standard** into its aged care services. Relevant actions include those on comprehensive care at the end of life (actions 5.15-5.16), advance care planning (5.17), and shared decision making at end of life (5.20).

Apply aged care-specific strategies

The following is a non-exhaustive list of suggested additional strategies to support achievement of Module Item 14 in the context of the aged care service.

Recognising and planning for needs for palliative and end-of-life care

- Implement processes to guide the workforce in recognising when the older person requires and would benefit from palliative care and/or is approaching the end of their life. These can include:
  - supporting workers and health professionals to use risk prediction tools, trigger tools and questions
  - communicating with the older person and their supporters to identify signs they may be approaching the end of their life
  - 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.

- Implement processes for end-of-life planning that support the older person, their supporters and/or substitute decision maker to:
  - discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions
  - review advance care planning documents to align with their current needs, goals and preferences.
- Provide clear guidance for the workforce on decision-making when an older person's wishes and preferences are not known.

Comprehensive palliative and end-of-life care

- Use comprehensive care processes to plan and deliver palliative and end-of-life care, in line with the person's goals, preferences and wishes, that:
  - prioritises the comfort and dignity of the older person
  - supports the older person's spiritual, cultural, and psychosocial needs
  - identifies and manages changes in pain and symptoms
  - provides timely access to specialist palliative care and other services when needed
  - provides timely access to specialist equipment and medicines for pain and symptom management
  - communicates information about the older person's preferences for palliative care and the place where they wish to receive this care to workers and supporters
  - provides information about the process when a person is dying and about loss and bereavement to supporters.

Care during the last days of life

- Implement processes to ensure timely recognition when a person is approaching the last days of life and to:
  - ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day
  - respond to rapidly changing needs including pressure care, oral care, eye care, bowel and bladder care and delirium
  - minimise unnecessary transfer to hospital, where this is in line with the older person's preferences.

Examples of evidence

To demonstrate that the service provider meets this Module Item, choose examples of evidence from the list below that are currently in use. Other forms of evidence can also be used as relevant to the local circumstances.

Documents

- Policies, procedures or protocols for managing palliative and end-of-life care needs that address:
  - requirements for recognising end of life and supporting an older person to prepare for end of life
  - supervision and support that is provided to members of the workforce providing end-of-life care
  - requirements for recognising the last days of life and responding to rapidly changing needs
  - roles and responsibilities for management and workers in supporting palliative and end-of-life care.
- Sample of medication records and clinical notes for older people in palliative care or approaching the end of life, showing whether:
  - medications prescribed to manage palliative and end-of-life symptoms are administered, reviewed, and available 24 hours a day
  - medications have been reviewed to minimise unnecessary or unwanted medications.
- Sample of care documentation for older people in palliative care or at the end of life showing:
  - discussion of goals and preferences for palliative and end-of-life care
  - advance care planning documents that are up to date
  - monitoring of and response to changing care needs.
- Training documents and records related to this Module Item.
- Agreements with, and referral pathways to, external organisations and health professionals such as specialist palliative care services.
- Meeting minutes or similar indicating that the service provider's management and governing body monitor and discuss processes for palliative and end-of-life care, including improvements required.

Feedback

- Feedback from aged care workers and health professionals (as relevant to their role) about:
  - their confidence in dealing with palliative and end-of-life care
  - whether they are supported to deal with loss and grief.
- Feedback from older people and their supporters about the management of palliative and end-of-life care.

Appendix 1: Mapping of Module Items

The mapping table below cross-references each item in the Module with the related outcome from the ACQ Standards and the action in the NSQHS Standards:

- NSQHS Standards actions that should be extended to the aged care context for that Module Item
- ACQ Standards outcomes which are most closely related to the Module Item. These are included because the service provider may wish to access additional information and resources related to these outcomes that are published by the Aged Care Quality and Safety Commission.

