



Australian Government

Department of Health

SINGLE AGED CARE QUALITY FRAMEWORK

Draft Aged Care Quality Standards Consultation Paper
2017



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MAKING A SUBMISSION

This paper has been prepared by the Department of Health (the department) as a basis for consultation on proposed changes to the aged care standards.

The department is keen to consult widely and engage with as many individuals and organisations with an interest in aged care standards and reform as possible. These include:

- consumers, their families and carers
- key sector groups
- aged care organisations
- staff of aged care organisations, health and disability services providers
- advocacy groups.

The department invites your comments on this consultation paper.

The department will consider all comments carefully and use the information we receive to inform the further development of the standards (discussed in more detail in this paper). With your consent, your comments we receive will be made publicly available.

You can submit your comments via the department's [consultation hub](https://consultations.health.gov.au/) at <https://consultations.health.gov.au/>

If you are having difficulty completing an online submission, please contact qualityagedcare@health.gov.au for assistance.

You must ensure that the department receives your comments by **Friday 21 April 2017**.
Late submissions will not be accepted.

Thank you for your interest and we look forward to receiving your comments.

CONTEXT AND PURPOSE OF THIS CONSULTATION PAPER

Context

The Australian population is ageing and the expectations of older people are changing. In recognition of this, the Australian Government is making fundamental reforms to the aged care system to ensure that it provides high-quality services that meet consumer needs and preferences.

The reforms place consumers at the centre of their care, and have a significant focus on giving people greater choice and flexibility. Changes are being progressively implemented to create a competitive, market-based system where consumers drive quality and where red tape is reduced for organisations.

As part these reforms, the Australian Government is partnering with consumers, the aged care sector, experts and the community to develop a Single Aged Care Quality Framework (single quality framework) that will support an aged care system in which consumers drive quality.

The single quality framework will include:

- a new set of quality standards that will apply to all aged care services
- a new process to assess organisations' performance against the new standards
- improvements to the information available to consumers to support them to make choices about their aged care.

Quality standards for aged care

The quality standards for aged care are an important part of the broader aged care system—they promote consumer confidence that Australian Government funded aged care is safe and of a consistent quality. The standards support consumers by setting out core expectations for the safety and quality of care and services. Organisations can then demonstrate their performance against the standards and their performance can be assessed.

Under the current quality arrangements (some of which have been in place since 1997), aged care organisations that receive Australian Government funding need to meet one or more sets of quality standards depending on the types of aged care services they deliver. The four standards are:

- Accreditation Standards for residential care and short term restorative care delivered in a residential setting
- Home Care Standards for home care, short term restorative care delivered in a home setting, and care delivered under the Commonwealth Home Support Programme (CHSP)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework Standards for care delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)
- Transition Care Standards for flexible care providers delivering transition care.

The new single quality standards system

There are challenges in applying four different quality frameworks:

- it is difficult for consumers to understand what they can expect from organisations providing aged care services
- the system is complex for organisations
- the system can inhibit service delivery improvements.

To address these challenges, the government is proposing a single set of quality standards that will apply to all aged care services (including residential, home and flexible care). However, there will be scope for the standards to be tailored so that certain standards only apply to specific types of care. For example, a standard that relates to personal care or clinical care will not apply to an organisation that does not provide personal care or clinical care.

In addition, the standards have been designed to apply to multiple organisation types and service delivery environments. All organisations will be required to demonstrate that they have achieved the outcomes set out in the standards. However, the strategies for achieving those outcomes and the evidence used to assess the outcomes will differ depending on the type of organisation and the services it offers.

A single set of standards will increase consistency across aged care services and make it easier for consumers, and their families, carers and representatives, to understand what they can expect from their service. The standards will still focus on quality and safety for consumers, however they will also encourage care and services that promote quality of life and wellbeing by placing greater emphasis on consumer choice and identity and partnering with consumers in their care.

Purpose of this consultation paper

This consultation paper focuses on the development of the new quality standards for aged care. A separate consultation paper (entitled Single Aged Care Quality Framework—Options for assessing performance against quality standards—Options paper 2017) discusses options for a new process for assessing organisations' performance against the standards.

The purpose of this consultation paper is to seek stakeholder comment on the proposed quality standards. The quality standards comprise eight individual standards:

1. Consumer dignity, autonomy and choice
2. Ongoing assessment and planning with consumers
3. Delivering personal care and clinical care
4. Delivering lifestyle services and supports
5. Service environment
6. Feedback and complaints
7. Human resources
8. Organisational governance.

Once the standards are in their final stages of development, detailed guidance material will be developed to support the implementation of the quality standards and assist organisations to comply with them. Guidance material will include information about how the standards will be measured. Information will also be developed for consumers to help them to understand the standards and what they can expect. The draft resources will be developed in parallel with the piloting of the standards.

Important notes

- It is proposed that the draft standards discussed in this consultation paper will apply to all aged care organisations that are funded by the Australian Government. This will include residential care services, home care services, flexible care services, CHSP services, and services provided through NATSIFACP.
- As noted above, this consultation paper does not deal with the process that will be used to assess an organisation's performance against the new standards. We will seek your feedback on the assessment options through a separate options paper, entitled Single Aged Care Quality Framework—Options for assessing performance against quality standards—Options paper 2017.

DEVELOPMENT OF THE DRAFT QUALITY STANDARDS AND NEXT STEPS

Development of the draft standards

The department is committed to ensuring that the new standards are based on the experience of consumers, their families and aged care organisations. Also, wherever possible, the new standards should be consistent with standards in other sectors that intersect with aged care (such as healthcare and disability services).

The department has taken several steps in developing the standards to this point:

We closely examined the existing aged care standards to identify their strengths, limitations, gaps and areas of duplication. This highlighted:

- the need to create one set of aged care standards that support a single aged care system
- the importance of moving from a focus on an aged care organisation's processes and systems to creating more outcomes-focused standards.

The department is mindful of the need to reduce unnecessary regulatory burden. Therefore, in developing the standards, we have tried to minimise duplication between the standards, other aged care responsibilities and with other legislation as much as possible.

Also, the draft standards avoid replicating concepts that exist in common law or other legislation. For example, the standards do not expressly state that consumers must not be discriminated against on the basis of gender, because this is already a requirement in existing law; and we have not reproduced fire safety and food safety requirements where they are set out in other legislative schemes.

We reviewed the feedback we have received from consumers, their families and carers and aged care organisations since our review of the Accreditation Standards in 2011.

We sought advice from:

- the Australian Aged Care Quality Agency (the Quality Agency) about the systemic factors that influence better practice and also lead to noncompliance; and the capacity of an assessment body to assess and measure outcomes against both the existing standards and the new draft standards
- the Aged Care Complaints Commissioner about those areas that are most often the subject of complaints.

We closely examined quality standards in similar sectors—for example:

- the Draft National Safety and Quality Health Service Standards (Version 2)
- the National Standards for Disability Services
- the Health and Community Services Standards
- relevant state and territory standards.

The draft standards may not use the same wording as other standards (noting the different legislative and operational environments within which the standards sit), but many of the concepts and principles reflected in those other standards are also reflected in these draft standards.

We reviewed international and national literature on best practice in aged care and related sectors. Some of the key themes that emerged from the literature review were:

- the fundamental importance of consumers being treated with dignity and respect and being able to maintain their identity
- the importance of partnering with consumers to clearly identify consumer needs and preferences to drive the provision of care
- the importance of effective leadership and governance to promote a culture of continuous improvement.

We considered the work of the Aged Care Sector Committee on the Aged Care Roadmap, including the notion of expanding the range and type of organisations that consumers can select to meet their needs.

