Australian Government
Aged Care Quality and Safety Commission

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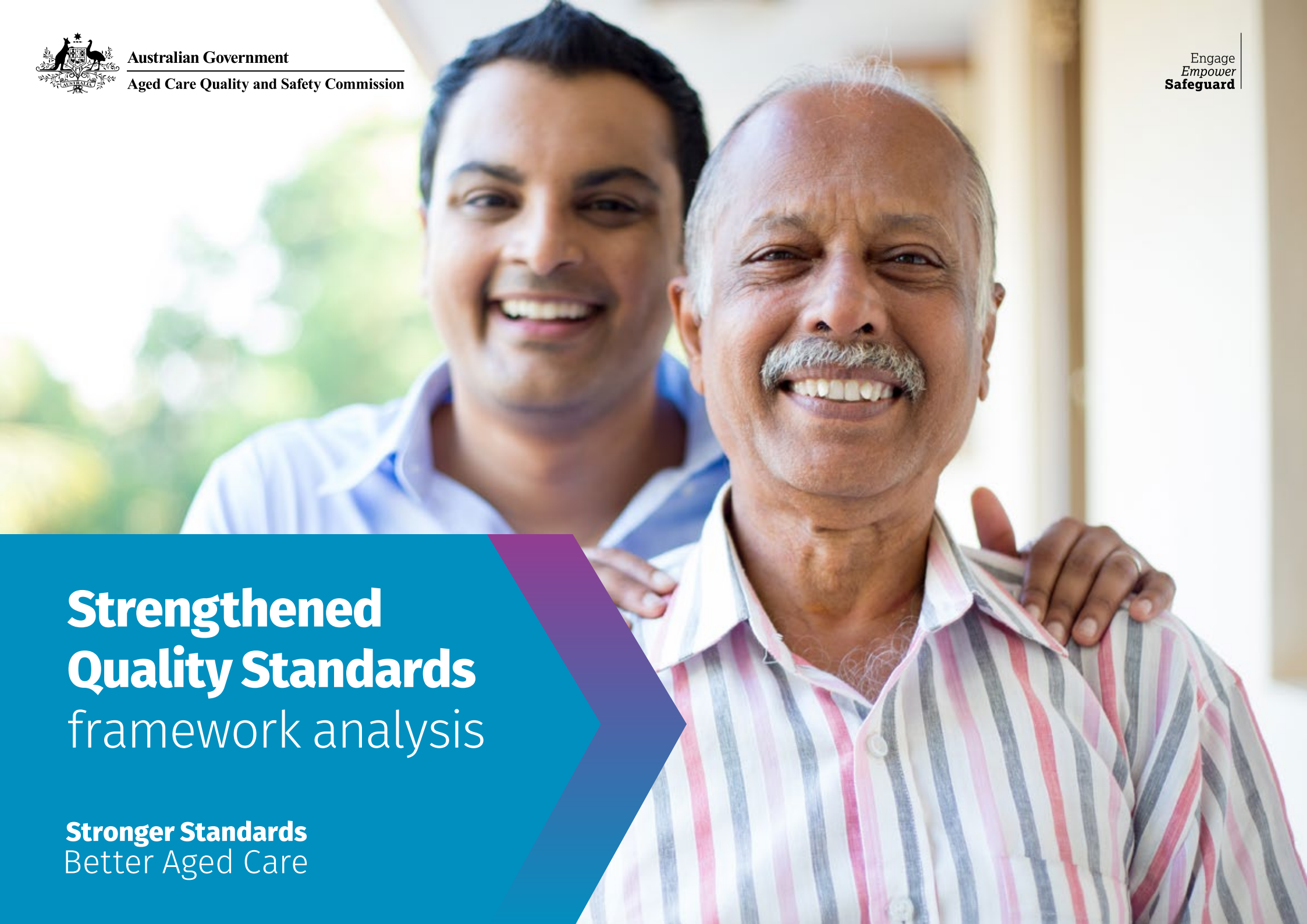

Strengthened Quality Standards framework analysis

Stronger Standards
Better Aged Care

Contents

Analysis references the draft strengthened Aged Care Quality Standards, current as at 14 December 2023. Any information and resources the Commission is providing in relation to the commencement of the strengthened Quality Standards are dependent on the finalisation of the draft legislation. This information should be considered draft only.

Introduction

The Aged Care Quality Standards are changing. The Standards are being strengthened as part of broader aged care reforms in response to the Royal Commission into Aged Care Quality Safety, including development of a new Aged Care Act and new regulatory model. The aged care reforms will put older Australians first, improving quality, safety, and choice in aged care. The improvements will increase protections for older people and empower them to exercise their rights. They will also better support continuous improvement in the sector.

The strengthened Quality Standards are intended to clarify expectations of safe quality care and help guide providers in lifting performance to deliver the care that older Australians need and expect. The final draft, released on 14 December 2023, reflects the public consultation process and findings from the pilot program.

The proposed new regulatory model consultation paper explains how the draft strengthened Quality Standards are intended to apply across different service types and the current thinking on the reform journey ahead. The Department of Health and Aged Care (the Department) is responsible for the new regulatory framework and finalising the strengthened Quality Standards through drafting into the new Act. You can find more information from the Department's website.

The Aged Care Quality and Safety Commission is supporting the sector to prepare for the implementation of the strengthened Quality Standards and related regulatory reforms.

We know that this will be a very significant change for the sector, and we will be producing a range of information and education resources to help the sector to get ready.

You can stay up to date with the latest news, including opportunities to help us ensure our content meets your needs via our website.

The purpose of this document is to show providers how the Standards have been strengthened. We first published this analysis on 27 June 2023 based on the strengthened Quality Standards published in March 2023. The strengthened Quality Standards have been updated by the Department following public consultation and a pilot audit program. We have now updated this version of the analysis current as of 10 January 2024 and based on the final draft of the strengthened Quality Standards as of 14 December 2023. We will update the document if the Standards change.

Understanding the strengthened Quality Standards

The Commission has developed a framework to understand and describe the strengthened Quality Standards.

This involved looking at the actions that sit under each of the 7 strengthened Quality Standards.

Each strengthened Quality Standard includes the:

- expectation statement for older people
- intent of each standard
- outcomes that providers would be assessed against
- actions which providers might take to achieve
- the outcome.

The framework has 4 elements:

- **Element 1** – identifies where requirements align with existing Quality Standard requirements
- **Element 2** – identifies actions which align with other existing provider responsibilities within the legislation
- **Element 3** – identifies where the strengthened Quality Standards clarify or add detail to the content of the current Standards
- **Element 4** – identifies actions that are new or enhanced

The Commission has mapped each of the 146 actions in the strengthened Quality Standards against that framework.

This document is current as at 10 January 2024 and will be updated as required.

Strengthened Quality Standards framework analysis

Draft strengthened Quality Standards	Number of actions associated with this Standard	**Element 1** Number of actions which **align with** existing Quality Standard requirements	**Element 2** Number of actions which align with other **existing provider responsibilities** within the legislation	**Element 3** Number of actions which **clarify existing requirements** within the current Quality Standards	**Element 4** Number of actions that **introduce new concepts or enhanced expectations** in comparison to the current Quality Standards
Standard 1: The Individual	21	5	7	9	
Standard 2: The Organisation	43	7	8	20	8
Standard 3: The Care and Services	22	3		17	2
Standard 4: The Environment	6	2		4	
Standard 5: Clinical Care	35	3		27	5
Standard 6: Food and Nutrition	10			4	6
Standard 7: The Residential Community	9		1	8	
	146	**20**	**16**	**89**	**21**
		14%	11%	61%	14%

