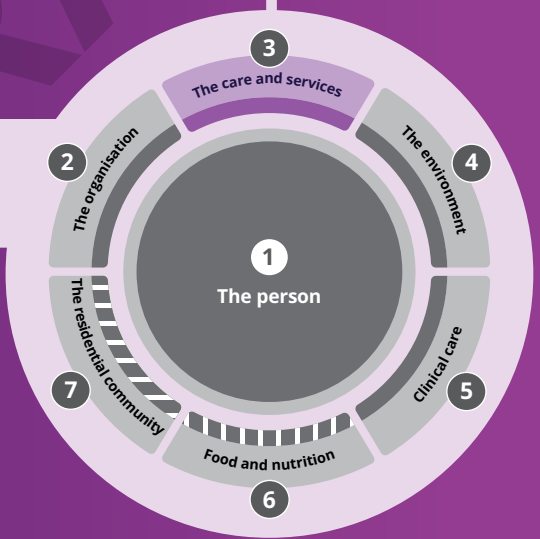
Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Draft
Standard 3
Care and Services

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

January 2024



Contents

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

Purpose of the guidance

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

This draft guidance material is intended to support providers to comply with the strengthened Quality Standards.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

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 The draft guidance shows how providers can demonstrate they meet each Standard outcome.

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

Consultation

We are consulting on the draft guidance materials for providers that deliver government-funded aged care services.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

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

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

- Have you read and understood the draft Guidance material for the strengthened Quality Standard?
- To what extent do you feel the draft Guidance is fit-for-purpose for the different service types you deliver?
- To what extent do you feel the draft Guidance easy to understand and interpret?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

You can provide your feedback by filling in this feedback form or using the QR code on this page before midday (AEST) on 30 April 2024.

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

Structure of this document

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

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

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

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

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

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

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

Guidance on Standard 3: The Care and Services

What is the intent?

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

In delivering care and services, providers and workers must draw on all relevant

Standards, with particular reference to Standard 1, including to ensure care is tailored to the individual and what's important to them. Family and carers are recognised as having an important role in assisting or providing care and services.

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

"The care and services I receive:

- are safe and effective
- optimise my quality of life, including through maximising independence and reablement
- meet my current needs, goals and preferences
- are well planned and coordinated
- respect my right to take risks."

What are the key concepts?

The following key concepts are covered by Standard 1: The Person:

Outcome 3.1 Assessment and planning	Outcome 3.2 Delivery of care and services	Outcome 3.3 Communicating for safety and quality	Outcome 3.4 Coordination of care and services
Needs, goals and preferences	Activities of daily living	Communication barriers	Partnership
Preventative care	Trauma aware and healing informed care	Transitions of care	Transitions of care
Quality of life	Culturally safe care	Care Statements	
Reablement	Contemporary, evidence-based practice	Deterioration	
Care and services plan	Quality of life		
Access *	Reablement		
Mental health *	Maintenance of function *		
Cognitive and physical function *	Goals of care		
Informed consent	Restrictive practices		
Deterioration	Worker continuity *		
Risk assessment *	Dignity of risk		
Supported decision making			
Advance care planning			

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

Guidance for Outcome 3.1: Assessment and Planning

What is the Outcome that needs to be achieved?

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

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

Why is this Outcome important?

Outcome 3.1 explains the main elements of assessment and planning in aged care. Good assessment and planning is critical to the delivery of quality care and services that meets older persons' needs.

Actions 3.1.1 to 3.1.6 describe the systems that you as the provider, have to implement to:

- Develop individualised care and service plans for the needs, goals and preferences of each older person.
- Communicate and partner with older people during assessment and planning.
- Complete regular reviews and updates of care and service plans.
- Complete advance care planning.

The following key concepts have been strengthened:

- Consideration of quality of life, reablement and maintenance of function.
- Using strategies to manage risk.
- When care and services plans need to be reviewed.

How can you achieve Outcome 3.1 in practice?

Governing body	
Actions	**Associated activities**
3.1.1 The provider implements a system for assessment and planning that: a) Identifies and records the needs, goals and preferences of the older person b) Identifies risks to the older person's health, safety and wellbeing and, with the older person, identifies strategies for managing these risks c) Supports preventative care and optimises quality of life, reablement and maintenance of function d) Involves relevant health professionals where required e) Directs the delivery of quality care and services. **3.1.2** Assessment and planning is based on ongoing communication and partnership with the older person and others that the older person wishes to involve. **3.1.3** The outcomes of assessment and planning are effectively communicated to: a) The older person, in a way they understand b) The older person's family, carers and others involved in their care, with the older person's informed consent. **3.1.4** Care and services plans are individualised and: a) Describe the older person's needs, goals and preferences b) Are current and reflect the outcomes of assessments c) Include information about the risks associated with care and services delivery and how workers can support older people to manage these risks d) Are offered to, and able to be accessed by, the older person e) Are used and understood by workers to guide the delivery of care and services. *Continued on the next page*	**Check that the provider organisation has a system for assessment and planning, including advance care planning. These need to be used by workers to guide the delivery of care and services.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Planning and delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.