We have taken into account feedback we received during recent discussions about aged care, including through:

- the department's consultation on other related reforms such as changes to home care to increase consumers' choice and control
- the Quality Dialogue. In the later part of 2015, the Quality Agency sought feedback on a Let's talk about quality discussion paper and held stakeholder forums to explore the concept of quality in aged care. The Quality Dialogue focused on concepts such as putting consumers front and centre and fostering a quality culture that encourages excellence. The feedback from the Quality Dialogue gave us significant insight into the concept of quality in aged care as well as valuable information about what is important to consumers.

We worked closely with a Technical Advisory Group (TAG) that provided advice on the development of the draft standards. The TAG includes experts in standards development, quality management systems, service delivery and accreditation processes, aged care organisations (both private and not-for-profit) and consumer representatives. Members also have experience working in rural and remote settings and with Indigenous consumers, consumers from culturally and linguistically diverse backgrounds and lesbian, gay, bisexual, transgender and intersex (LGBTI) consumers.

These processes and inputs have informed both the approach to, and the content of, the draft standards. But the most important input on the draft standards will be from consumers, their families and carers, aged care organisations, staff of organisations, and other professionals in the aged care sector and related sectors. This input is now being sought through this consultation process.

Next steps

Once we have considered the results of this consultation, the standards will be revised and then the standards will be piloted in the second half of 2017.

Changes to the standards will mean that aged care legislation will also need to be amended so that it refers to the new standards. In addition, the Charters of Care Recipients' Rights and Responsibilities will be reviewed and revised to form a single charter across aged care.

Subject to the agreement of the Australian Government and amendments to the legislation, we expect that the new standards will take effect from 1 July 2018. Further work will also be undertaken to develop any necessary education and guidance material to support the implementation of the new standards.

Your advice

The department seeks your comments on all aspects of the standards. However, we are particularly interested in your comments on:

- whether the standards reflect the matters of most importance and highest priority for the delivery of safe, quality, consumer-centred care and services
- how easy or difficult the outcomes, statements and requirements are to understand
- whether there are any matters missing from the standards that you would expect to be included
- any challenges that organisations might have when they are implementing the standards.

ABOUT THE DRAFT STANDARDS

Concepts reflected in the standards

Focus on consumer outcomes

The draft standards emphasise the consumer and the outcomes that they experience. The standards assume that consumers will continue to make choices and decisions about their care, noting that they may be supported by others to do so. This is consistent with the government's aged care policy, which seeks to create a quality framework focused on consumer experience and quality of life.

Each of the new draft standards is expressed in three ways:

- a statement of outcome for the consumer
- a statement of expectation for the organisation
- organisational requirements to demonstrate that the standard has been met.

This structure allows quality assessors' monitoring processes to focus on both the consumer's experience (outcome) and the systems and processes that the organisation has in place to support the provision of safe and quality care and services.

The draft standards reflect the standard of care and services that the community can expect from all organisations that provide Australian Government funded aged care. Compliance with the standards will be mandatory, and the government may take action on non-compliance either under the aged care legislation or through the funding agreement with the organisation.

However, we recognise that many organisations will choose to go beyond these core standards and provide an even higher quality of care and services.

The change to a more consumer-centred approach will mean that changes must be made to the way that assessments are carried out. As the standards are being developed and finalised, we are working with stakeholders to identify the most appropriate assessment methodology.

Consumer needs, goals and preferences

All of the draft standards refer to the consumer's needs, goals and preferences:

- **needs** are intended to reflect the care and service requirements of the consumer
- **goals** are intended to reflect the future needs or ambitions of the consumer
- **preferences** are intended to reflect how the consumer wishes to have care and services delivered.

For example, a consumer may:

- need support to shower
- have a goal to shower as independently as possible
- have a preference to be supported to shower in the morning by a staff member of the same gender.

Relationship between standards

The standards have been designed to operate together as shown in Figure 1. Therefore, they should not be read or applied in isolation. For example, under Standard 1 (Consumer dignity, autonomy and choice), organisations are required to communicate information effectively in a form that the consumer understands. This requirement is relevant to all information that is given to the consumer, whether it is about care and services planning, feedback and complaints mechanisms or information specific to the organisation. It is also highly relevant to the requirements in Standard 7 (Human resources). Similarly, consumers should be empowered to exercise choice and to influence the care and services they receive to the extent that they wish. This critical concept is the main focus of Standard 1 (Consumer dignity, autonomy and choice), but it will also necessarily apply across all standards.

Application of standards to organisations

The standards that will apply to organisations will depend on the type of care and services that they provide. For example, we expect that all organisations would comply with:

- Standard 1—Consumer dignity, autonomy and choice
- Standard 2—Ongoing assessment and planning with consumers
- Standard 6—Feedback and complaints
- Standard 7—Human resources
- Standard 8—Organisational governance.

However, some standards will apply only where the organisation is providing particular types of care and services. For example:

- Standard 3 (Delivering personal care and/or clinical care) will only apply to organisations that provide personal care or clinical care or both. This standard will apply to all organisations providing residential care, most organisations providing home care and flexible care, but it may not apply to all organisations providing CHSP services
- Standard 4 (Delivering lifestyle services and supports) will likely apply to organisations that are also providing personal care or clinical care, but it could also apply to organisations that are only providing lifestyle services and supports
- Standard 5 (Service environment) will only apply where the organisation is delivering care through a physical environment—for example, residential care services, multi-purpose services, day therapy services, and overnight respite services.

The standards have been structured so that organisations will only have to meet the standards that are relevant to them.

Assessment against standards

Organisations will be required to demonstrate that they meet the standards relevant to them. As part of the development of a single quality framework, the department is also examining ways to streamline the way in which quality assessments are carried out. We have prepared a separate paper that examines options for streamlining (see *Single Aged Care Quality Framework—Options for assessing performance against quality standards—Options paper 2017*).

Terminology

This section defines some of the key terms used in the standards. Definitions are also included in the glossary at the end of this document.

Consumer refers to the person receiving care and services. Where applicable, it may also include the person's representative, carer, family member or substitute decision maker. In some cases, the nature of the standard means that the word 'consumer' can only refer to the person receiving the care—for example, under Standard 1, 'Each consumer is treated with dignity and respect'. In other cases—for example, where the consumer is unable to, or chooses not to, exercise the right or take the responsibility that is referred to in the standard—the word may capture others. For example, where a standard requires an organisation to give certain information to a consumer, this might more appropriately be provided to their representative if the consumer does not have the capacity to understand the information and has chosen a representative to support or assist them. This is consistent with the way the current aged care legislation operates. The aged care legislation refers to 'care recipients' rather than 'consumers', but the same concept applies—the term 'care recipient' can apply to the care recipient and/or their representative depending on the context.

Carer refers to a person who provides personal care, support and assistance to a consumer. This does not include a member of the organisation's workforce such as a person who is contracted or paid to provide those services or a person who provides the services in the course of doing voluntary work for a charitable, welfare or community organisation. This definition is consistent with that used in the Carer Recognition Act 2010.

Organisation refers to the care and services provider. Currently, the aged care legislation uses the term 'approved provider', but this term does not capture providers that deliver CHSP and certain grant-funded NATSIFACP services. As the standards are intended to apply to all organisations that receive an Australian Government subsidy or funding to provide aged care (regardless of whether they are currently an approved provider), we have used the term 'organisation'. The standards will apply to organisations providing:

- residential care
- home care
- flexible care, including innovative care services, multi-purpose services (in a manner consistent with the spirit and intent of the standards), short-term restorative care and transition care
- CHSP
- NATSIFACP services.