Standard 1: The Person

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
1.1	Person-centred care	The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services. The provider understands and values the older person, including their identity, culture, ability, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person, taking into account their needs, goals and preferences. **Outcome statement updated to reduce duplication with Outcome 3.2.**	1.1.1	The way the provider and workers engage with older people supports them to feel safe, welcome, included and understood.	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe. • 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life. • 4 (3)(b) Services and support for daily living promote each consumer's emotional, spiritual and psychological wellbeing. • 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function.	Align	**Note:** Older people with specific needs and diverse backgrounds are identified more fully under the Intent of Standard 1. While we recognise the need to improve outcomes for all older people from diverse backgrounds and with specific needs, we have intentionally specified Aboriginal and Torres Strait Islander peoples and people living with dementia in response to findings from the Royal Commission regarding the need for additional efforts to improve outcomes for these groups. Workers can build trusting relationships with older people by listening to, and engaging with, the older person in a way that is right for them, free from judgement or assumptions.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.1	Person-centred care	The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services. The provider understands and values the older person, including their identity, culture, ability, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person, taking into account their needs, goals and preferences. **Outcome statement updated to reduce duplication with Outcome 3.2.**	1.1.2	The provider implements strategies to: a. identify the older person's individual background, culture, diversity, beliefs and life experiences as part of assessment and planning and use this to direct the way their care and services are delivered b. identify and understand the individual communication needs and preferences of the older person c. ask and record if an older person identifies as Aboriginal and Torres Strait Islander person d. deliver care that meets the needs of older people with specific needs and diverse backgrounds, including Aboriginal and Torres Strait Islander peoples and people living with dementia e. deliver care that is culturally safe, trauma aware and healing informed, in accordance with contemporary, evidence-based practice	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe.	Clarify	Clarified to contain more specific actions regarding how to ensure consumers' identity, culture and life experiences **are upheld and valued**.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
				f. support older people to cultivate relationships and social connections, including, for older people who are Aboriginal and Torres Strait Islander persons, connection to community, culture and country g. continuously improve its approach to inclusion and diversity. **Actions (d), (e), (f) aligned with evidence-based terminology and provide clarification.**			

Standard 1: The Person

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1.1	Person-centred care	The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services. The provider understands and values the older person, including their identity, culture, ability, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person, taking into account their needs, goals and preferences. **Outcome statement updated to reduce duplication with Outcome 3.2.**	1.1.3	The provider and workers recognise the rights, and respects the autonomy, of older people, including their right to intimacy and sexual and gender expression.	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe. – 1 (3)(c)(iv) make connections with others and maintain relationships of choice, including intimate relationships.	Existing legislation	Provision in existing legislation in relation to **recognising rights, respecting older persons autonomy and independence; and decision making**. • *Code of Conduct for Aged Care* • *Charter of Aged Care Rights 2014*

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.1	Person-centred care	The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services. The provider understands and values the older person, including their identity, culture, ability, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person, taking into account their needs, goals and preferences. **Outcome statement updated to reduce duplication with Outcome 3.2.**	1.1.4	Workers have professional and trusting relationships with older people and work in partnership with them to deliver care and services.	• 1 (3)(c)(iv) make connections with others and maintain relationships of choice, including intimate relationships. • 2 (3)(c) Assessment and planning: – (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and – (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 7 (3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity.	Clarify	Clarified to include requirement to demonstrate workers have **professional and trusting relationships** with older people.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.2	Dignity, respect and privacy	The provider delivers care and services in a way that: a. is free from all forms of discrimination, abuse and neglect b. treats older people with dignity and respect c. respects the personal privacy of older people. The provider demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld. **Outcome statement updated to improve clarity and align to the draft Statement of Rights.**	1.2.1	The provider implements a system to recognise, prevent and respond to violence, abuse, racism, neglect, exploitation and discrimination. **Note:** A 'system to recognise, prevent and respond to violence, etc.' includes incident management systems, worker training, encouraging reporting of incidents (by both workers and older people).	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe. • 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Existing legislation	Provision in existing legislation in relation to incident management systems and reportable incidents. • *Aged Care Act 1997* - s54-1(1)(e) • *Quality of Care Principles 2014* - s15NC-15NF

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.2	Dignity, respect and privacy	The provider delivers care and services in a way that: a. is free from all forms of discrimination, abuse and neglect b. treats older people with dignity and respect c. respects the personal privacy of older people. The provider demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld. **Outcome statement updated to improve clarity and align to the draft Statement of Rights.**	1.2.2	Older people are treated with kindness, dignity and respect.	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe. • 7 (3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity.	Align	

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.2	Dignity, respect and privacy	The provider delivers care and services in a way that: a. is free from all forms of discrimination, abuse and neglect b. treats older people with dignity and respect c. respects the personal privacy of older people. The provider demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld. **Outcome statement updated to improve clarity and align to the draft Statement of Rights.**	1.2.3	The relationship between older people, their family and carers is recognised and respected.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (ii) make decisions about when family, friends, carers or others should be involved in their care. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services. • 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.	Clarify	Clarified to include ongoing **recognition and respect of the relationship between older people, their family and carers** - which extends beyond existing requirements for older people to decide when to involve others.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.2	Dignity, respect and privacy	The provider delivers care and services in a way that: a. is free from all forms of discrimination, abuse and neglect b. treats older people with dignity and respect c. respects the personal privacy of older people. The provider demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld. **Outcome statement updated to improve clarity and align to the draft Statement of Rights.**	1.2.4	The personal privacy of older people is respected, older people have choice about how and when they receive intimate personal care or treatment, and this is carried out sensitively and in private.	• 1 (3) The organisation demonstrates the following: – 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. – 1 (3)(b) Care and services are culturally safe. – 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered. – 1 (3)(f) Each consumer's privacy is respected and personal information kept confidential. • 7 (3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity.	Clarify	Clarified to include express reference to **having choice** over **when and how** the older person receives physical care or treatment and that this is **carried out in private**. **Changes made with this release reflect alignment with terminology used in Aged Care.**

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.1	The provider implements a system to ensure information given to older people to enable them to make informed decisions about their care and services: a. is current, accurate and timely b. is plainly expressed and presented in a way the older person understands. **Note:** As part of Action 1.3.1, where the provider (and/or workers) require translating or interpreting services to communicate effectively with older people, it is expected that the provider would arrange this. **Action re-worded to improve clarity.**	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.	Align	

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.2	The provider implements a system to ensure that older people give their informed consent where this is required for a treatment, procedure or other intervention.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions; and (iv) make connections with others and maintain relationships of choice, including intimate relationships. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can.	Clarify	Clarified to include explicit requirement for **informed consent** for decisions about care.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.3	The provider implements a system: a. to ensure older people who require support with decision-making are identified and provided access to the support necessary to make, communicate and participate in decisions that affect their lives b. that involves family and carers in supporting decision making where possible c. that uses substitute decision makers only after all options to support an older person to make decisions are exhausted.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions; and (iv) make connections with others and maintain relationships of choice, including intimate relationships. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.	Clarify	Clarified to include **identification** of older people who may require decision making support, and appropriate use of **substitute decision makers**.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.4	The provider supports older people to access advocates of their choosing.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (ii) make decisions about when family, friends, carers or others should be involved in their care. • 6 (3)(b) Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.	Existing legislation	Provision in existing legislation in relation to **access to advocates**. • *Charter of Aged Care Rights* • *User Rights Principles 2014* - s8 and 18

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.5	The provider supports older people to live the best life they can, including by understanding the older person's goals and preferences and enabling positive risk-taking that promotes the person's autonomy and quality of life.	1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (ii) make decisions about when family, friends, carers or others should be involved in their care. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iii) supporting consumers to live the best life they can.	Align	

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.3	Choice, independence and quality of life	Older people can exercise choice and make decisions about their care and services, with support when they want or need it. Older people are provided timely, accurate, tailored and sufficient information, in a way they understand. Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life. **Outcome statement changed to capture independence in the 3rd paragraph.**	1.3.6	The provider records, monitors and responds to changes to the older person's quality of life.	• 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 3 (3) The organisation demonstrates the following: – (d) deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner – (e) information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 4 (3) The organisation demonstrates the following: – (a) each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, well-being and quality of life – (d) information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Align	

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.1	Prior to entering into any agreement or care commencing (whichever comes first), the provider gives older people information to enable them to make informed decisions about their care and services. **Note:** It is expected that (as per Outcome 1.3), all information relating to agreements is provided to older people in a way they understand, including where this may require the provider to engage a translator or interpreter to help communicate with older people.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Existing legislation	Provision in existing legislation in relation to **understanding the terms of care agreements**. • *User Rights Principles 2014* - s14, 19AC, 22(3) and 23AF (2)