Governing body (continued)	
Actions	**Associated activities**
3.1.5 Care and services plans are reviewed regularly, including when: a) The older person's needs, goals or preferences change, or the care and services plan is not effective b) The older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes c) The care that can be provided by an older person's family or carer changes d) Transition occurs e) Risks emerge or there are changes or an incident that impacts the older person f) Care responsibility changes between others involved in the older person's care. **3.1.6** The provider has processes for advance care planning that: a) Support the older person to discuss future medical treatment and care needs, in line with their needs, goals and preferences, including beliefs, cultural and religious practices and traditions b) Support the older person to complete and review advance care planning documents, if and when they choose c) Support the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose d) Ensure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.	**Check that the provider organisation has a system for assessment and planning, including advance care planning. These need to be used by workers to guide the delivery of care and services.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Planning and delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.

Provider organisation	
Actions	**Associated activities**
3.1.1 The provider implements a system for assessment and planning that: a) Identifies and records the needs, goals and preferences of the older person b) Identifies risks to the older person's health, safety and well-being and, with the older person, identifies strategies for managing these risks c) Supports preventative care and optimises quality of life, reablement and maintenance of function d) Involves relevant health professionals where required e) Directs the delivery of quality care and services. **3.1.2** Assessment and planning is based on ongoing communication and partnership with the older person and others that the older person wishes to involve. **3.1.3** The outcomes of assessment and planning are effectively communicated to: a) The older person, in a way they understand b) The older person's family, carers and others involved in their care, with the older person's informed consent. *Continued on the next page*	**Develop and implement a system for completing assessments.** Your system should include processes to: • Find out who the older person wants to involve in their assessment and planning. You need to get consent from the older person. Use your organisation's system for getting consent (Outcome 1.3). You need to involve people in the assessment process who the older person chooses to involve. • Have conversations with the older person. You need to do this to understand each older person's goals of care and optimise their quality of life, reablement, and maintenance of function. The following information needs to be documented within the care and services plan: – The older person's needs, goals and preferences (Outcome 1.1). – Risks to their health, safety and wellbeing. Also include how you will manage these risks (Outcome 2.4). – Resources and support needed in the delivery of care and services. For older people in residential care, this information needs to inform the support older people need to do activities of daily living (Outcome 7.1). • Share information (Outcome 2.1). Workers need to inform older people that their care and services plans are always available and accessible to them. Use your information management system to do this (Outcome 2.7). • Involve health professionals if specialist care is needed. For example, a mental health specialist or nutrition specialist may be needed (Outcome 5.5). • Make sure care and service plans are available to workers and older people. Care and service plans need to be used by workers to guide the delivery of care and services. Care and services plans need to be individualised. This means, they need to show the older person's unique needs, goals and preferences (Outcome 3.2 and Outcome 3.3). This will help make sure care and services are delivered safely and in line with older people's needs and preferences. When requested, care and services plans need to be made available to: • The older person. You need to share this information in a way they understand. Your workers need to support older people where cognitive impairments have been found (Outcome 3.2). • Individuals the older person wishes to involve in their care and services. This needs to include the older person's family and carers. Care and services plans need to be up to date. You need to perform a re-assessment and review plans: • Following an incident (Outcome 2.5). *Continued on the next page*

Provider organisation (continued)	
Actions	**Associated activities**
3.1.4 Care and services plans are individualised and: a) Describe the older person's needs, goals and preferences b) Are current and reflect the outcomes of assessments c) Include information about the risks associated with care and services delivery and how workers can support older people to manage these risks d) Are offered to, and able to be accessed by, the older person e) Are used and understood by workers to guide the delivery of care and services.	• If there are changes in the older person's circumstances. For example, a change to: – The older person's needs, goals or preferences (Outcome 1.1) – The older person's ability to perform activities of daily living – The older person's mental health, cognitive or physical function. This includes physical and mental capacity or condition. – The care that family or carers can provide to the older person. – Care responsibilities among those providing care and services to the older person. – Risks at the older person's home (Outcome 2.4). • At transitions. More information about transitions can be found at (Outcome 3.4 and Outcome 7.2).
3.1.5 Care and services plans are reviewed regularly, including when: a) The older person's needs, goals or preferences change, or the care and services plan is not effective b) The older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes c) The care that can be provided by an older person's family or carer changes d) Transition occurs e) Risks emerge or there are changes or an incident that impacts the older person f) Care responsibility changes between others involved in the older person's care.	**Develop and implement processes for advance care planning.** These processes need to: • Support the older person to discuss future medical treatment and care needs. This discussion needs to be centred around the older person's needs, goals and preferences, including beliefs, cultural and religious practices and traditions (Outcome 1.1). • Support the older person to complete and review advance care planning documents, if and when they choose. You need to support older people to have choices and exercise dignity of risk (Outcome 1.2 and Outcome 1.3). • Support the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose. More information about supported decision making can be found at (Outcome 1.3). • Make sure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care. This needs to happen through use of your information management system (Outcome 2.7) and communication system (Outcome 3.3). Informed consent needs to be obtained from the older person any time their information is shared (Outcome 1.3). Processes for advance care planning need to be integrated with your systems for quality clinical care (Standard 5) where relevant.