Workforce applies to all people working in an organisation who have assigned roles and responsibilities for the care of, administration of, support of or involvement with consumers in the organisation. A member of the workforce is anyone employed, hired, retained or contracted by the organisation (whether directly or through an employment or recruitment agency) to provide care and/or services under the control of the organisation. It also includes volunteers who provide care and/or services on the invitation of the organisation.

Examples of members of the workforce are:

- employees and contractors of the organisation who provide care to consumers (this includes all staff employed, hired, retained or contracted to provide services under the control of the organisation, whether in the residential aged care setting, a community setting or in the consumer's own home)

- allied health professionals contracted by the organisation to provide care to consumers
- kitchen, cleaning, laundry, garden and office personnel that the organisation employs either directly or through a contract agency.

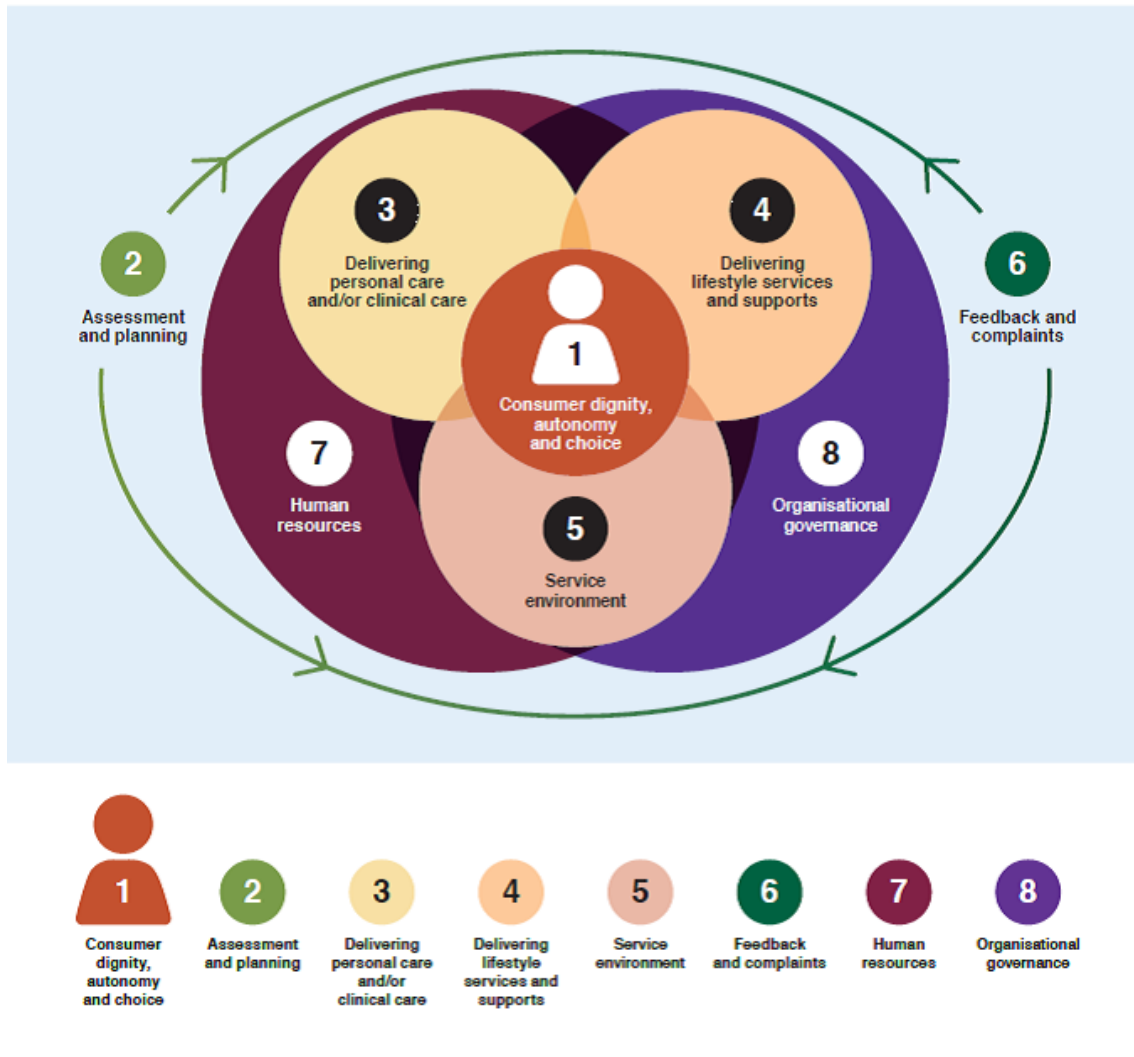
Individuals who are not considered part of the workforce include:

- visiting medical practitioners, pharmacists and other allied health professionals who have been requested by, or on behalf of, a consumer but are not contracted by the organisation
- tradespeople who perform work other than under the control of the organisation (that is, independent contractors)—for example, plumbers, electricians or delivery people who are utilised on an as-needs basis.

In some cases, organisations subcontract or broker the delivery of services such as cleaning services. These organisations would not be separately assessed against the standards by an assessing body. Rather, the organisation that receives funding from the Australian Government would be expected to ensure its workforce (including subcontractors) meets its responsibilities. This is because ultimately the funded organisation will be held responsible for the delivery of safe and quality care and services in accordance with the standards.

Governing body refers to the individual, or group of individuals, with overall responsibility and ultimate accountability for the organisation. In some cases, this may be a Board. In other cases, where the organisation does not have a Board, the CEO or the service owner would be the person with ultimate accountability for the organisation, including for the strategic and operational decisions that affect the safety and quality of care and services.

How quality standards work together



This diagram represents how the draft standards work together. It places consumer dignity, autonomy and choice at the centre and groups the care, services and service environment standards around the consumer to represent the scope of aged care services that an organisation may deliver. Organisational governance and human resources standards support and influence all delivery standards. Assessment and planning and feedback and complaints standards are circling the other standards to demonstrate how these standards inform and drive all aspects of care and continuous improvement.

Figure 1 - How quality standards work together

DRAFT STANDARDS

1. Consumer dignity, autonomy and choice

Consumer outcome
I am treated with dignity and respect, and can maintain my identity. I can make choices about my care and services and how they support me to live the life I choose.
Organisation statement
The organisation: <ul style="list-style-type: none">• has a culture of inclusion, acceptance and respect for consumers• supports consumers to exercise choice and independence.
Requirements
The organisation demonstrates the following: <ol style="list-style-type: none">1.1 Each consumer is treated with dignity and respect.1.2 Each consumer's identity, culture and diversity is respected.1.3 Consumers are able to (or, when needed, supported to):<ol style="list-style-type: none">a. exercise autonomyb. exercise choice and make decisions about their own care and the way that care and services are deliveredc. make connections with others and maintain relationships of choice.1.4 Where a consumer's choices involve risk to their health and/or safety, they are supported to understand the risks, the potential consequences to themselves and others, and how varying degrees of risk can be managed to assist the consumer to live the way they choose.1.5 Information provided to consumers:<ol style="list-style-type: none">a. is current, accurate and effectively communicated in a form that the consumer understandsb. is timely and supports them to exercise choice.1.6 Each consumer's personal privacy and confidentiality is respected and upheld.