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.2	The provider supports older people to understand information provided to them, including any agreement they will be required to enter into the terms relating to their rights and responsibilities, the care and services to be provided and the fees and other charges to be paid. **Note:** It is expected that (as per Outcome 1.3), all information relating to agreements is provided to older people in a way they understand, including where this may require the provider to engage a translator or interpreter to help communicate with older people.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Existing legislation	Provision in existing legislation in relation to **understanding rights and responsibilities, and fees and charges**. • *User Rights Principles 2014* - s14, 19AC, 22 and 23AF (2)

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.3	The provider allows older people the time they need to consider and review their options and seek external advice before making decisions. **Note:** It is expected that (as per Outcome 1.3), all information relating to agreements is provided to older people in a way they understand, including where this may require the provider to engage a translator or interpreter to help communicate with older people. **Action updated to clarify the expectation that providers would allow older people the time they need to review and consider information before making decisions.**	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.	Clarify	Clarified to ensure older people are allowed **the time they need** to consider and review their options and seek **external advice** before entering into an agreement about their care and services. Provisions in existing legislation speaks partially to the key concepts: • *User Rights Principles 2014* - s15(3)(a)(ii) and • 23(3)(a)(ii) include agreement cannot be varied without mutual consent following adequate consultation and reasonable notice.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.4	The provider informs the older person of any changes to previously agreed fees and charges and seeks their informed consent to implement these changes before they are made. **Note:** It is expected that (as per Outcome 1.3), all information relating to agreements is provided to older people in a way they understand, including where this may require the provider to engage a translator or interpreter to help communicate with older people.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.	Clarify	Clarified to include explicit requirements to inform older people of **changes to previously agreed fees and charges**, and the need to seek their **informed consent** before implementing changes. Provisions in existing legislation speaks partially to the key concepts: • *User Rights Principles 2014* - s15(3)(a)(ii) and • 23(3)(a)(ii) include agreement cannot be varied without mutual consent following adequate consultation and reasonable notice.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.5	The provider implements a system to ensure prices, fees and payments are accurate and transparent for older people.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.	Clarify	Clarified to include specific requirements for **providers to implement a system** to ensure prices, fees and payments are accurate and transparent for older people.

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.6	The provider ensures invoices are timely, accurate, clear and presented in a way the older person understands.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.	Existing legislation	Provision in existing legislation in relation to **invoices which are clear and easy to understand**. • *User Rights Principles 2014* - s14, 19AE

Standard 1: The Person

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
1.4	Transparency and agreements	Older people have autonomy and can take time and seek advice before entering into any agreements about their care and services. Older people are supported to understand agreements, fees and invoices to make informed decisions. **Outcome statement updated to introduce the expectation that older people be supported to make informed decisions about their agreements, fees and invoices in line with other areas of the Standards.**	1.4.7	The provider promptly addresses any overcharging and provides refunds to older people.	N/A	Existing legislation	Provision in existing legislation in relation to **addressing overcharging and providing refunds to older people**. • *User Rights Principles 2014* - s15 Fees and Payments Principles s11 and 13

Standard 2: The Organisation

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
2.1	Partnering with older people	Meaningful and active partnerships with older people inform organisation priorities and continuous improvement. **Outcome statement updated to improve clarity and focus on continuous improvement.**	2.1.1	The governing body partners with older people to set priorities and strategic directions for the way care and services are provided.	• 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.	Clarify	Clarified from engagement to **partnering directly** with older people. **Standard Intent changed** to enhance worker voice.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.1	Partnering with older people	Meaningful and active partnerships with older people inform organisation priorities and continuous improvement. **Outcome statement updated to improve clarity and focus on continuous improvement.**	2.1.2	The provider supports older people to participate in partnerships and partners with older people: a. who reflect the diversity of those who use their services b. who identify as Aboriginal and Torres Strait Islander to ensure care and services are accessible to, and culturally safe for, Aboriginal and Torres Strait Islander peoples. **Action updated to condense Actions 2.1.5 and 2.1.6 into 2.1.2.**	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (iii) make decisions about their own care and the way care and services are delivered; and (iv) make decisions about when family, friends, carers or others should be involved in their care; and (v) communicate their decisions. • 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. • 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.	Clarify	Clarified to **supporting** older people to **participate** in **partnerships** and specify the partnerships must reflect diversity and support accessibility for Aboriginal and Torres Strait Islander older peoples.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.1	Partnering with older people	Meaningful and active partnerships with older people inform organisation priorities and continuous improvement. **Outcome statement updated to improve clarity and focus on continuous improvement.**	2.1.3	The provider partners with older people in the design, delivery, evaluation and improvement of quality care and services. **Action updated to incorporate governance considerations removed from 2.1.3.**	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. • 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.	Clarify	Clarified to **partnering** with older people in the **governance** of the organisation.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.2	Quality and safety culture	The governing body leads a culture of safety, inclusion and quality, that focuses on continuous improvement, embraces diversity and prioritises the safety, health and wellbeing of older people and the workforce. **Outcome statement updated to improve clarity.**	2.2.1	The governing body leads a positive culture of quality care and services and continuous improvement and demonstrates that this culture exists within the organisation.	• 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (ii) continuous improvement.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.2	Quality and safety culture	The governing body leads a culture of safety, inclusion and quality, that focuses on continuous improvement, embraces diversity and prioritises the safety, health and wellbeing of older people and the workforce. **Outcome statement updated to improve clarity.**	2.2.2	In strategic and business planning, the governing body: a. prioritises the safety, health and wellbeing of older people and workers b. ensures that care and services are accessible to, and appropriate for, people with specific needs and diverse backgrounds, Aboriginal and Torres Strait Islander peoples and people living with dementia c. actively engages and consults with workers d. considers legislative requirements, organisational and operational risks, workforce needs and the wider organisational environment. **Action updated to enhance worker voice.**	• 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iii) supporting consumers to live the best life they can.	New/ enhanced	New/enhanced requirements on the governing body: • for **strategic and business planning**. • to address, through strategies and business planning, access issues for **First Nations people** and older people living with **dementia**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.1	The provider implements a quality system that: a. supports quality care and services for all older people b. sets out accountabilities and responsibilities for supporting quality care and services, specific to different roles c. sets strategic and operational expectations to support quality care and services d. enables the governing body to monitor the organisation's performance in delivering quality care and services, informed by: (i) feedback from family, carers and workers (ii) analysis of risks, complaints and incidents (and their underlying causes) (iii) Quality Indicator data (iv) contemporary, evidence-based practice e. supports the provider to meet strategic and operational expectations and identify opportunities for improvement.	• 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance. • 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship (ii) minimising the use of restraint (iii) open disclosure.	Clarify	Clarified to include specific requirements for a **quality system**, which takes into consideration a broader range of inputs.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.2	The governing body monitors investment in priority areas to deliver quality care and services.	• 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance, including the assignment	New/ enhanced	New/enhanced requirement which ensures investments in priority areas **deliver improved outcomes** for older people.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.3	The provider regularly reviews and improves the effectiveness of the quality system.	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (ii) continuous improvement.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.4	The provider regularly reports on its quality system and performance to older people, family, carers and workers. **Action updated to enhance the worker voice.**	N/A	New/ enhanced	New/enhanced requirement to **regularly report on quality system** and performance to **older people**, families, carers and workers.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.5	The provider practices open disclosure and communicates with older people, family, carers and workers when things go wrong. **Action updated to enhance the worker voice.**	• 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (iii) open disclosure. • 6 (3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.3	Accountability and quality system	The governing body is accountable for the delivery of quality care and services and maintains oversight of all aspects of the organisation's operations. The provider's quality system enables and drives continuous improvement of the care and services. Current policies and procedures guide the way workers undertake their roles. **Outcome changed to include specific requirements from Outcome 2.7 regarding current policies and procedures guiding practice for a quality system, which takes into consideration a broader range of inputs.**	2.3.6	The provider maintains and implements policies and procedures that are current, regularly reviewed, informed by contemporary, evidence-based practice, and are understood and accessible by workers and relevant parties. **Action moved from 2.7 (Information management).**	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance, including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Clarify	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.4	Risk management	The provider uses a risk management system to identify, manage and continuously review risks to older people, workers and the provider's operations. **Outcome statement updated to improve clarity.**	2.4.1	The provider implements a risk management system to identify, assess, document, manage and regularly review risks to older people, workers and the organisation.	• 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified requirements in relation to **risk management systems**, including **regularly reviewing** risks to older people, workers and the organisation.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.4	Risk management	The provider uses a risk management system to identify, manage and continuously review risks to older people, workers and the provider's operations. **Outcome statement updated to improve clarity.**	2.4.2	The provider puts strategies in place and undertakes actions to prevent, control, minimise or eliminate identified risks.	• 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers.	Clarify	Clarified requirements in relation to **risk management systems**, including broad **risk mitigation** strategies and actions.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.4	Risk management	The provider uses a risk management system to identify, manage and continuously review risks to older people, workers and the provider's operations. **Outcome statement updated to improve clarity.**	2.4.3	The provider collects and analyses data and engages with older people and workers to inform risk assessment and management. This feeds into the provider's quality system to improve care and services.	• 6 (3) The organisation demonstrates the following: – 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. – 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarifies expectations that providers use input and feedback to inform continuous improvement including in relation to risk assessment and management, including collecting and **analysing data**, engaging with older people and workers, to inform **quality systems**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.4	Risk management	The provider uses a risk management system to identify, manage and continuously review risks to older people, workers and the provider's operations. **Outcome statement updated to improve clarity.**	2.4.4	The provider regularly reviews and improves the effectiveness of the risk management system.	• 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified requirements, requiring an effective **risk management system**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.1	The provider implements an incident management system to record, investigate, respond to and manage incidents and near misses that occur in connection with the delivery of care and services and reduces or prevents incidents from recurring.	• 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Existing legislation	Provision in existing legislation in relation to **incident management system requirements and expectations**. Provision in existing legislation in relation to **incident management**: • *Quality of Care Principles 2014* - Part 4B • *Accountability Principles 2014* - S53C • *Aged Care Act 1997* - S54-1 and S54-3