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Provider organisation (continued)	
Actions	**Associated activities**
3.1.6 The provider has processes for advance care planning that: a) Support the older person to discuss future medical treatment and care needs, in line with their needs, goals and preferences, including beliefs, cultural and religious practices and traditions b) Support the older person to complete and review advance care planning documents, if and when they choose c) Support the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose d) Ensure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.	**Make sure workers who provide care and services have the time, support and resources to plan for and deliver care. The care and services workers plan for and deliver need to be tailored to each older person.** You need to assess your workers' abilities during the hiring process. You also need to provide workers with guidance and training on how to provide tailored care for each older person. Guidance and training needs to include how workers can complete assessments and develop care and services plans. Training and guidance need to be in line with: • The organisation's policies and procedures. • Their roles and responsibilities. You can find more details about this in guidance material for Standard 2. **Make sure workers delivering care and services can understand and access care and services plans.** Care and services plans need to be stored in line with your information management system (Outcome 2.7). Care and services plans need to be available to workers when they need them. **Monitor that care and services plans describe the current needs, goals, and preferences of older people.** To understand if assessment and planning processes are effective, you need to review: • Older people's care and service documents. For example, care and services plans, progress notes, and advance care planning documents. • Complaints (Outcome 2.6). • Feedback (Outcome 2.6). • Incident information (Outcome 2.5). You should be looking for situations where: • Incidents have been reported where the wrong service or care has been provided. • A care and services plan was not reviewed after a change in circumstance. • An older person's needs, goals, or preferences were not documented in their care and services plan or advance care planning documents. You also need to assess whether workers are following your quality management system (O2.9). You can do this through performance assessments and system checks. If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to be open about it and share this information with older people, their family and carers (Outcome 2.3). You can find more information on monitoring the quality system in the guidance material for Standard 2 (Outcome 2.3).

Worker

Actions	Associated activities
3.1.1 The provider implements a system for assessment and planning that: a) Identifies and records the needs, goals and preferences of the older person b) Identifies risks to the older person's health, safety and wellbeing and, with the older person, identifies strategies for managing these risks c) Supports preventative care and optimises quality of life, reablement and maintenance of function d) Involves relevant health professionals where required e) Directs the delivery of quality care and services. **3.1.2** Assessment and planning is based on ongoing communication and partnership with the older person and others that the older person wishes to involve. **3.1.3** The outcomes of assessment and planning are effectively communicated to: a) The older person, in a way they understand b) The older person's family, carers and others involved in their care, with the older person's informed consent. **3.1.4** Care and services plans are individualised and: a) Describe the older person's needs, goals and preferences b) Are current and reflect the outcomes of assessments c) Include information about the risks associated with care and services delivery and how workers can support older people to manage these risks d) Are offered to, and able to be accessed by, the older person e) Are used and understood by workers to guide the delivery of care and services. *Continued on the next page*	**Use the system for assessment and planning.** Depending on the worker's role this can include: • Finding out who the older person wants to involve in their assessment and planning. Workers need to get consent from the older person. Use the provider organisation's system for getting consent (Outcome 1.3). Workers need to involve people in the assessment process who the older person chooses to involve. • Having conversations with the older person. Workers need to do this to understand each older person's goals of care. Also, to optimise older people's quality of life, reablement, and maintenance of function. Workers need to make sure the following information is documented within the care and services plan: – Older people's needs, goals and preferences (Outcome 1.1). – Risks to their health, safety and wellbeing. Also, how these risks are being managed (Outcome 2.4). – Resources and support needed in the delivery of care and services. For older people living in residential care, this information needs to inform the support older people need to do activities of daily living (Outcome 7.1). • Sharing information (Outcome 2.1). Workers need to inform older people that their care and services plans are always available and accessible to them. Workers need to use the provider organisation's information management system (Outcome 2.7). • Involving health professionals if specialist care is needed. For example, a mental health specialist or nutrition specialist may be needed (Outcome 5.5). • Supporting older people in understanding their care and services plan. This can include explaining what the care and services plan is and how it is used. • Performing a re-assessment and updating care and services plans depending on: – The older person's needs, goals or preferences (Outcome 1.1). – The older person's ability to perform activities of daily living. – The older person's mental health, cognitive or physical function. This includes physical and mental capacity or condition. – The care that family or carers can provide to the older person. – Care responsibilities amongst those providing care and services to the older person. – The older person's exposure to emerging risks (Outcome 2.4). – The older person's needs after an incident. Care and services plans need to be updated to include any changes to the level of support and care needed. *Continued on the next page*

Worker (continued)

Actions	Associated activities
3.1.5 Care and services plans are reviewed regularly, including when: a) The older person's needs, goals or preferences change, or the care and services plan is not effective b) The older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes c) The care that can be provided by an older person's family or carer changes d) Transition occurs e) Risks emerge or there are changes or an incident that impacts the older person f) Care responsibility changes between others involved in the older person's care. **3.1.6** The provider has processes for advance care planning that: a) Support the older person to discuss future medical treatment and care needs, in line with their needs, goals and preferences, including beliefs, cultural and religious practices and traditions b) Support the older person to complete and review advance care planning documents, if and when they choose c) Support the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose d) Ensure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.	**Apply processes for advance care planning.** Depending on the worker's role this can include: • Supporting the older person to discuss future medical treatment and care needs. Workers need to focus advance care planning discussions around the older person's needs, goals and preferences. This needs to include consideration of their beliefs, cultural and religious practices and traditions (Outcome 1.1). • Supporting the older person to complete and review advance care planning documents, if and when they choose. Workers need to support older people to have choices and exercise dignity of risk (Outcome 1.2 and Outcome 1.3). • Supporting the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose. More information about supported decision making can be found at Outcome 1.3. • Making sure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care. This needs to happen through use of the organisation's information management system (Outcome 2.7) and communication system (Outcome 3.3). Workers need to obtain informed consent from the older person any time their information is shared (Outcome 1.3). Workers also need to refer to the organisation's systems for quality clinical care (Standard 5) where relevant.