Rationale and evidence

Standard 1 reflects five important concepts:

- **Dignity and respect**—Being treated with dignity and respect is essential to quality of life. It includes:
 - recognising strengths and empowering consumers to maintain independence
 - communicating respectfully
 - promoting a consumer's dignity by recognising and respecting their individuality
 - respecting consumers' privacy, including ensuring protection and respect for consumers' personal privacy and belongings
 - supporting consumers to continue to live their lives in keeping with their preferences
 - supporting consumers to maintain their intimate and social relationships as they choose. Research shows that the concepts of agency (a consumer's ability to act

independently and make their own choices) and active participation are particularly important in fostering social inclusion and building social support.¹

- **Identity, culture and diversity**—All aged care services are expected to deliver care that is non-discriminatory and inclusive. For example, all services are expected to deliver services that are culturally, linguistically and LGBTI responsive, inclusive and sensitive. Respecting a person’s identity, culture and diversity also means:
 - understanding an individual’s needs and preferences
 - providing care that is reflective of, and responsive to, their culture, ethnicity, language, gender, sexuality, religion and spirituality.
- **Choice**—The strong message through all consultations and the experience of the department and the Quality Agency is that choice is central to quality of life in aged care. Quality is influenced by the consumer’s right to make informed choices, to understand the range of choices available to them, and to retain independence for as long as they wish. Enabling choice includes recognition that:
 - consumers may have fluctuating levels of capacity that influence their ability to make choices. For example, capacity may relate to cognitive function or the ability to communicate. At times, a consumer may be able to make choices. At other times, they may need additional support or the assistance of a substitute decision maker. Nevertheless, there is a range of decisions that a consumer can make that will support the consumer to live the way they choose and enhance quality of life
 - not all older people wish to exercise control over elements of their care and support. In some cases, the consumer may wish to nominate a representative who will make decisions on their behalf. The standard recognises that in all cases consumers should be empowered to exercise choice and to influence the provision of care and services to the extent that they wish
 - choice is influenced by the role of the organisation and the scope of the agreement between the organisation and the consumer. A consumer’s agreement cannot contain less favourable conditions, rights and responsibilities than those set out in the aged care legislation. However, choice will be subject to the care and services that the organisation is required to provide
 - in some cases, access to a range of organisations and to particular care and services may be limited by location and environment
 - consumers will not always be able to exercise unfettered choice, including where this adversely impacts on others. For example, a consumer may choose to watch a certain program on television at high volume in a shared living area. The consumer’s desire to do this may be restricted by the wishes and needs of others. However, there may be other options for assisting the consumer to watch television at a higher volume—the consumer can use headphones, the use of the television can be scheduled or the consumer could have a television in their bedroom.

¹ Aged and Community Services Australia, *Social isolation and loneliness among older Australians*, Issues Paper No. 1, October 2015, p. 10.

- **Opportunity to take risks**—In consultations about quality, both consumers and organisations have raised the concept of ‘dignity of risk’—that is, the right for consumers to make their own choices about their care and services—and the need to balance management of risk to older persons with preserving their autonomy and right to choose. The standard therefore emphasises:
 - the need for organisations to support consumers to understand the consequences of their choices
 - the nature of any risks to the consumer and others
 - how risk can be managed to assist consumers to live in the way they choose.
- **Information**—Giving consumers timely information that they understand is critical to their ability to make an informed choice. The kind of information and the way it is communicated will be influenced by both the capacity and the needs of individual consumers.

2. Ongoing assessment and planning with consumers

Consumer outcome
I am a partner in the ongoing assessment and planning of my care and services.
Organisation statement
The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and wellbeing in accordance with the consumer's needs, goals and preferences.
Requirements
<p>The organisation demonstrates the following:</p> <p>2.1 Ongoing partnership with the consumer and/or their family and carer in assessment and planning of their care and services.</p> <p>2.2 Assessment and planning:</p> <ul style="list-style-type: none">a. identifies the consumer's current needs, goals and preferencesb. focuses on optimising health and wellbeingc. includes the role of, and relevant information from, other providers, organisations and individuals in responding to the needs and preferences of the consumerd. is reviewed regularly and when circumstances change or when incidents impact on the needs, goals or preferences of the consumere. informs the delivery of safe and quality care and servicesf. includes advance care planning and end of life planning if the consumer wishesg. is documented in a care and services plan that is available where the care and services are provided and to the consumer if requested. <p>2.3 Care and services are implemented and continuously monitored and evaluated for effectiveness.</p> <p>2.4 Effective and timely collaboration and communication with others responds to the needs, goals and preferences of, and risks to, the consumer to ensure the continuity of care and services.</p>

Rationale and evidence

Assessment and planning:

- informs the delivery of safe and quality care and services in accordance with the needs, goals and preferences of the consumer
- mitigates the risk of adverse outcomes for consumers.

This position is well supported in international literature and reflected in a range of national standards² and international standards.

Standard 2 reflects a number of important concepts:

² Such as the Australian Commission of Safety and Quality in Health Care Draft National Safety and Quality Health Service Standards (Version 2).

- **Partnering with the consumer**—Understand the consumer’s needs and wishes from the very beginning of the care relationship is the foundation for ensuring that their needs, goals and preferences are addressed and consumer-centred care is delivered. Partnering involves sharing information in an ongoing way, seeking feedback from the consumer and supporting and encouraging consumers to participate in planning their own care to the extent they wish. At the consumer’s discretion, partnering may also involve working with the family members, carers and others to set goals and make decisions about care. The importance of partnering with consumers is consistent with consumer expectations and is comprehensively addressed in other national standards.³
- **Assessment and planning is an ongoing and iterative process**—Assessment and planning should:
 - focus on optimising a consumer’s health and wellbeing, reablement, and improving functional participation. Planning is an opportunity to explore how the service might improve or restore the consumer’s functioning and overall wellbeing
 - reflect changes in the care needs of the consumer over time, along with changes in their goals and preferences
 - include advance care planning and end of life planning where the consumer wishes.⁴
- **Care and services plans**—A care and services plan must reflect the outcomes of assessment and planning for each consumer. The Quality Agency has found that accurate, appropriate and current care and services plans are inextricably linked to the delivery of safe and quality care and services and positive outcomes for consumers. The plan may take different forms, but it should be available to those providing care to the consumer and be updated as the consumer’s needs, goals and preferences change, and following care transitions (such as returning from a hospital stay).
- **Effective and timely collaboration and communication with others**—To ensure that assessment and planning can support comprehensive, coordinated and safe care and services, organisations need to:
 - understand the role of collaboration and communication with others
 - ensure that the information they receive from others is incorporated into the care plans
 - ensure that communication with others is timely and effective.

Strong networks with other organisations providing care and services underpin effective assessment and planning and enable organisations to respond to the diverse needs of consumers.

The standard recognises that one organisation is unlikely to be able to provide all the necessary care and services in response to the needs, goals and preferences of consumers. It also identifies the importance of information sharing in managing risks to consumers—for example, where a consumer is moving from hospital to a residential care service. Information sharing can take a variety of forms—for example, it may involve a home care provider leaving notes for a consumer’s carer between visits to ensure that relevant information is shared.

³ Including the Australian Commission of Safety and Quality in Health Care Draft National Safety and Quality Health Service Standards (Version 2) and the National Standards for Disability Services.

⁴ It is recognised that these terms are used interchangeably in some jurisdictions and separately in others. The focus of the standard is on ensuring that the consumer’s wishes are identified and reflected in the delivery of care.