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.2	The provider takes timely action to respond to and manage incidents.	• 6 (3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. • 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Existing legislation	Provision in existing legislation in relation to **incident management system requirements and expectations**. • *Quality of Care Principles 2014* - Part 4B - S54-3 relating to reporting of incidents

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.3	The provider supports older people, family and carers to report incidents and encourages their involvement in identifying ways to reduce incidents from occurring.	• 6 (3) The organisation demonstrates the following: – 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified to include **support** for older people, family and carers to report incidents and **encourages their involvement** in identifying ways to reduce incidents from occurring.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.4	The provider supports the workforce to prevent, recognise, respond to and report incidents.	• 7 (3)(c) The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles. • 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified to articulate specific **incident management responsibilities** for the **workforce**.
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.5	The provider collects and analyses incident data. Outcomes are reported to older people and workers and feed into the provider's quality system to improve the quality of care and services.	• 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (ii) continuous improvement (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Existing	Provision in existing legislation in relation to **incident management reporting**. • *Aged Care Act 1997* - s63-1G (3) • *Quality of Care Principles 2014* - s15LB (1) • *Accountability Principles 2014* - s53E

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.5	Incident management	The provider uses an incident management system to safeguard older people and acknowledge, respond to, effectively manage and learn from incidents.	2.5.6	The provider regularly reviews and improves the effectiveness of the incident management system.	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (ii) continuous improvement (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (iv) managing and preventing incidents, including the use of an incident management system.	Existing legislation	Provision in existing legislation in relation to **review and continuous improvement of incident management systems**. • *Quality of Care Principles 2014* - s15LB

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.1	The provider implements a complaints management system to receive, record, respond to and report on complaints.	• 6 (3) The organisation demonstrates the following: – 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. – 6 (3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (vi) feedback and complaints.	Existing legislation	Provision in existing legislation in relation to **complaint resolution mechanisms**. • *Aged Care Act 1997* - s56-4

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.2	The provider encourages and supports older people, families and carers, workers and others to provide feedback and make complaints.	• 6 (3) The organisation demonstrates the following: – 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.3	Older people are empowered to access advocates, language services and other ways of raising and resolving feedback and complaints.	• 6 (3) The organisation demonstrates the following: – 6 (3)(b) Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.4	The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong.	• 6 (3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.	Existing legislation	Provision in existing legislation in relation to **complaint resolution expectations and requirements**. • *Aged Care Act 1997* - s56-4 • *Code of Conduct for Aged Care* also refers to providers/ workers promptly taking steps to act on concerns.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.5	The provider collects and analyses feedback and complaints data. Outcomes are reported to the governing body, older people and workers and inform the provider's quality system to improve the quality of care and services.	• 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (vi) feedback and complaints.	Clarify	Clarified requirements in relation to review of feedback and complaints, to include specific requirements to **report outcomes to older people and workers**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.6	Feedback and complaints management	Older people, **workers** and others are encouraged and supported to provide feedback and make complaints about care and services **without reprisal**. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services. **Outcome Statement changed to capture the worker's voice and require no reprisal when feedback is provided.**	2.6.6	The provider regularly reviews and improves the effectiveness of the complaints management system.	• 6 (3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (vi) feedback and complaints.	Clarify	Clarified to include monitoring **effectiveness of complaints resolution mechanism**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.7	Information management	Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it. The information of older people is confidential and managed appropriately, in line with their informed consent.	2.7.1	The provider implements an information management system to securely manage records.	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management.	Existing legislation	Provision in existing legislation in relation to **information management systems** which securely manage records. • *Aged Care Act 1997* - s62-1

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.7	Information management	Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it. The information of older people is confidential and managed appropriately, in line with their informed consent.	2.7.2	The provider's information management system ensures that: a. workers and older people have access to the right information at the right time to deliver and receive quality care and services b. the accuracy and completeness of information collected and stored is maintained c. informed consent is sought to collect, use and store the information of older people or to disclose their information (including assessments) to other parties d. older people understand their right to access or correct their information or withdraw their consent to share information e. information from different sources is integrated.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. • 1 (3)(f) Each consumer's privacy is respected and personal information kept confidential. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management.	Clarify	Clarified requirements in relation to information management systems, including specific requirements regarding: • the system enabling appropriate access to information • the accuracy and completeness of information collected and stored in the system. Provisions in existing legislation speak partially to the key concepts in relation to older people understanding and having access to information held about them. • *Charter of Aged Care Rights 2014*

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.7	Information management	Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it. The information of older people is confidential and managed appropriately, in line with their informed consent.	2.7.3	The provider regularly reviews and improves the effectiveness of the information management system.	8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management.	Clarify	Clarified to introduce a specific action for providers to **review and improve** the effectiveness of the information management system.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.8	Workforce planning	The provider understands and manages its workforce needs and plans for the future.	2.8.1	The provider implements a workforce strategy to: a. identify, record and monitor the number and mix of workers required and engaged to manage and deliver quality care and services b. meet minimum care requirements and engage with workers on how planning and rostering will achieve these requirements c. identify the skills, qualifications and competencies required for each role d. engage suitably qualified and competent workers e. use direct employment to engage workers whenever possible and minimise the use of independent contractors **Action updated to reflect worker voice.**	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (iv) workforce governance – including the assignment of clear responsibilities and accountabilities. • 7 (3)(a) The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. • 7 (3)(c) The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles.	Clarify	Clarified requirements in relation to workforce governance – including implementation of a **workforce strategy**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.8	Workforce planning	The provider understands and manages its workforce needs and plans for the future.	2.8.2	Mitigate the risk and impact of workforce shortages and worker absences or vacancies. The provider implements strategies for supporting and maintaining a satisfied and psychologically safe workforce.	• 7 (3)(a) The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. • 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. • 7 (3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce.	New/ enhanced	New/enhanced requirement regarding supporting and maintaining a **satisfied and psychologically safe workforce**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.1	The provider maintains records of worker pre-employment checks, contact details, qualifications and experience.	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Existing legislation	Provision in existing legislation in relation to **workforce checks and record management**. • *Records Principles 2014* - s6B and 9