What are the key resources that can be referred to?

You can find more information on Outcome 3.1 in:

- [TO BE COMPLETED]

Key legislation about this Outcome includes:

- [TO BE COMPLETED]

Other obligations that you should know about include:

- [TO BE COMPLETED]

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

Guidance for Outcome 3.2: Delivery of care and services

What is the Outcome that needs to be achieved?

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

Why is this Outcome important?

Outcome 3.2 explains how care and services need to be delivered in aged care. There is a focus on provision of care and services in a way that is culturally safe and as planned. As planned refers to the agreed plan with older people in Outcome 3.1.

Actions 3.2.1 to 3.2.9 describe the systems and processes that you as providers, need to implement for:

- Delivering culturally safe, trauma aware, and healing informed care and services
- Delivering care and services in a way that optimises the older person's quality of life, reablement, and maintenance of function. This needs to be consistent with older people personal preferences, and across all activities of daily living. Activities of daily living includes personal care, personal hygiene, mobility support, and social support.
- Timely and appropriate referrals
- Caring for older people living with dementia
- Minimising the use of restrictive practices
- Involving older people in worker selection and maximising worker continuity for the benefit of older people
- Supporting workers to:
  - Recognise risks and other changes, and respond to these in a timely manner
  - Communicate effectively with older people.

Continued on the next page

The following key concepts have been strengthened:

- Contemporary, evidence-based practice.
- Tailoring care and services to the needs, goals, and preferences of each older person.
- Supporting quality of life.
- Supporting reablement.
- Supporting older people to use equipment, aids, and devices.
- Use of referrals to support early identification and intervention.
- Reablement and maintenance of function.
- Strategies for workers to:
  - Assess risk.
  - Identify deterioration.
  - Respond and escalate risks in a timely manner.
- Use of a system to identify the skills and strengths of people with dementia. This is so older people can be encouraged to use these skills and strengths on a daily basis.
- Involvement of older people in worker selection.
- Effective communication.

How can you achieve Outcome 3.2 in practice?

Governing body	
Actions	**Associated activities**
3.2.1 Older people receive culturally safe, trauma aware and healing informed care and services that: a) are provided in accordance with contemporary, evidence-based practices b) meet their current needs, goals and preferences c) optimise their quality of life.	**Check that the provider organisation has a system for assessment and planning, including advance care planning. These need to be used by workers to guide the delivery of care and services.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Planning and delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.
3.2.2 The provider delivers care and services in a way that optimises the older person's quality of life, reablement and maintenance of function, where this is consistent with their preferences.	
3.2.3 Older people are supported to use equipment, aids, devices and products safely and effectively.	
3.2.4 The provider ensures older people receive timely and appropriate referrals to support early identification and intervention, reablement, maintenance of function and quality of life, including to: a) Health professionals b) My Aged Care for re-assessment as required.	
3.2.5 The provider implements strategies for supporting workers to: a) Recognize risks or concerns related to an older person's health, safety and wellbeing b) 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 c) Respond to, and escalate, risks in a timely manner.	

Continued on the next page

Governing body (continued)	
Actions	**Associated activities**
3.2.6 The provider implements a system for caring for older people living with dementia that: a) Incorporates contemporary, evidence-based strategies for the timely recognition of dementia and the delivery of care that best supports people living with dementia b) Enables the identification and regular review of the strengths and skills of people living with dementia and encourages use of these in day-to-day activities c) Enables family, carers and health professionals involved in the older person's care to act as partners in planning and delivering the older person's care (in line with the older person's wishes).	**Check that the provider organisation has a system for assessment and planning, including advance care planning. These need to be used by workers to guide the delivery of care and services.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Planning and delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.
3.2.7 The provider minimizes the use of restrictive practices and, where restrictive practices are used, these are: a) Used as a last resort b) Used in the least restrictive form and for the shortest time needed c) Used with the informed consent of the older person d) Monitored and regularly reviewed.	
3.2.8 The provider makes reasonable efforts to involve the older person in selecting their workers (including the gender of, and language spoken by, workers providing care) and maximise worker continuity.	
3.2.9 The provider supports workers to: a) Understand the way different older people communicate, including people living with dementia or have difficulty communicating. b) Communicate effectively with different older people, both verbally and non-verbally.	