3. Delivering personal care and/or clinical care

<p>Consumer outcome</p>
<p>I get personal care and/or clinical care that is safe and right for me.</p>
<p>Organisation statement</p>
<p>Personal care and clinical care services are delivered in accordance with the consumer's needs and preferences to optimise health and wellbeing and to maximise the consumer's function.</p>
<p>Requirements</p>
<p>The organisation demonstrates the following:</p> <ul style="list-style-type: none"> 3.1 Personal care is safe, effective, aligns with the consumer's preferences, and optimises their health and wellbeing. 3.2 Clinical care is best practice, appropriate to the consumer, involves shared decision making and optimises the consumer's health and wellbeing. 3.3 The needs and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. 3.4 Sudden or unexpected deterioration or change of a consumer's function, capacity or physical condition is recognised and responded to in a timely manner. 3.5 Where care that the consumer requires is not an expected component of services provided, the service facilitates timely referrals to other providers, organisations and individuals. 3.6 Critical information about the consumer's condition, needs and preferences is communicated within the organisation or with relevant others where responsibility for care is shared and care is coordinated. 3.7 Identification and management of high-impact or high-prevalence risks associated with the care of each consumer, including but not limited to falls, pressure injuries, medication misadventure, choking, malnutrition, dehydration, pain and delirium. 3.8 Minimisation of infection-related risks to consumers, workforce and the broader community through implementing: <ul style="list-style-type: none"> a. standard and transmission-based precautions to prevent and control infection b. antimicrobial stewardship.

Rationale and evidence

The delivery of safe, effective and quality personal and clinical care is a basic consumer and community expectation. Standard 3 sets out the key requirements that underpin the delivery of consumer-centred, safe, effective and quality personal care and clinical care. The standard would apply to any service that delivers personal care (such as bathing, assistance with toileting, and assistance with eating) or clinical care (such as nursing care).

Standard 3 reflects the following concepts:

- **Clinical care is best practice**—‘Best practice’ means that, to achieve the best possible outcomes for consumers, the diagnosis, treatment or care that is provided is timely and based on the best available evidence. ‘Best available evidence’ recognises that there is not always strong evidence for all aspects of clinical care. However, where evidence is available, this should be relied on to inform the provision of best-practice clinical care. The use of this term is consistent with the Draft National Safety and Quality Health Service Standards (Version 2) and also the National Standards for Disability Services.
- **Connected and comprehensive care**—Organisations that provide aged care are expected to have strong networks with other health professionals and service providers to ensure that, when the organisation cannot meet the consumer’s needs, there is appropriate referral to, or involvement of, others. In order to deliver good clinical care and personal care outcomes, critical information must be shared throughout the care process—both within the organisation and with other organisations and individuals. This includes strong clinical care and personal care handovers and effective referral and coordination pathways. Research from a number of sources suggests that the risk of discontinuity in care is minimised when there is strong dialogue and exchange of information between relevant providers. Advance care planning also helps to ensure that decisions on transitions between care providers are in line with the consumer’s wishes.
- **End of life care**—The standard expressly requires that the needs and preferences of consumers who are nearing end of life are recognised, their comfort is maximised and their dignity is preserved. Comprehensive care at the end of life should be consistent with the principles of consumer-centred, goal-directed and compassionate care that are set out in the *National consensus statement: essential elements for safe and high-quality end-of-life care*.⁵
- **Unexpected deterioration or change**—The standard requires that sudden or unexpected deterioration or change in a consumer’s function, capacity or physical condition is recognised and responded to in a timely manner. This requirement was included because there is evidence that:
 - warning signs of clinical deterioration are not always identified or acted on appropriately⁶
 - early identification of deterioration may improve outcomes for the consumer and lessen the degree of intervention that is needed in the future.

The workforce must be able to recognise and respond to sudden or unexpected deterioration of a consumer’s condition—for example, they must know the signs and symptoms, and there must be consistent monitoring of a consumer’s wellbeing and effective communication of concerns during handover.

The organisation must have effective systems for responding to deterioration. To improve care, organisations should also collect, analyse and use information resulting from incidents (such as an event that resulted, or could have resulted, in unintended or unnecessary harm to a consumer).

- **Identification and management of high-impact or high-prevalence risks to the consumer**—Different consumers will have different clinical and personal care needs. This standard requires organisations that deliver personal and/or clinical care to have systems in

⁵ Australian Commission of Safety and Quality in Health Care, *National consensus statement: essential elements for safe and high-quality end-of-life care*, Sydney, 2015.

⁶ Such as in the Australian Commission of Safety and Quality in Health Care, *Draft National Safety and Quality Health Services Standards, Version 2*, p. 59.

place that enable them to identify and manage personal care and clinical risks for each consumer. For older people, some risks are more likely to present or to have a high impact if they are not managed appropriately. The standard therefore sets out some risks that are often present in the aged population and lead to poor health outcomes or adverse events. However, it does not limit the requirements for risk management to these risks only. The examples given in the standard are:

- **Falls**—Falls are a significant cause of harm to older people, however, many falls can be prevented. Best practice in fall and injury prevention includes implementing fall prevention strategies, or identifying falls risks and implementing targeted, individualised strategies that are resourced adequately, and monitored and reviewed regularly.⁷ Organisations would be expected to engage with consumers to put in place strategies to minimise the risk of falls and to minimise harm from falls
- **Choking**—Swallowing difficulties are prevalent among older people. Unmanaged swallowing problems can lead to death as a result of choking. Organisations would be expected to identify the risks associated with choking and to put in place strategies to reduce the risk, in consultation with consumers
- **Adverse events or outcomes from medication misadventure**—Studies have highlighted the impact of medication misadventure, including medication errors, on avoidable hospital admissions, morbidity and mortality. Older people living in aged care homes generally have multiple medical conditions and use of a number of drugs together, and are at high risk of drug-related problems.⁸ Organisations would be expected to have in place policies and procedures that support quality use of medicines⁹
- **Delirium**—Delirium remains a common¹⁰, serious and under-recognised problem that affects many older people. Poor recognition of the signs of delirium is an obstacle to the provision of quality care. Organisations that deliver clinical care would be expected to have strategies to enable early identification and management of delirium and its underlying causes¹¹
- **Pain management**—Appropriate pain management is critical to a consumer's quality of life. This should continue to be a focus of the provision of quality clinical care
- **Pressure injuries**—Pressure injuries are a major contributor to morbidity and decreased quality of life in residential care. Australian research in this area has reported prevalences of pressure injuries ranging from 26% to 42% of care

⁷ Australian Commission on Safety and Quality in Health Care, *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Community Care 2009*, Sydney, ACSQHC: 2009; Australian Commission on Safety and Quality in Health Care, *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Facilities 2009*, Sydney, ACSQHC: 2009.

⁸ For example, Nishtala, PS et al. 2011, 'A retrospective study of drug-related problems in Australian aged care homes: medication reviews involving pharmacists and general practitioners', *Journal of Evaluation in Clinical Practice* vol. 17, no. 1, pp. 97–103.

⁹ *The National Strategy for Quality Use of Medicines*, Commonwealth of Australia. 2002

¹⁰ *Position Statement 13 Delirium in Older People*, Australian and New Zealand Society for Geriatric Medicine, Revised 2012.

¹¹ For further information, see Clinical Epidemiology and Health Service Evaluation Unit, Melbourne Health, & Delirium Clinical Guidelines Expert Working Group 2006, *Clinical practice guidelines for the management of delirium in older people*, AHMAC Health Care of Older Australians Standing Committee 2006, Victorian Government Department of Human Services, Melbourne.

recipients.¹² Organisations would be expected to minimise the risk of pressure injuries for susceptible consumers

- **Malnutrition and dehydration**—Under-nutrition and dehydration are associated with infections (including urinary tract infections and pneumonia), pressure ulcers, anaemia, hypotension, confusion and impaired cognition, decreased wound healing, and hip fractures. Organisations that provide residential care would be expected to manage these risks for each consumer.