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.2	The provider deploys the number and mix of workers to enable the delivery and management of quality care and services.	• 7 (3)(a) The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.3	Workers have access to supervision, support and resources.	• 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.	Clarify	Clarified to include specific requirement for **workers** to have access to **supervision and resources**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.4	The provider maintains and implements a training system that: a. includes training strategies to ensure that workers have the necessary skills, qualifications and competencies to effectively perform their role b. draws on the experience of older people to inform training strategies c. is responsive to feedback, complaints, incidents, identified risks and the outcomes of regular worker performance reviews.	• 7 (3)(c) The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles. • 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. • 7 (3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce.	Clarify	Clarified to include requirements for a training system that **draws on the experience of older people** and is **responsive to** multiple inputs.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.5	The provider regularly reviews and improves the effectiveness of the training system.	8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Clarify	Clarified continuous improvement requirements to explicitly reference regular reviews and improvements of the **training system**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.6	All workers regularly receive competency-based training in relation to core matters, at a minimum: a. the delivery of person-centred, rights-based care b. culturally safe, trauma aware and healing informed care c. caring for people living with dementia d. responding to medical emergencies e. the requirements of the Code of Conduct, the Serious Incident Response Scheme, the Quality Standards and other requirements relevant to the worker's role.	• 7 (3)(c) The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles. • 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.	Clarify	Clarified workforce training requirements to include explicit **competency-based training** in relation to **core matters**.

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.9	Human resource management	The care and services needs of older people are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise and experience to provide quality care and services. Workers are provided with training and supervision to effectively perform their role. **Outcome statement expanded to include the requirement for provision for worker training and supervision.**	2.9.7	The provider undertakes regular assessment, monitoring and review of the performance of workers.	• 7 (3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce.	Align	

Standard 2: The Organisation

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
2.10	Emergency and disaster management	Emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of older people and workers.	2.10.1	The provider develops emergency and disaster management plans that describe how the organisation and workers will respond to an emergency or disaster and manage risks to the health, safety and wellbeing of older people and workers.	N/A	New/ enhanced	New requirements for **emergency and disaster management planning** to align with existing requirements outside the Quality Standards.
2.10	Emergency and disaster management	Emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of older people and workers.	2.10.2	The provider implements strategies to prepare for, and respond to, an emergency or disaster.	N/A	New/ enhanced	New requirements for **emergency and disaster management preparation and response strategies** to align with existing requirements outside the Quality Standards.
2.10	Emergency and disaster management	Emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of older people and workers.	2.10.3	The provider engages with older people, family, carers and workers about the emergency and disaster management plans.	N/A	New/ enhanced	New/enhanced requirement for **emergency and disaster management planning** to include **engagement with older people, families, carers and workers**.
2.10	Emergency and disaster management	Emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of older people and workers.	2.10.4	The provider regularly tests and reviews the emergency and disaster management plans in partnership with older people, families, carers, workers and other response partners.	N/A	New/ enhanced	New/enhanced requirement **for regular testing and review of emergency and disaster management plans**.

Standard 3: The Care and Services

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	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.	• 2 (3) The organisation demonstrates the following: – 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services – 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 4 (3) The organisation demonstrates the following: – 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life – 4 (3)(b) Services and supports for daily living promote each consumer's emotional, spiritual and psychological wellbeing. • 8 (3) The organisation demonstrates the following: – 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.	Clarify	Clarified to articulate the components of an older person's health and wellbeing which need to be considered during the planning process, articulate that **strategies** need to be identified to **manage** associated **risks**, and include consideration of **quality of life, reablement and maintenance of function optimisation**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	3.1.2	Assessment and planning are based on ongoing communication and partnership with the older person and others that the older person wishes to involve.	• 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 8 (3) The organisation demonstrates the following: – 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.	Align	

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	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.	• 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.	Clarify	

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	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.	• 2 (3) The organisation demonstrates the following: – 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services – 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning – 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided, if the consumer wishes – 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3) The organisation demonstrates the following: – 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Align	

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	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 an 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. **Action expanded to incorporate an action removed from Standard 5.**	• 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.	Clarify	Clarified to more clearly articulate detail regarding **when** care and **services** plans need to be **reviewed**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.1	Assessment and planning	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. **Outcome statement changed for clarification.**	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. **Action added to Outcome 3.1, moved from Outcome 5.4.**	• 2 (3) The organisation demonstrates the following: – 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and well being, informs the delivery of safe and effective care and services. – 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing.	Clarify	Where care and services plans are accessed by older people, the provider may develop a summary version, noting that care and services plans are often likely to include significant volumes of information about a person's care and services. However, the older person must have access to their full care and services plan if requested.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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.	• 3 (3) The organisation demonstrates the following: – 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life.	Clarify	Clarified to include **contemporary best practice** (not just best practice), articulate that care must be tailored to **needs, goals, and preferences** and that quality of life must be **supported**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life.	Clarify	Clarified to include greater focus on providing care and services which **support reablement**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	3.2.3	Older people are supported to use equipment, aids, devices and products safely and effectively.	• 4 (3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.	Clarify	Clarified to include a specific action to **support** older people to **use equipment, aids, devices** and products **safely and effectively**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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.	• 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services. • 4 (3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified to articulate that referrals are to **support early identification** and **intervention**, **reablement**, maintenance of function and quality of life, and an action that includes referrals to health professionals and My Aged Care which is more specific than existing requirements.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	3.2.5	The provider implements strategies for supporting workers to: a. recognise 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.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to articulate the need for **strategies** for **workers** to **recognise risks** or concerns related to an older person, **identify** deterioration or changes in the older person, and **respond** to and **escalate risks** in a timely manner.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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).	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services. • 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	New/ enhanced	New/enhanced requirement to have a **system** to **identify** and review the **skills and strengths** of people living with dementia and **encouraging their use** on a day-to-day basis.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	3.2.7	The provider minimises 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. **Note:** It is intended this Action align with any requirements regarding the use of restrictive practices in the legislation.	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 8 (3) The organisation demonstrates the following: – 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship (ii) minimising the use of restraint (iii) open disclosure.	Align	For residential care and short-term restorative care delivered in a residential setting these actions are aligned with the restrictive practice requirements detailed in Part 4A of the Quality of Care Principles.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.	Clarify	New/enhanced requirement to make reasonable efforts to **involve older persons** in **selecting** their **workers**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.2	Delivery of care and services	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. **Note:** This outcome is intended to apply to all care and services, where a provider is subject to the Quality Standards regardless of the service type or setting.	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.	• 1 (3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 7 (3) The organisation demonstrates the following: – 7 (3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity.	Clarify	Clarified to include specific actions for providers to support workers to **understand** the way **different older people communicate**, including people who have difficulty communicating, **communicate effectively** with different older people, **both verbally and non-verbally**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.3	Communicating for safety and quality	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 included in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.	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)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified requirements in relation to communication, to articulate that **critical information** is required to be **effectively communicated in a timely way**.
3.3	Communicating for safety and quality	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 included in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.	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)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified requirements in relation to communication, which specify **care episodes** where communication is critical, including during **transitions of care**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.3	Communicating for safety and quality	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 included in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.	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.	• Standard 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 8 (3) The organisation demonstrates the following: – 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. – 8 (3)(c) Effective organisation wide governance systems relating to the following: (vi) feedback and complaints.	Clarify	Clarified to include a **formal process** for all those involved in the older person's care to **escalate concerns** about their **health and wellbeing**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.3	Communicating for safety and quality	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 included in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.	3.3.4	The provider implements processes that: a. correctly identify and match older people to their care and services b. provides Care Statements to older people in residential aged care.	2 (3) The organisation demonstrates the following: – 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. – 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	New/ enhanced	New/enhanced requirements to: • **identify and match** older people to their care and services • provide **monthly care statements**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.4	Coordination of care and services	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.	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.	• 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified to include a requirement to **identify** others involved in the older person's care and ensure coordination.
3.4	Coordination of care and services	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.	3.4.2	Carers are recognised as partners in the older person's care and involved in the coordination of care and services.	• 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.	Clarify	Clarified requirements in relation to others involved in the older persons care, to include **recognition and involvement of carers**.