Provider organisation	
Actions	**Associated activities**
3.2.1 Older people receive culturally safe, trauma aware and healing informed care and services that: a) are provided in accordance with contemporary, evidence-based practices b) meet their current needs, goals and preferences c) optimise their quality of life.	**Develop strategies for providing quality and safe care and services.** Your strategies need to describe how care and services plans will be delivered. Strategies need to describe how care and services will: • Meet the needs, goals, and preferences of older people (Outcome 1.1). • Optimise older people's quality of life, reablement, and maintenance of function. For example, it needs to be clear how: – Timely referrals will be made to health professionals (Outcome 3.4). – My Aged Care will be used for a re-assessment. • Be culturally safe, appropriate for people with specific needs and diverse backgrounds (Outcome 1.1). • Be trauma aware, and healing informed (Outcome 1.1). • Follow contemporary practice that is based on evidence (Outcome 2.3). • Maximise worker continuity. For example, by supporting older people to choose their workers based on their gender and language spoken. • Minimise use of restrictive practices. You need to make sure that restrictive practices are: – Only used as a last resort. This means, you need to try all other options first. – Used in the least restrictive form and for the shortest time needed. This means, the least restrictive option needs to be chosen. – Only used if the older person provides consent. You need to use your system for informed consent. A supported decision maker need to be used if the older person needs help making decisions. Refer to Outcome 1.3 for further detail. – Monitored regularly. You need to make sure that you check if there any other options, even if it has been agreed that restrictive practices can be used.
3.2.2 The provider delivers care and services in a way that optimises the older person's quality of life, reablement and maintenance of function, where this is consistent with their preferences.	
3.2.3 Older people are supported to use equipment, aids, devices and products safely and effectively.	
3.2.4 The provider ensures older people receive timely and appropriate referrals to support early identification and intervention, reablement, maintenance of function and quality of life, including to: a) Health professionals b) My Aged Care for re-assessment as required.	
3.2.5 The provider implements strategies for supporting workers to: a) Recognize risks or concerns related to an older person's health, safety and wellbeing b) 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 c) Respond to, and escalate, risks in a timely manner.	**Develop systems to provide care for older people living with dementia.** • Your strategies need to: – Recognise early signs of dementia by using contemporary strategies that are based on evidence (Outcome 2.9). – Include processes for workers to assess the strengths and skills of older people living with dementia. You need to encourage older people to use these strengths and skills. For older people in residential care, you can use the strategies to support older people's daily living (Outcome 7.1). – Include processes to partner with the older person, their family, carers and health professionals. You need to involve these people when planning and delivering care and services to the older person (Outcome 2.1). Outcome 1.3 provides detail on informed consent and supported decision making.
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Provider organisation (continued)	
Actions	**Associated activities**
3.2.6 The provider implements a system for caring for older people living with dementia that: a) Incorporates contemporary, evidence-based strategies for the timely recognition of dementia and the delivery of care that best supports people living with dementia b) Enables the identification and regular review of the strengths and skills of people living with dementia and encourages use of these in day-to-day activities c) Enables family, carers and health professionals involved in the older person's care to act as partners in planning and delivering the older person's care (in line with the older person's wishes). **3.2.7** The provider minimizes the use of restrictive practices and, where restrictive practices are used, these are: a) Used as a last resort b) Used in the least restrictive form and for the shortest time needed c) Used with the informed consent of the older person d) Monitored and regularly reviewed. **3.2.8** The provider makes reasonable efforts to involve the older person in selecting their workers (including the gender of, and language spoken by, workers providing care) and maximise worker continuity. **3.2.9** The provider supports workers to: a) Understand the way different older people communicate, including people living with dementia or have difficulty communicating. b) Communicate effectively with different older people, both verbally and non-verbally.	**Develop strategies to support workers to deliver quality and safe care and services.** These strategies need to be developed in line with the requirements of your risk management system (Outcome 2.4). These strategies need to support workers to: • Recognise risks or concerns about an older person's health, safety and wellbeing. • Identify deterioration or changes to an older person's ability to do activities of daily living (Outcome 7.1). • Maintain or improve mental health, cognitive or physical function. This includes mental and physical capacity, or condition. You need to make sure a medical review is done if you notice deterioration (Outcome 5.3). • Respond to risks. For example, if there is an increased risk of falls. You need to have escalation procedures to make sure workers are aware who they can contact if they need support. • Understand the way different older people want information to be shared with them. This includes people living with dementia or who have difficulty communicating. • Share information with older people during the delivery of care and services based on their diverse needs. This includes both verbal and non-verbal communication. • Support older people to use equipment, aids, devices, and products safely and well. Refer to Standard 4 for further guidance around equipment management. • Trigger appropriate referrals and confirm these have been made in a timely manner. For example, referrals to health professionals. • Provide care to older people living with dementia. Care needs to follow contemporary strategies that are based on evidence (Outcome 2.3). • Understand how to minimise the use of restrictive practices. • Record decisions to confirm restrictive practices were used: – As a last resort. – For the shortest time needed. – With the informed consent of the older person. • Involve older people in selection of the people who provide their care. Tools and templates should be suitable and developed to: • Enable record keeping. • Minimise administrative burden. *Continued on the next page*

Provider organisation (continued)	
Actions	**Associated activities**
	Make sure workers who deliver care and services have the ability and capacity to perform their role. You need to assess your workers' ability to deliver care and services during the hiring process. You also need to provide workers with guidance and training on how to deliver care and services in line with: • The organisation's policies and procedures. • Their roles and responsibilities. You can find more information in the guidance material for Standard 2. **Monitor that care and services is delivered safely and in line with older people's needs and preferences.** You should do periodic reviews of care and service delivery across a sample of older people and workers. This needs to confirm care and services are being delivered as planned. For example by: • Completing older person experience surveys. • Observing care delivery. • Analysing feedback and complaints data (Outcome 2.6). This would be helpful to confirm that: • Workers understand how to: – Use equipment, aids, devices, and products safely and well – Trigger timely referrals to health professionals – Care for older people living with dementia. This needs to be in line with contemporary strategies that are based on evidence – Minimise use of restrictive practices. – Involve older people in selection of the people who provide their care. – Share information well with older people during the provision of care and services. • Enough detail is included in documentation to outline key decisions. 'Enough' detail means that it is clear what decisions were made, and by whom. Information needs to be included in progress notes and care and service plans. • Workers are delivering care in line with the care and services plan. You can find more information on monitoring the quality systems in the guidance material for Standard 2 (Outcome 2.3).