The examples given in the standard are not an exhaustive list of all the clinical issues that may arise. Rather, they indicate some of the risks that organisations are expected to identify and manage when providing clinical care to consumers. By appropriately managing risks, the outcome for the consumer is safe and appropriate care that optimises their health and wellbeing.

- **Infection prevention and control**—Infection management minimises the risk of transmission by isolating infectious agents (or a person) and applying standards and transmission-based precautions as safe work practice in aged care services. Infection prevention and control programs will vary in scope and complexity depending on the nature of the care being provided and the local context and risk.¹³
- **Antimicrobial stewardship**—The inappropriate use of antimicrobials, including antibiotics, leads to the emergence of antimicrobial resistant (AMR) infections. AMR infections significantly affect consumers' safety and wellbeing because they require more complex and longer treatments and result in increased morbidity and mortality. AMR infections not only impact on the individual consumer but can also spread and affect other consumers. Good antimicrobial stewardship preserves the effectiveness of antimicrobials that are currently available and is therefore key to providing quality care to older people and reducing the growth in resistant organisms.

In 2014, the World Health Organization published a global report on AMR and the importance of preventing and containing AMR. Since that time, the Australian Government has developed Australia's first National AMR Strategy 2015–2019,¹⁴ which focuses on minimising the development and spread of AMR across all health and aged care settings.

We acknowledge that, ultimately, medical practitioners are responsible for prescribing antimicrobials. However, effective antimicrobial stewardship ensures that the risks of AMR are minimised. Organisations are expected to adopt measures to minimise AMR such as:

- increasing awareness within the organisation about AMR
- administering antibiotics appropriately (which can minimise the length of time antibiotics are required)
- adopting care strategies to minimise the need for antibiotics (such as measures to reduce the risk of urinary tract infections or treat minor skin infections).

¹² For example, Santamaria, N et al. 2009, 'Reducing pressure ulcer prevalence in residential aged care: results from phase II of the PRIME trial', *Wound Practice and Research*, vol. 17, no. 1, pp. 12–22.

¹³ National Health and Medical Research Council 2010, *Australian guidelines for the prevention and control of infection in healthcare*, Commonwealth of Australia, Canberra.

¹⁴ Australian Government, Department of Health & Department of Agriculture 2015, *Responding to the threat of antimicrobial resistance: Australia's first National Antimicrobial Resistance Strategy 2015–2019*, Commonwealth of Australia, Canberra.

4. Delivering lifestyle services and supports

Consumer outcome
I get the services and supports I need to help me do the things I want to do.
Organisation statement
The organisation facilitates the consumer's access to services and supports that enhance wellbeing and quality of life.
Requirements
The organisation demonstrates the following: 4.1. Lifestyle services and supports: a. are aligned with the consumer's needs and preferences b. focus on optimising the consumer's wellbeing and quality of life. 4.2. Consumers are supported to: a. participate in the community within and outside the service b. select and maintain social and personal relationships c. do the things of interest to them. 4.3. Information about the consumer's needs and preferences is communicated within the organisation and with relevant others where responsibility for services is shared and services are coordinated.

Rationale and evidence

Some organisations may not deliver personal care and clinical care, or they may deliver other services in conjunction with personal care or clinical care. The standards refer to those other services as lifestyle services and supports. Some examples of lifestyle services and supports are:

- domestic assistance, such as cleaning and laundry services
- food services, including meals, food advice, delivery and preparation
- services to:
 - encourage and support consumers to engage in social activity and to participate in a wide range of interests and activities of interest to them
 - take part in community life.

Standard 4 requires organisations to provide lifestyle services and supports in a way that enhances a consumer's wellbeing and quality of life. As part of comprehensive assessment and planning, the organisation (in partnership with the consumer) would identify activities that are meaningful and of interest to the consumer.

To support the consumer to engage in chosen activities, an organisation may need to:

- expand the scope of activities that it offers so that individual interests can be fostered
- provide opportunities to participate in activities outside of the service.

The standard recognises:

- that lifestyle services and supports should be provided in line with any clinical advice about a particular consumer. For example, catering services may need to be modified to avoid particular foods for some consumers (due to allergies, diabetes or cultural needs) or have food texture modified for consumers who have difficulty swallowing
- the role that organisations have in supporting consumers to maintain and develop relationships both within and outside of the service. This is particularly relevant for consumers who are in residential care. Research shows that social isolation can influence depression and reduce quality of life for older people. The standard requires that organisations support each consumer as far as possible (consistent with the consumer's preferences) to maintain relationships of choice.¹⁵ Social inclusion for consumers in residential aged care facilities is not just about giving consumers opportunities to join in various activities that the service provides; it is also about ensuring that consumers feel socially connected, have control over their lives, have privacy, and are able to contribute to those they feel connected to¹⁶
- that an organisation cannot necessarily provide all of the lifestyle services or activities that are necessary to sustain quality of life for each consumer. However, it is expected that the organisation would support the consumer to pursue activities they are interested in, engage in meaningful social activities and maintain and develop relationships to the extent that they wish.

¹⁵ Knight, T & Mellor, D 2007, 'Social inclusion of older adults in care: Is it just a question of providing activities?', *International Journal of Qualitative Studies on Health and Well-being*, vol. 2, pp. 76–85.

¹⁶ Ibid.

5. Service environment

Consumer outcome
I feel safe and comfortable in the service's physical environment.
Organisation statement
The organisation provides a safe, secure and comfortable service environment that promotes independence, function and enjoyment.
Requirements
The organisation demonstrates the following: 5.1. Consumers experience: a. a safe, clean, secure, well-maintained and comfortable service environment b. a welcoming and culturally appropriate service environment comfortable internal temperatures, ventilation and noise levels c. suitable furniture and equipment. 5.2. The design and layout of the service optimises consumer independence and function. 5.3. Consumers can move freely within the service environment, including both indoor and outdoor areas. 5.4. Consumers can personalise their environment.

Rationale and evidence

Standard 5 relates to the physical environment that the organisation provides for residential care, respite care and day therapy centres. The standard is not intended to:

- duplicate work, health and safety laws or requirements under building legislation
- apply to home care where the service environment is the consumer's home
- extend to all environments that consumers might visit, such as bowling clubs or libraries.

The focus of the standard is on ensuring that, where the organisation is providing a physical environment, the environment is fit for purpose, supports quality of life and promotes independence, function and enjoyment for consumers. For example, organisations could consider:

- whether the design and layout of the service supports consumers' ability to participate in the service community and allows them to move about the service¹⁷
- how consumers are supported to move freely within the service environment (including access to outdoor areas that may at times be secure)
- if the environment encourages consumers to interact
- if consumers in residential care can have somewhere to go that is private
- whether consumers are able to make full use of the resources available to them
- encouraging consumers to personalise their living areas (consistent with the organisation's work, health and safety obligations)

¹⁷ Fleming, R & Purandare, N 2010, 'Long-term care for people with dementia: environmental design guidelines', *International Psychogeriatrics*, vol. 22, no. 7, pp. 1084–96.

- ensuring the environment is welcoming and culturally appropriate in that it reflects the cultural, linguistic and spiritual needs of the consumers who use the environment.

The standard therefore covers more than just security and safety; it also recognises that a clean, comfortable, welcoming and well-maintained environment is essential to quality of life.