Standard 3: The Care and Services

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
3.4	Coordination of care and services	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.	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. **Note:** Under the new Support at Home Aged Care Program, it is expected there will be a care management service type. Where this service is being provided, care coordination would be the responsibility of this provider.	• 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified requirements in relation to planned and coordinated **transitions of care**.

Standard 4: The Environment

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
4.1a	Environment and equipment at home	Providers support older people to mitigate environmental risks relevant to their care and services. Where equipment is used in the delivery of care and services or given to the older person by the provider, it is safe and meets the needs of older people.	4.1a.1	Where care and services are delivered in the older person's home, as relevant to the services being delivered, the provider: a. identifies any environmental risks to the safety of the older person b. discusses with the older person, any environmental risks and options to mitigate these.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services. • 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. • (3)(2) The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer's needs, goals and preferences to optimise health and wellbeing.	Clarify	Clarified to include specific action to **identify and discuss** with the older person any **environmental risks** in the older persons home and how these can be **mitigated**.

Standard 4: The Environment

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
4.1a	Environment and equipment at home	Providers support older people to mitigate environmental risks relevant to their care and services. Where equipment is used in the delivery of care and services or given to the older person by the provider, it is safe and meets the needs of older people.	4.1a.2	Equipment and aids provided by the provider are safe, clean, well-maintained and meets the needs of older people. **Note:** These requirements would apply to care and services delivered to older people in their own home.	• 4 (3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained. • 5 (3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.	Align	
4.1b	Environment and equipment in a service environment	Older people access care and services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Equipment used in the delivery of care and services is safe and meets the needs of older people.	4.1b.1	The provider ensures the service environment is: a. routinely cleaned and well-maintained b. safe, welcoming and comfortable c. fit-for-purpose.	• 5 (3) The organisation demonstrates the following: – 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function. – 5 (3)(b) The service environment: (i) is safe, clean, well maintained and comfortable – 5 (3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.	Clarify	Clarified to include that the service environment is **fit-for-purpose**.

Standard 4: The Environment

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
4.1b	Environment and equipment in a service environment	Older people access care and services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Equipment used in the delivery of care and services is safe and meets the needs of older people.	4.1b.2	The provider ensures the service environment: a. is accessible, including for older people with disability b. promotes movement, engagement and inclusion through design c. enables older people to move freely both indoors and outdoors d. unobtrusively reduces safety risks, optimises useful stimulation and is easy to navigate.	• 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function. • 5 (3)(b) The service environment: (ii) enables consumers to move freely, both indoors and outdoors. • 5 (3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.	Clarify	Clarified to include specific actions relating to a service environment which: • is accessible, including for older **people with a disability** • promote movement, engagement and inclusion **through design** • **unobtrusively reduce safety risks**, optimises useful stimulation and is easy to navigate.
4.1b	Environment and equipment in a service environment	Older people access care and services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Equipment used in the delivery of care and services is safe and meets the needs of older people.	4.1b.3	Equipment used in the delivery of care and services is safe, clean, well-maintained and meets the needs of older people.	• 4 (3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained. • 5 (3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.	Align	

Standard 4: The Environment

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
4.2	Infection prevention and control	The provider has an appropriate infection prevention and control system. Workers use hygienic practices and take appropriate infection prevention and control precautions when providing care and services.	4.2.1	The provider implements a system for infection prevention and control that is used where care and services are delivered, which: a. identifies an appropriately qualified and trained infection prevention and control lead b. prioritises the rights, safety, health and wellbeing of older people c. complies with contemporary, evidence-based practice d. describes standard and transmission-based precautions appropriate for the setting, including cleaning practices, hand hygiene practices, respiratory hygiene, cough etiquette and waste management and disposal e. ensures personal protective equipment is available to workers, older people and others who may need it.	• 3 (3)(g) Minimisation of infection-related risks through implementing: (i) standard and transmission-based precautions to prevent and control infection. • 3 (3) The organisation demonstrates the following: – 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints.	Clarify	Expands upon existing infection and control requirements to include requirements for an **infection control lead**, that precautions must be **appropriate for the setting**, detail as to what must be included, that it must **respond to novel viruses, be informed by immunisation rates** and **respond promptly** to outbreaks. Clarified to include specific requirements relating to **personal protective equipment** for infection prevention and control.

Standard 4: The Environment

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
				f. supports workers, older people and others who need to use personal protective equipment to correctly use the personal protective equipment g. includes additional precautions to respond promptly to novel viruses and outbreaks of infectious diseases (suspected or confirmed) h. communicates and manages infection risks to older people, family, carers and workers i. is informed by worker and older person immunisation and infection rates j. undertakes risk-based vaccine-preventable disease screening and immunisation for older people and workers k. implements disease screening and immunisation requirements for visitors. **Action updated and re-ordered to improve clarity. Actions 4.2.1 and 4.2.2 were combined due to similarity. Actions incorporated from Outcome 5.2.**	• 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system. • 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship (ii) minimising the use of restraint (iii) open disclosure. • 3 (3)(g) Minimisation of infection-related risks through implementing: (i) standard and transmission based precautions to prevent and control infection. • 7 (3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.		

Standard 5: Clinical Care

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
5.1	Clinical governance	The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.	5.1.1	The governing body: a. sets priorities and strategic directions for safe and quality clinical care and ensures that these are communicated effectively to workers and older people b. endorses the clinical governance framework c. monitors the safety and quality of clinical systems and performance.	• 8 (3)(b) The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Expands on the existing requirements relating to governing bodies, with specific actions relating to **clinical governance**. Provisions in existing legislation speak partially to the key concepts in relation to clinical governance: • *Accountability Principles 2014* - S53B(2): requirement for quality care advisory body to include people involved in provision of clinical care • *Aged Care Act 1997* - S63-1D: responsibilities of certain providers relating to the governing body to include at least one member with clinical care experience and • S63-1E: to seek advice from a person with clinical experience if necessary.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
					• 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship (ii) minimising the use of restraint (iii) open disclosure.		