Worker

Actions	Associated activities
3.2.1 Older people receive culturally safe, trauma aware and healing informed care and services that: a) are provided in accordance with contemporary, evidence-based practices b) meet their current needs, goals and preferences c) optimise their quality of life.	**Use the systems for providing quality and safe care and services to older people.** Depending on the worker's role, this should involve regular updates of each older person's care and services plan. Records should demonstrate that: • Older people living with dementia have been provided with care that is in line with contemporary strategies (Outcome 2.3) and evidence based. • Use of restrictive practices has been minimised. When these have been used, workers need to keep records (Outcome 2.3). Records need to confirm that restrictive practices were used: – As a last resort. – For the shortest time needed. – With the informed consent of the older person. • Workers understand the different ways to share information with older people that they care for. • Workers deliver care that meets the needs, goals, and preferences of the older person (Outcome 1.1). • Care is culturally safe, trauma aware, and healing informed (Outcome 1.1). Workers need to be able to access and put in place strategies for each individual older person. **Implement the systems to provide care for older people living with dementia.** Depending on the worker's role, workers may need to: • Recognise early signs of dementia by using contemporary strategies that are based on evidence (Outcome 2.9). • Assess the strengths and skills of older people living with dementia. • Encourage older people to use their strengths and skills during daily living (Outcome 7.1). • Partner with the older person, their family, carers and health professionals when planning and delivering care and services to the older person (Outcome 2.1).
3.2.2 The provider delivers care and services in a way that optimises the older person's quality of life, reablement and maintenance of function, where this is consistent with their preferences.	
3.2.3 Older people are supported to use equipment, aids, devices and products safely and effectively.	
3.2.4 The provider ensures older people receive timely and appropriate referrals to support early identification and intervention, reablement, maintenance of function and quality of life, including to: a) Health professionals b) My Aged Care for re-assessment as required.	
3.2.5 The provider implements strategies for supporting workers to: a) Recognize risks or concerns related to an older person's health, safety and wellbeing b) 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 c) Respond to, and escalate, risks in a timely manner.	
Continued on the next page	*Continued on the next page*

Worker (continued)

Actions	Associated activities
3.2.6 The provider implements a system for caring for older people living with dementia that: a) Incorporates contemporary, evidence-based strategies for the timely recognition of dementia and the delivery of care that best supports people living with dementia b) Enables the identification and regular review of the strengths and skills of people living with dementia and encourages use of these in day-to-day activities c) Enables family, carers and health professionals involved in the older person's care to act as partners in planning and delivering the older person's care (in line with the older person's wishes). **3.2.7** The provider minimizes the use of restrictive practices and, where restrictive practices are used, these are: a) Used as a last resort b) Used in the least restrictive form and for the shortest time needed c) Used with the informed consent of the older person d) Monitored and regularly reviewed. **3.2.8** The provider makes reasonable efforts to involve the older person in selecting their workers (including the gender of, and language spoken by, workers providing care) and maximise worker continuity. **3.2.9** The provider supports workers to: a) Understand the way different older people communicate, including people living with dementia or have difficulty communicating. b) Communicate effectively with different older people, both verbally and non-verbally.	**Use the tools and templates provided when delivering care and services.** Depending on the worker's role, workers may need to: • Recognise risks or concerns related to an older person's health, safety and wellbeing • Assess deterioration or changes to an older person's ability to do activities of daily living (Outcome 7.1). This can include changes to mental health, cognitive or physical function. This includes changes to mental and physical capacity or condition. A medical review needs to be done if workers observe any change (Action 5.3.3 – Outcome 5.3). • Respond to risks where applicable. Workers need to escalate risk to management if additional support is needed to make sure the safe delivery of care. • Understand the way different older people want information shared with them. This includes older people who live with dementia or have difficulty communicating. • Share information well with different older people. This includes both verbal and non-verbal communication. • Use and help older people to use equipment, aids, devices, and products safely and well. • Trigger referrals to health professionals. • Minimise use of restrictive practices. • Record decisions to confirm restrictive practices were used. Records need to confirm that restrictive practices were used: – As a last resort. – For the shortest time needed. – With the informed consent of the older person. • Help older people to select the people who provide their care.

What are the key resources that can be referred to?

You can find more information on Outcome 3.2 in:

- [TO BE COMPLETED]

Key legislation about this Outcome includes:

- [TO BE COMPLETED]

Other obligations that you should know about include:

- [TO BE COMPLETED]

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

Guidance for Outcome 3.3: Communicating for safety and quality

What is the Outcome that needs to be achieved?

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

Why is this Outcome important?

Outcome 3.3 explains how important it is to communicate critical information to those involved in the care and services to older people. It also explains ways for them to escalate their concerns.

The following key concepts have been strengthened:

- Communication of critical information.
- Timely communication.
- Formal processes for escalating concerns about older people's health and wellbeing.
- Matching older people with their care and services.
- Providing Care Statements.

How can you achieve Outcome 3.3 in practice?