6. Feedback and complaints

Consumer outcome
When I give feedback or make complaints, I see appropriate action taken. I feel safe and comfortable making complaints.
Organisation statement
Regular input and feedback from consumers, carers, the workforce and others is sought and is used to inform individual and organisation-wide continuous improvements.
Requirements
The organisation demonstrates the following: 6.1. The organisation uses an effective feedback and complaints resolution system based on fairness, accessibility, responsiveness, open disclosure, resolution and learning. 6.2. Regular feedback is sought from consumers, carers, the workforce and others about their experiences of the service. 6.3. Consumers, carers and others are encouraged and supported to make complaints, provide feedback and access advocacy services, language services and other mechanisms for resolving complaints. 6.4. The workforce is supported to recognise, report and appropriately respond to complaints. 6.5. Systems are in place to ensure information from feedback and complaints is used to drive continuous improvement in the quality of care and services.

Rationale and evidence

Standard 6 has been developed in close consultation with the Aged Care Complaints Commissioner to ensure that it is consistent with contemporary best practice for complaints management. The content of the standard reflects the key stages of effective complaints management as described in the Better practice guide to complaint handling in aged care services.¹⁸ For example, the requirement to demonstrate open disclosure aligns the standard with contemporary practice regarding the principles of open communication and transparent processes, including acknowledgement and apology when failings are identified.

The standard is intended to:

- be more comprehensive than existing requirements by encouraging consumers to provide feedback to their organisation about their experience within the service, whether positive or negative
- focus on those qualities of a complaints management system that drive continuous improvement, inform service improvements and achieve resolution of issues for consumers and others.

The standard also:

¹⁸ Aged Care Complaints Commissioner 2016, *Better practice guide to complaint handling in aged care services*, Commonwealth of Australia, Canberra.

- recognises that local resolution of complaints leads to faster and more sustainable outcomes and is more likely to preserve and build the relationship between the consumer and the organisation
- acknowledges that it is important for consumers to feel safe and comfortable in giving feedback or making a complaint
- reflects the fact that to allow for continuous improvement, it is important to monitor and report on the actions that are taken as a result of feedback and complaints.

Some consumers will face particular and additional barriers to providing feedback and making complaints. The consumer may have cognitive or communication difficulties, or language or cultural barriers. In some cases the nature of the complaint may be particularly sensitive or private. Organisations are expected to support consumers to make complaints. The kinds of support the organisation offers might include:

- making sure the consumer feels comfortable and safe to make a complaint
- offering a third party to record the complaint
- giving the consumer access to resources about how to make complaints and what they can complain about.

An organisation's complaints resolution system must be accessible, confidential, prompt and fair; and it must support all consumers to make a complaint or give feedback.

7. Human resources

Consumer outcome
I get quality care and services when I need them from people who are knowledgeable and considerate.
Organisation statement
The organisation has sufficient skilled and qualified workforce to provide safe, respectful and quality care and services.
Requirements
<p>The organisation demonstrates the following:</p> <ul style="list-style-type: none">7.1. Sufficient workforce to deliver and manage safe and quality care and services.7.2. Each member of the workforce:<ul style="list-style-type: none">a. interacts with consumers in a way that is culturally appropriate, respectful and considerateb. has the skills, capabilities, qualifications, knowledge, attributes and attitude to effectively perform their role.7.3. The workforce is supported, trained and equipped to deliver the outcomes required by these standards.7.4. The organisation listens to, and communicates with, the workforce about the safety and quality of care and services.7.5. Ongoing assessment, monitoring and review of:<ul style="list-style-type: none">a. the roles, responsibilities and accountabilities of the workforceb. the suitability of the staffing model to deliver safe and quality care and servicesc. the performance of each member of the workforce.

Rationale and evidence

The critical focus of Standard 7 is that the organisation has a skilled and qualified workforce sufficient to deliver and manage safe and quality care and services.

An effective human resources system supports the competency of an organisation's workforce and the delivery of safe, respectful and quality care and services.¹⁹

Standard 7 contains five key concepts:

- **The sufficiency of an organisation's workforce**—This requirement relates to the organisation's workforce profile and its capacity to meet its responsibilities to deliver safe, quality care.

Organisations providing residential and community aged care services are required to ensure they have adequate numbers of appropriately skilled staff to meet consumers' needs. It is the responsibility of individual services to use Australian Government funding to ensure they

¹⁹ Quality Improvement Council (QIC), Health and Community Service Standards, <http://www.qip.com.au/standards/quality-improvement-council-qic-health-and-community-services-standards/>

have the staffing mix and numbers they require for their consumers to receive high-quality care.

In addition, organisations must have systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, including state government requirements for the qualifications of nursing and care personnel.

- **The attributes, attitude and performance of the workforce**—This requirement highlights that, in addition to the skills, capabilities, qualifications and knowledge that the workforce must have to perform their role effectively, the way that the role is performed is also important. A strong theme that emerged through the Quality Dialogue was the need for staff to respect consumers and to have the ability to communicate and engage in positive relationships. A commitment to consumer-centred care fosters appropriate interactions with individual consumers to identify their strengths and understand their goals.

Each member of the workforce would be expected to operate within their scope of practice where required. ‘Scope of practice’ refers to the practices that an individual may engage in consistent with their professional registration, standards, qualifications, skills, knowledge, experience and professional suitability.

The National Regulation and Accreditation Scheme (NRAS) regulates matters to do with the qualifications and professional standards of some health professions, and some other allied health professions regulate these through their professional bodies. However, regulation and registration does not extend to all staff within an aged care service, including personal care assistants and others. Also, the NRAS does not address the attributes and attitude of the organisation’s workforce and the way in which members of the workforce interact with consumers. Standard 7 (Human resources) is intended to address these matters for all members of the workforce.

- **Organisational support for the workforce**—The workforce should be supported, trained and equipped to deliver the outcomes that these standards require. The standard also highlights the significance of listening to, and communicating with, the workforce about the safety and quality of care and services.
- **Assessment, monitoring and review**—The standard requires the organisation to regularly assess, monitor and review the make-up, suitability and performance of its workforce. This is critical to the organisation’s ability to deliver safe and quality services that are responsive to consumers’ needs and preferences.

8. Organisational governance

Consumer outcome
I am confident the organisation is well run and that the consumer voice and experience is sought and heard.
Organisation statement
The governing body is accountable for safe and quality care and services.
Requirements
<p>The organisation demonstrates the following:</p> <ul style="list-style-type: none">8.1. The organisation partners with consumers in the planning, delivery and evaluation of care and services.8.2. Defined roles, responsibilities and accountabilities within the organisation that are clearly assigned to, and understood by, the workforce.8.3. Organisation-wide systems for:<ul style="list-style-type: none">a. reviewing compliance with legislative requirements and relevant standardsb. continuous improvement that focuses on safe and quality care and servicesc. risk management that incorporates identification, analysis and management of risks and incidents that impact on consumers or on the provision of care and servicesd. information management.8.4. The organisation's governing body:<ul style="list-style-type: none">a. makes quality care and services an organisational priorityb. seeks, listens to and learns from the experience of consumers, carers, the workforce and communityc. provides integrated corporate and clinical governance and leadership and sets strategies to deliver safe and quality care and services that enhance the consumer's quality of lifed. monitors and supervises the performance of the organisation against the standards.

Rationale and evidence

Governance refers to the framework of rules, systems and processes put in place to control and monitor an organisation. Good governance underpins good conduct and the good judgment of those who are charged with running an organisation.²⁰ A systematic approach to governance allows organisations to manage their affairs with proper oversight and accountability, and it is a cornerstone for the provision of safe and quality care and services.

Different organisations have different corporate structures and governing bodies. For example, some rely on a Board, while other single-person organisations may rely on the same person to perform managerial, service delivery and governance functions. The standard recognises the crucial role that the governing body (however it is constituted) plays in driving the organisation and achieving quality outcomes for consumers.