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.1	Clinical governance	The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.	5.1.2	The provider implements the clinical governance framework as part of corporate governance, to drive safety and quality improvement. **Action updated and sub-points moved to other Outcomes.**	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (iii) financial governance (iv) workforce governance – including the assignment of clear responsibilities and accountabilities (v) regulatory compliance (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system. • 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship (ii) minimising the use of restraint (iii) open disclosure.	Clarify	Clarified to demonstrate the relationship between clinical and corporate governance in safety and quality improvement.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.1	Clinical governance	The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.	5.1.3	The provider implements processes to ensure workers providing clinical care are qualified, competent and work within their defined scope of practice or role.	• 7 (3)(c) The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles.	Clarify	Clarified to include a specific action for providers to implement processes to ensure workers providing clinical care work within their **defined scope of practice** or role. **Note:** Provisions in existing legislation speak partially to the key concepts in relation to clinical staffing requirements: • *Code of Conduct for Aged Care* • *Aged Care Act 1997* - S54-1A • *Quality of Care Principles 2014* - Part 4C.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.1	Clinical governance	The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.	5.1.4	The provider and health professionals agree on their respective roles, responsibilities and protocols for providing quality clinical care.	• 2 (3)(c) Assessment and planning: (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) workforce governance – including the assignment of clear responsibilities and accountabilities.	New/ enhanced	New/enhanced requirement for the **provider and health professionals** to **agree** on their **respective roles**, **responsibilities** and **protocols** for providing **clinical care** - which is not included within the scope of the current requirements under Standard 8.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.1	Clinical governance	The governing body meets its duty of care to older people and continuously improves the safety and quality of the provider's clinical care. The provider integrates clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care for older people.	5.1.5	The provider works towards implementing a digital clinical information system that: a. integrates clinical information into nationally agreed digital health and aged care records b. supports interoperability using established national Healthcare Identifiers, terminology and digital health standards c. has processes for workers and others to access information in compliance with legislative requirements. **Action updated to improve clarity and reduce repetition.**	N/A	New/ enhanced	New/enhanced requirement for providers to work towards implementing a **digital clinical information system**.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.2	Preventing and controlling infections in clinical care	Older people, workers, health professionals and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance. Infection risks are minimised and, if they occur, are managed effectively.	5.2.1	The provider implements an antimicrobial stewardship system that complies with contemporary, evidence-based practice and is relevant to the service context.	• 8 (3)(e) Where clinical care is provided – a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship. • 3 (3)(g) Minimisation of infection-related risks through implementing: (i) standard and transmission-based precautions to prevent and control infection; and (ii) practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.	Clarify	Clarified to include an action to implement an antimicrobial stewardship system that **is relevant to the service context**.
5.2	Preventing and controlling infections in clinical care	Older people, workers, health professionals and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance. Infection risks are minimised and, if they occur, are managed effectively.	5.2.2	The provider implements processes to minimise and manage infection when providing clinical care that includes but is not limited to: a. performing clean procedures and aseptic techniques b. using, managing and reviewing invasive devices including urinary catheters c. minimising the transmission of infections and other complications from infections.	• 3 (3)(g) Minimisation of infection-related risks through implementing: (i) standard and transmission-based precautions to prevent and control infection; and (ii) practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.	Clarify	Clarified to include a specific action to **minimise and manage infections** when performing **clean procedures**, **aseptic techniques**, and **using, managing, and reviewing invasive devices** when providing clinical care.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.1	The provider implements a system for the safe and quality use of medicines, including processes to ensure: a. ensure medicines-related information is available to workers and the older person b. ensure workers and others caring for an older person have access to the older person's up-to-date medicines list and other supporting information at transitions of care c. ensure safe administration including assessing the older person's swallowing ability, determining suitability of crushing medicines and providing alternative safe formulations when required d. minimal interruptions to the administration of prescribed medicines including supporting access to medicines when an older person is prescribed a new medicine or an urgent change to their medicine	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(g) Minimisation of infection-related risks through implementing: (ii) practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified requirements regarding the **safe and quality use of medicines** that includes a number of specific processes.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
				e. ensure a current, accurate and reliable record of all medicines is documented and the clinical reasons for the treatment are stated, including pro re nata (PRN) medicines f. support remote access for prescribing. **Action updated to improve clarity**			

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.2	The provider has processes to ensure medication reviews are conducted including: a. at the commencement of care, at transitions of care and annually when care is ongoing b. when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell c. when there is polypharmacy and the potential to deprescribe d. when a new medicine is commenced, or a change is made to an existing medicine or to the medication management plan e. when there is an adverse event potentially related to medicines. **Action 5.3.2(b) updated to improve clarity.**	• 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	New/ enhanced	New/enhanced requirement for providers to have **processes to ensure medication reviews** are conducted and **includes actions to specify when these must occur**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.3	The provider documents existing or known allergies or side effects to medicines, vaccines or other substances at the commencement of care and monitors and updates documentation when new allergies or side effects occur.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services.	Clarify	Clarified to include a specific action for providers to **document existing or known allergies** or **side effects** to medicines, vaccines or other substances at the commencement of care and monitor and update documentation when new allergies or side effects occur.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.4	The provider implements processes to identify, monitor and mitigate risks to older people associated with the use of high-risk medicines, including reducing the inappropriate use of psychotropic medicines.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	Clarify	Clarified to include a specific action for providers to **implement processes to identify, monitor and mitigate risks** to older people **associated with the use of high-risk medicines**, including reducing the inappropriate use of psychotropic medicines. **Note:** Provisions in existing legislation speak partially to the key concepts to **minimise restrictive practices** in residential care settings and STRC provided in a residential setting: • *Quality of Care Principles 2014* - s15FB

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.5	The provider has processes to report adverse medicine and vaccine events to the Therapeutic Goods Administration. **Action updated to improve clarity.**	N/A	New/ enhanced	New/enhanced requirement for providers to **report adverse medicine and vaccine events** to the Therapeutic Goods Administration.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.3	Safe and Quality use of Medicines	Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm. Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person. Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement. **Outcome statement updated to ensure clarity in the roles relating to medicine prescription and management of adverse events.**	5.3.6	The provider regularly reviews and improves the effectiveness of the system for the safe and quality use of medicines. **Note:** These actions apply to providers responsible for medication management including prescribing, dispensing, provision of information about medicines, storing, administering and monitoring medicines.	• 8 (3)(c) Effective organisation wide governance systems relating to the following: (i) information management (ii) continuous improvement (v) regulatory compliance (vi) feedback and complaints.	New/ enhanced	New/enhanced requirement for providers to regularly **review and improve the effectiveness of the system for the safe and quality use of medicines**.

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Outcome #	Outcome	Outcome statement*	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.4	Comprehensive care	Older people receive comprehensive, safe and quality clinical care that is safe, quality, evidence based, person-centred and delivered by qualified health professionals. Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function. The provider has systems and processes that support coordinated multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences. The provider supports early identification of and response to changing clinical needs. **Outcome updated to improve clarity.**	5.4.1	The provider implements an assessment and planning system that supports partnering with the older person, families, carers and others to set goals of care and support decision making.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 2 (3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.	Align	

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Outcome #	Outcome	Outcome statement*	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.4	Comprehensive care	Older people receive comprehensive, safe and quality clinical care that is safe, quality, evidence based, person-centred and delivered by qualified health professionals. Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function. The provider has systems and processes that support coordinated multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences. The provider supports early identification of and response to changing clinical needs. **Outcome updated to improve clarity.**	5.4.2	The provider conducts a comprehensive clinical assessment on commencement of care, at regular intervals and when needs change that includes: a. facilitating access to a comprehensive medical assessment with a general practitioner b. identifying, documenting and planning for clinical risks, acute conditions and exacerbations of chronic conditions c. identifying an older person's level of clinical frailty and communication barriers and planning clinical care to optimise the older person's quality of life, independence, reablement and maintenance of function. d. identifying and providing access to the equipment, aids, devices and products required by the older person. **Action updated to improve clarity and reduce repetition.**	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.	Clarify	Clarified to include specific action for providers to conduct **a comprehensive clinical assessment** and specifies what this should include, and introduces the concept of **reablement**. **Note:** Provisions in existing legislation speak partially to the key concepts in relation to **access to health professionals**: • *Quality of Care Principles 2014* - s1, Part 2, 2.7

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Outcome #	Outcome	Outcome statement*	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.4	Comprehensive care	Older people receive comprehensive, safe and quality clinical care that is safe, quality, evidence based, person-centred and delivered by qualified health professionals. Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function. The provider has systems and processes that support coordinated multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences. The provider supports early identification of and response to changing clinical needs. **Outcome updated to improve clarity.**	5.4.3	The provider refers and facilitates access to relevant health professionals and medical, rehabilitation, allied health, oral health, specialist nursing and behavioural advisory services to address the older person's clinical needs. **Action updated to improve clarity and reduce repetition.**	• 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Align	

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Outcome #	Outcome	Outcome statement*	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.4	Comprehensive care	Older people receive comprehensive, safe and quality clinical care that is safe, quality, evidence based, person-centred and delivered by qualified health professionals. Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function. The provider has systems and processes that support coordinated multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences. The provider supports early identification of and response to changing clinical needs. **Outcome updated to improve clarity.**	5.4.4	The provider implements processes to: a. deliver coordinated, multidisciplinary and holistic comprehensive care in line with the care and services plan b. communicate and collaborate with others involved in the older person's care, in line with the older person's needs and preferences c. facilitate access to after-hours and urgent clinical care d. provide timely notification to the person's general practitioner, family, carers and health professionals involved in the older person's care when clinical incidents or changes occur. **Action updated: some concepts moved to Standard 3.**	• 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Clarify	Clarified to include a specific action for providers to **implement processes** to **monitor** clinical conditions and **routinely review** and **evaluate** the effectiveness of the older person's **care and services plan** and update the plan. Clarified to include a specific action for providers to **implement processes** to: • **deliver** coordinated, multidisciplinary and holistic **comprehensive care** in line with the care and services plan • **communicate and collaborate** with others involved in the older person's care, in line with the older person's needs and preferences • **facilitate access to after-hours** and urgent clinical care **Note:** This action is based on feedback received.