Governing body	
Actions	**Associated activities**
3.3.1 The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers, family, carers and health professionals involved in the older person's care. **3.3.2** The provider's communication system is used when: a) The older person commences receiving care and services b) The older person's needs, goals or preferences change c) Risks emerge, there is a change, deterioration or an incident that impacts the older person d) Handover or transitions of care occurs between workers or others involved in the older person's care. **3.3.3** The provider implements processes for older people, family carers and health professionals involved in the older person's care to escalate concerns about the older person's health, safety or wellbeing. **3.3.4** The provider implements processes to: a) Correctly identify and match older people to their care and services b) Provide Care Statements to older people in residential aged care.	**Check that the provider organisation communicates for safety and quality.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further details can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.

Provider organisation	
Actions	**Associated activities**
3.3.1 The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers, family, carers and health professionals involved in the older person's care. **3.3.2** The provider's communication system is used when: a) The older person commences receiving care and services b) The older person's needs, goals or preferences change c) Risks emerge, there is a change, deterioration or an incident that impacts the older person d) Handover or transitions of care occurs between workers or others involved in the older person's care. **3.3.3** The provider implements processes for older people, family carers and health professionals involved in the older person's care to escalate concerns about the older person's health, safety or wellbeing. **3.3.4** The provider implements processes to: a) Correctly identify and match older people to their care and services b) Provide Care Statements to older people in residential aged care.	**Develop and implement a communication system.** A communication system should include processes that make sure: • Those involved in the care of an older person are provided with critical information. This can include workers, family, carers and health professionals. Information needs to be shared in a timely manner. This will help make sure older people receive the care and services they need. Critical information in relation to the older person, can include: – Information in their care and services plan (Outcome 3.1). – Risks and mitigative controls (Outcome 2.4). – Comprehensive care needs (Outcome 5.4). – Food, drink and nutritional needs and preferences (Outcome 6.2). • Care and services plans are stored in the provider organisation's information management system (Outcome 2.7). Each plan needs to have a unique identifier to each older person. • There are ways to escalate concerns about the older person. Older people, their families, carers, and health professionals involved in the older person's care need to be able to escalate concerns. You need to make sure contact details for all those involved in the care and services of the older person are kept up to date. This information needs to be stored using your information management system (Outcome 2.7). If care and services is provided in a residential aged care environment, your communication system needs to include preparation and delivery of Care Statements. **Make sure workers are supported to communicate for safety and quality.** This should include development of communication guides, training, and other strategies to support workers. It is important that support materials aid record keeping while minimising administrative burden. It may be helpful to develop a list of common scenarios and how workers can share information in each situation. For example: • When the older person starts receiving care and services. • When the older person's needs, goals or preferences change. It should be noted that partnership with the older person and those involved in their care and services should occur on a regular basis (Outcome 2.1). • When risks have been found (Outcome 2.4). • When there is a change of circumstance, deterioration, or after an incident had occurred (Outcome 2.5). • During a transition (Outcome 3.4 and Outcome 7.2). *Continued on the next page*

Provider organisation (continued)	
Actions	**Associated activities**
	You should encourage workers to consider: • What information needs to be shared. • How quickly the information needs to be escalated. • Who should be involved. • How this information can be most effectively shared. For example, whether it is better to make a phone call, send a letter, or have a conversation in person. Each older person's diverse needs have to be considered (Outcome 1.1). Information shared should be recorded in progress notes or similar in line with your information management system (Outcome 2.7). **Monitor that workers communicate for safety and quality.** To understand if the communication system is effective, you need to review: • Older people's care and services (Outcome 3.1). • Complaints (Outcomes 2.6). • Feedback (Outcomes 2.6). • Incident information (Outcomes 2.5) You will be looking for incidents where: • Older people did not understand something. • Critical information was not shared. You also need to assess whether workers are following your quality management system (Outcome 2.9). You can do this through performance assessments and system checks. If you find any issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to be open about it and share this information with older people, their family and carers (Outcome 2.3). You can find more information on monitoring the quality systems in the guidance material for Standard 2 (Outcome 2.3).

Worker

Actions	Associated activities
3.3.1 The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers family, carers and health professionals involved in the older person's care. **3.3.2** The provider's communication system is used when: a) The older person commences receiving care and services b) The older person's needs, goals or preferences change c) Risks emerge, there is a change, deterioration or an incident that impacts the older person d) Handover or transitions of care occurs between workers or others involved in the older person's care. **3.3.3** The provider implements processes for older people, family carers and health professionals involved in the older person's care to escalate concerns about the older person's health, safety or wellbeing. **3.3.4** The provider implements processes to: a) Correctly identify and match older people to their care and services b) Provide Care Statements to older people in residential aged care.	**Use the communication system.** Critical information about the older person's care and services needs to be shared well with the older person. This information may also need to be shared with workers and any others involved in the older person's care. For example, their family, carers and health professionals. The communication system needs to be used with the older person's informed consent and using the information management system (Outcome 1.3 and Outcome 2.7). Depending on the worker's role, information needs to be shared with older people: • When the older person commences receiving care and services. • If the older person's needs, goals or preferences change. • If risks emerge that impacts the older person. • If there is a change or deterioration that impacts the older person. • If there is an incident that impacts the older person. • If handover or transitions of care occurs between workers or others involved in the older person's care. This communication system needs to be used to: • Enable concerns to be escalated about the older person's health, safety or wellbeing. • Correctly find and match older people with their care and services. This should occur during development of the older person's care and services plan. • Develop and provide Care Statements to older people living in residential aged care.