²⁰ Australian Institute of Company Directors, *Guiding principles of good governance*.

Research conducted in Australia and overseas notes the importance of leaders in influencing the quality of care by supporting staff, shaping culture, setting direction, and monitoring progress in safety and quality performance. The standard focuses on the importance of active leadership, and the need for strategies for the delivery of safe and quality care to be set and monitored.

The standard also introduces the concepts of partnering with consumers, and accountability to consumers, their carers and the community. It requires the organisation to demonstrate that it seeks consumers' views, listens to them and learns from their experience.

Standard 8 requires organisations to have following organisation-wide systems in place:

- **Compliance with relevant requirements**—As part of its system of governance, the organisation must have a system for identifying and reviewing compliance with its regulatory responsibilities. It is not intended that the Quality Agency would examine whether the organisation is complying with its responsibilities under all of the applicable laws identified (because this is the responsibility of each of the relevant regulatory bodies).
- **Continuous improvement**—Organisations with strong cultures of continuous improvement have sound governance capabilities that enable them to identify improvement opportunities, manage resources effectively and prioritise quality outcomes. It is expected that continuous improvement would be demonstrated against all standards.
- **Risk management**—Organisation-wide risk management is indivisible from good governance, and effective risk management underpins all the draft standards. It is expected that incidents (be they clinical incidents or incidents relating to the provision of personal care or lifestyle services) would be identified through the organisation's risk management system, analysed and used to improve the organisation's performance and delivery of quality care and services.
- **Information systems**—Organisations must have secure, appropriate and effective information systems.

Clinical governance is a discrete concept. However, in organisations that deliver clinical care, it is expected that clinical governance would be an integral part of the corporate governance of the organisation so that, ultimately, the governing body is accountable for the safety and quality of the care and services that the organisation provides. Extensive research in the healthcare sector has identified the impact of good clinical governance on service performance. Key aspects of effective clinical governance include:

- strong clinical leadership (including defined accountability that is clearly communicated and understood)
- comprehensive policies and procedures, including in relation to evidence-based care, scope of clinical practice, incident and risk management, and record keeping
- management and monitoring of clinical performance and effectiveness.

The standard is intended to encourage managers and the governing body, as well as clinicians, to be engaged in clinical governance and quality improvement so that clinical and managerial priorities are aligned.

The standard:

- recognises that there is no 'one size fits all' solution for effective governance. Factors that may influence how an organisation is governed include:
 - the size of the organisation
 - the nature of the organisation's activities (for example, complexity, risks, geography)
 - the organisation's values and constitution.
- can be assessed at the service level or at the organisation level. It is intended that assessment against the standard could be tailored so that the standard could be applied in any organisation, no matter how large or small.
- is not intended to be a comprehensive statement of all matters relevant to good governance. For example, it does not specify the requirements of organisations such as the Australian Securities and Investments Commission or the Australian Charities and Not-for-profits Commission, to which many organisations are also subject. Rather, it focuses on those aspects of governance that are critical to the provision of consumer-centred, quality care and services. The matters that are specifically referred to in the standard reflect those areas that are:
 - challenging for some organisations
 - at the heart of organisational failure in aged care
 - consistently identified by the Quality Agency as indicators of performance and overall quality of care.

GLOSSARY

Terminology and Definitions

Advance care planning

A process for exploring a consumer's preferences about health and personal care and preferred health outcomes. An advance care plan may be used to guide decisions about care.

Aged care service

An aged care service that delivers:

- residential care
- home care
- flexible care (including multipurpose services, innovative care services, short-term restorative care and transition care)
- the Commonwealth Home Support Program

Antimicrobial resistance

Failure of an antimicrobial (a chemical substance that inhibits or destroys bacteria, viruses or fungi) to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.

Antimicrobial stewardship

Ongoing actions by organisations to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate a broad range of strategies, including monitoring and review of antimicrobial use.

Best practice (in the context of clinical care)

The diagnosis, treatment or care provided is timely and based on the best available evidence, which is used to achieve the best possible outcomes for consumers.

Carer

A person who provides personal care, support and assistance to a consumer. This does not include a member of the organisation's workforce, such as a person who is contracted or paid to provide the services or a person who provides the services in the course of doing voluntary work for a charitable, welfare or community organisation.

Clinical governance

An integrated component of corporate governance in organisations that provide clinical care. It encompasses the systems used by organisations, from Boards to the frontline clinical and other workforce, to account to consumers and the community for assuming the delivery of safe, effective, consistent, consumer-centred clinical care and for continuously improving the safety and quality of clinical care and services.

Consumer

The person receiving care and services. Where applicable, it may also include the person's representative, carer, family member or substitute decision maker. For further information, see page 12.

Consumer-centred care

An approach to the planning, delivery and evaluation of care and services that is founded in mutually beneficial partnerships among consumers and organisations. Consumer-centred care is respectful of, and responsive to, the preferences, needs and values of consumers.

Continuous improvement

A systematic, ongoing program to raise an organisation's performance to meet and maintain a set of standards or requirements; and to pursue consistently safe, quality care and services for each consumer.

An organisational continuous improvement system:

- is planned and systematic. It focuses on achieving compliance requirements, it responds to the needs and feedback of consumers and other stakeholders, and it continuously improves the standard of care and services for each consumer
- actively develops an organisational culture where the workforce is supported to pursue safe and quality care and services through improvement and innovation
- regularly monitors and assesses how well organisational systems are working to provide safe and quality care and services and the outcomes that have been achieved
- makes changes and improvements in response to monitoring and feedback
- is focused on results and demonstrates improvement in processes, outputs and outcomes.

Diversity

A systematic, ongoing program to raise an organisation's performance to meet and maintain a set of standards or requirements; and to pursue consistently safe, quality care and services for each consumer.

The varying social, economic and geographic circumstances of consumers as well as their cultural backgrounds, religions, beliefs, practices and languages. The term also covers people of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender or intersex (LGBTI)).

Continuous improvement

A systematic, ongoing program to raise an organisation's performance to meet and maintain a set of standards or requirements; and to pursue consistently safe, quality care and services for each consumer.

End of life care

The care provided to consumers when they are nearing the end of their life. It can include physical, spiritual and psychological support.

Governing body

The individual, or group of individuals, with overall accountability and ultimate accountability for the organisation. For further information, see page 13.

Medication Misadventure

A medication incident, medication error, adverse drug event or adverse drug reaction.

Open disclosure

The open discussion of adverse events or concerns and exchange of information between people.

Open disclosure may include:

- an apology or expression of regret
- a factual explanation of what happened
- an opportunity for the consumer, their family, carers and representatives to describe their experience
- a discussion of the potential consequences of the adverse event or concern
- an explanation of the steps being taken to manage the adverse event or concern and prevent reoccurrence.

Reablement

Assistance provided that aims to assist a person to maximise his or her independence and autonomy. Reablement supports are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Supports could include training in a new skill, modification to a person's home environment, or having access to equipment or assistive technology.

Representative

A person who is nominated by the consumer as a person to be told about matters affecting the consumer; or a person who nominates himself or herself as a person to be told about matters affecting a consumer; and who the organisation is satisfied has a connection with the consumer and is concerned for the safety, health and wellbeing of the consumer.

Risk management

The design and implementation of a program to identify and avoid organisational risks to consumers, the workforce, visitors and the organisation.

Shared decision making (in the context of clinical care)

A consultation process in which a clinician and a consumer jointly participate in making a health decision, having discussed the options and their benefits and harms and having considered the consumer's values, preferences and circumstances.