Module Item		Related ACQ Standards outcomes		Related NSQHS Standards actions	
1	**Person-centred care**	Standard 1: The Individual	1.1	Clinical Governance Standard Partnering with Consumers Standard Comprehensive Care Standard	1.04, 1.08, 1.15, 1.21, 1.33 2.06-2.08(incl.), 2.10-2.12(incl.) 5.07, 5.08, 5.30
2	**Dignity, respect and privacy**	Standard 1: The Individual	1.2	Clinical Governance Standard Partnering with Consumers Standard	1.11-1.14(incl.) All
3	**Choice, independence and quality of life**	Standard 1: The Individual	1.3	Partnering with Consumers Standard Comprehensive Care Standard	2.03-2.07(incl.), 2.10 5.13(c)
4	**Agreements, fees and pricing**	Standard 1: The Individual	1.4	Partnering with Consumers Standard	2.04, 2.10
5	**Workforce and HR management**	Standard 2: The Organisation	2.8 2.9	Clinical Governance Standard Partnering with Consumers Standard Recognising and Responding to Acute Deterioration Standard	1.13, 1.19-1.28(incl.) 2.01(c), 2.14 8.01(c)
6	**Emergency and disaster management**	Standard 2: The Organisation	2.10	Clinical Governance Standard Partnering with Consumers Standard	1.10(f) 2.11(a)

Module Item		Related ACQ Standards outcomes		Related NSQHS Standards actions	
7	**Assessment and planning**	Standard 3: Care and Services Standard 5: Clinical Care	3.1 5.4	Partnering with Consumers Standard Comprehensive Care Standard Communicating for Safety Standard	2.05(b), 2.10 5.03, 5.04(a), 5.07-5.14(incl.), 5.17 6.04(b), 6.07(a), 6.08, 6.11
8	**Delivery of comprehensive care**	Standard 3: Care and Services Standard 5: Clinical Care Standard 7: Residential Community	3.2 5.4 5.6 7.1	Clinical Governance Standard Partnering with Consumers Standard Comprehensive Care Standard Communicating for Safety Standard Recognising and Responding to Acute Deterioration Standard	1.08, 1.29(b), 1.30(a), 1.33 2.03(a), 2.04, 2.08, 2.10(a, b) 5.04(b-d), 5.13, 5.14(a-c), 5.29, 5.30, 5.33, 5.35, 5.36 6.01, 6.04(a), 6.06(a), 6.07-6.10(incl.) 8.01(c), 8.04-8.09(incl.)
9	**Clinical safety**	Standard 5: Clinical Care	5.5	Comprehensive Care Standard Recognising and Responding to Acute Deterioration Standard	5.07, 5.10, 5.21-5.28(incl.), 5.31, 5.32 8.05, 8.06(d), 8.10, 8.12
10	**Care coordination and transition**	Standard 3: The Organisation Standard 5: Clinical Care Standard 7: Residential Community	3.4 5.4 7.2	Partnering with Consumers Standard Comprehensive Care Standard Communicating for Safety Standard Recognising and Responding to Acute Deterioration Standard	2.06, 2.07 5.03- 5.06(incl.), 5.13, 5.14(a) 6.04(b, c), 6.07-6.10(incl.) 8.10
11	**Environment**	Standard 4: The Environment	4.1a 4.1b	Clinical Governance Standard Preventing and Controlling Infections Standard (revised 2021)	1.29-1.31(incl.) 3.13, 3.14(a, c)
12	**Infection prevention and control**	Standard 4: The Environment Standard 5: Clinical Care	4.2 5.2	Preventing and Controlling Infections Standard (revised 2021)	3.02(c), 3.05(a-c), 3.06, 3.07(a, c, d), 3.13(c), 3.15, 3.16(g, h)
13	**Food and nutrition**	Standard 6: Food and Nutrition	6.1- 6.4	Partnering with Consumers Standard Comprehensive Care Standard	2.11 5.02, 5.03, 5.27, 5.28
14	**Palliative and end-of-life care**	Standard 5: Clinical Care	5.7	Partnering with Consumers Standard Comprehensive Care Standard	2.06 5.15-5.17(incl.), 5.20, 5.29(a)

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