What are the key resources that can be referred to?

The can find more information on Outcome 3.3 in:

- [TO BE COMPLETED]

Key legislation about this Outcome includes:

- [TO BE COMPLETED]

Other obligations that you should know about include:

- [TO BE COMPLETED]

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

Guidance for Outcome 3.4: Coordination of care and services

What is the Outcome that needs to be achieved?

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

Why is this Outcome important?

Outcome 3.4 explains how you, as a provider, can effectively coordinate transitions of older people to those involved in their care and services.

The following key concepts have been strengthened:

- Identifying others involved in an older person's care so that it can be coordinated.
- Recognition and involvement of carers.
- Transitions of care.

How can you achieve Outcome 3.4 in practice?

Governing body	
Actions	**Associated activities**
3.4.1 The provider, in partnership with the older person, identifies others involved in the older person's care and ensures coordination and continuity of care. **3.4.2** Carers are recognised as partners in the older person's care and involved in the coordination of care and services. **3.4.3** The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the older person and other providers of care and services, and this is documented, communicated and effectively managed.	**Check that the provider organisation coordinates care and services effectively.** The governing body: • Is accountable for the organisation's delivery of quality care and service (Outcome 2.2 and Outcome 2.3). • Needs to maintain oversight of all aspects of their operations by reviewing the organisation's reports on the: – Delivery of care and services. – Management of complaints, feedback and incidents relating to care and services (Outcome 2.5 and Outcome 2.6). – Quality of care and services delivered by workers (i.e., performance assessments). • Leads a culture of safety, inclusion and quality. This is done by monitoring and investigating priority areas found in the reports listed above. If the governing body finds issues or ways the provider organisation can improve through these reviews, the governing body needs to address them. The governing body needs to provide feedback and support to the provider to be able to improve. If things go wrong, the governing body needs to: • Practice open disclosure. This means being open about what has gone wrong and sharing this information with older people, their family and carers. • Implement strategies to mitigate the risk of things going wrong again. Further detail on this can be found at Outcome 2.3. When monitoring the provider organisation's performance, this needs to include monitoring the performance of any subcontracted providers.

Provider organisation	
Actions	**Associated activities**
3.4.1 The provider, in partnership with the older person, identifies others involved in the older person's care and ensures coordination and continuity of care. **3.4.2** Carers are recognised as partners in the older person's care and involved in the coordination of care and services. **3.4.3** The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the older person and other providers of care and services, and this is documented, communicated and effectively managed.	**Develop and put in place strategies to coordinate transitions.** You need to put in place strategies for planned transitions in the following situations: • Whenever an older person is transitioning to and from hospital. • When an older person moves between other care services or stays in the community. The Commission expects that: • Those involved in the care and services of older people have been assessed. These people need to be involved in planning activities (Outcome 2.1). For example, carers need to be involved when an older person transfers to and from hospital so they understand any relevant changes to care and services. • The transition is planned and coordinated. The transition process needs to be documented in line with the information management system (Outcome 2.7). For residential aged care providers, you also need to achieve Outcome 7.2. **Make sure workers have the time, support, resources, and ability to coordinate care and services.** You need to assess your workers' ability to coordinate care and services during the hiring process. You also need to provide workers with guidance and training on how to coordinate care and services. Workers need to be able to do this in line with: • The organisation's policies and procedures. • Their roles and responsibilities. You can find more details about this in the guidance material for Standard 2. **Monitor that workers are consistently partnering with older people and other providers of care and services.** You need to: • Assess your workers are following your systems (Outcome 2.9). • Review older people's care and services (Outcome 3.1). • Review complaints, feedback, and incident information (Outcomes 2.6 and 2.5). This is to help you understand if care and services have been coordinated effectively. If you find issues or ways you can improve through your reviews and assessments, you need to address them. If things go wrong, you need to be open about it and share this information with older people, their family, and carers (Outcome 2.3). You can find more information on monitoring the quality systems in the guidance material for Standard 2 (Outcome 2.3).

Worker	
Actions	**Associated activities**
3.4.1 The provider, in partnership with the older person, identifies others involved in the older person's care and ensures coordination and continuity of care. **3.4.2** Carers are recognised as partners in the older person's care and involved in the coordination of care and services. **3.4.3** The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the older person and other providers of care and services, and this is documented, communicated and effectively managed.	**Enable transitions by communicating with anyone involved in the older person's care and services.** Depending on the worker's role, they may need to enable a planned and coordinated transition. This can involve: • Confirming with older people if any specific individuals need to be involved in their care. Individuals include carers, other providers and family members. This should be documented in the care and services plan. • Making sure there is a planned and coordinated transition to or from the provider. This needs to happen in collaboration with the older person and other providers of care and services. This needs to be documented, shared, and effectively managed. This means, this information needs to be in documents like the care and services plan, transition plan, or other document. • Making sure all relevant parties remain involved and informed as agreed during assessment and planning processes.

What are the key resources that can be referred to?

You can find more information on Outcome 3.4 in:

- [TO BE COMPLETED]

Key legislation about this Outcome includes:

- [TO BE COMPLETED]

Other obligations that you should know about include:

- [TO BE COMPLETED]

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

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

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