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Outcome #	Outcome	Outcome statement*	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.4	Comprehensive care	Older people receive comprehensive, safe and quality clinical care that is safe, quality, evidence based, person-centred and delivered by qualified health professionals. Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function. The provider has systems and processes that support coordinated multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences. The provider supports early identification of and response to changing clinical needs. **Outcome updated to improve clarity.**	5.4.5	The provider implements processes to monitor clinical conditions and reassess when there is a change in diagnosis or deterioration in behaviour, cognition, mental, physical or oral health, and at transitions of care.	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified to include a specific action for providers to **implement processes** to: • **notify** the older person's General Practitioner, families, carers and relevant health professionals when **clinical incidents or changes** occur.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.1	The provider implements a system that supports the identification, monitoring and management of high impact and high prevalence clinical care risks, including but not limited to Actions 5.5.2 to 5.5.10 **Action added for clarity.**	• 2 (3) (a) Assessment and planning, including consideration of risks to the consumer's health and well-being, informs the delivery of safe and effective care and services • 3 (3) (a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and well-being. • 3 (3) (b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3) (f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified to require the provider to have effective systems and supports in place to ensure appropriate management of high impact and high prevalence risks.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.2	**Choking and swallowing** The provider implements processes to support safe chewing and swallowing when the older person is eating, drinking, taking oral medicines and during oral care. **Action updated to reduce repetition.**	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Clarify	Clarified requirement for providers to ensure there are processes in place to support effective chewing and swallowing of older people.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.3	**Continence** The provider implements processes for continence care by: a. optimising the older person's dignity, comfort, function and mobility b. ensuring safe and responsive assistance with toileting c. managing incontinence d. protecting the older person's skin integrity and minimising incontinence associated dermatitis **Action updated to reduce repetition.**	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Clarify	Clarified to include a specific action for providers to **implement processes for continence care** and specifies what this should include. **Note:** Provisions in existing legislation speak partially to the key concepts in relation to **continence care**: • *Quality of Care Principles 2014* - s1, Part 2, 2.1(b)

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.4	**Falls and mobility** The provider implements processes to minimise falls and harm from falls by: a. maximising mobility to prevent functional decline b. delivering effective and timely post falls care c. monitoring falls and injuries and review the reason for and consequences from falls **Action updated to improve clarity and reduce repetition.**	• 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Clarify	Clarified to include a specific action for providers to **implement processes** to **maximise mobility** to prevent functional decline, **minimise falls** and harm from falls, deliver effective and timely **post falls care** and monitor falls and injuries and **review the reason for and consequences** from falls. Provisions in existing legislation speak partially to the key concepts in relation to: • *Quality of Care Principles 2014* - s1, Part 2: – 2.1(e) in relation to **mobility aids** – 2.6 in relation to **rehabilitation support**

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.5	**Nutrition and Hydration** The provider implements processes to maintain an older person's nutrition and hydration by: a. conducting regular malnutrition screening b. minimising the impact of chronic conditions c. responding to the risk of malnutrition and when an older person is malnourished or has unplanned weight loss or gain. **Action updated to reduce repetition.**	• 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to include specific requirements regarding **malnutrition**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.6	**Mental health** The provider implements processes to optimise mental health by: a. actively promoting an older person's mental health and wellbeing b. responding to signs of deterioration in an older person's mental health c. responding supportively to distress and symptoms of mental illness including self-harm and suicidal thoughts, minimising risks to the psychological and physical safety of each older person **Action updated to improve clarity and reduce repetition.**	• 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner..	Clarify	Clarified to include a specific action for providers to implement processes to **identify, monitor and respond** to changes in an older person's **mental health and wellbeing** including distress, depressive symptoms, risk of self-harm, suicide or harming others.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.7	**Oral health** The provider implements processes to maintain oral health and prevent decline by: a. facilitating access to a dentist or other oral health practitioner for oral health assessments at the commencement of care, regularly and when required b. monitoring and responding to deterioration in oral health c. assisting with daily oral hygiene needs. **Action updated to improve clarity and reduce repetition.**	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified requirement to **maintain oral health** and **prevent decline** including through assessing, monitoring, reviewing and responding to oral health needs; and **assistance with** daily oral hygiene needs.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.8	**Pain** The provider implements processes to manage pain by: a. assessing the older person's pain including where the older person experiences challenges in communicating their pain b. planning for, monitoring and responding to the older person's need for pain relief c. ensuring pain management is available 24-hours a day. **Action updated to reduce repetition.**	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to include a specific action for providers to **implement processes** regarding pain management, including ensuring **pain management is available**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.9	**Pressure injury and wounds** The provider implements processes to prevent and manage pressure injuries and wounds by: a. conducting routine comprehensive skin inspections b. monitoring and responding to pressure injuries and wounds when they occur. **Action updated to improve clarity and reduce repetition.**	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to include a specific action for providers to implement processes to **prevent, monitor and respond** to **pressure injuries and wounds**.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.5	Clinical safety	Providers identify, monitor and manage high impact and high prevalence clinical care risks to ensure safe, quality clinical care and to reduce the risk of harm to older people. **Outcome updated to improve clarity.**	5.5.10	**Sensory Impairment** The provider implements processes to minimise and manage sensory impairment from hearing loss, vision loss and balance disorders by providing access to and supporting the use of assistive devices and aids to maximise the older person's independence, function and quality of life. **Action updated to improve clarity and reduce repetition.**	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 4 (3)(c) Services and supports for daily living assist each consumer to: (i) participate in their community within and outside the organisation's service environment; and (ii) have social and personal relationships; and (iii) do the things of interest to them.	Clarify	Clarified to specifically include responsibilities for older people with hearing loss, vision loss and balance disorders, and to maximise their wellbeing and **independence** and use of assistive equipment. **Note:** Provisions in existing legislation speak partially to the key concepts in relation to **hearing and vision impairments**: • *Quality of Care Principles 2014* - s1, Part 2, 2.1(f)

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.6	Cognitive impairment	Older people who experience cognitive impairment whether acute, chronic or transitory receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences. Situations and events that may lead to changes in behaviours are identified and understood.	5.6.1	The provider identifies and responds to the complex clinical care needs of people with delirium, dementia and other forms of cognitive impairment by: a. identifying and mitigating clinical risks b. delivering increased care requirements c. being alert to deterioration and underlying contributing clinical factors **Action updated for clarity with minor word changes.**	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified to include specific requirements regarding identifying and responding to the **complexity in the provision of clinical care needs** of people with delirium, dementia and other forms of cognitive impairment, and specifies what this should include. **Note:** Provisions in existing legislation speak partially to the key concepts in relation to **support for consumers with cognitive impairment**: • *Quality of Care Principles 2014* - s1, Part 2, 2.9

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.6	Cognitive impairment	Older people who experience cognitive impairment whether acute, chronic or transitory receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences. Situations and events that may lead to changes in behaviours are identified and understood.	5.6.2	The provider collaborates with older people with cognitive impairment, carers, families and others to understand the person and to optimise clinical care outcomes.	• 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(c) Assessment and planning: (i) is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer.	Clarify	Clarified to include a specific action for providers to **collaborate** with older people with cognitive impairment, carers, families and others to understand the person.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.6	Cognitive impairment	Older people who experience cognitive impairment whether acute, chronic or transitory receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences. Situations and events that may lead to changes in behaviours are identified and understood.	5.6.3	The provider implements processes to: a. identify and minimise situations that may precipitate changes in behaviour b. identify and respond to clinical and other identified causes of changes in behaviour.	• 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to include a specific action for providers to implement processes to proactively **minimise situations** that **may precipitate changes in behaviour** and identify and respond to **cause of changed behaviour**.
5.7	Palliative care and end-of-life care	The older person's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed, and their dignity is preserved. The older person's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life. **Note:** These actions apply to providers according to their service context and the services being delivered.	5.7.1	The provider has processes to recognise when the older person requires palliative care or is approaching the end of their life, supports them to prepare for the end-of-life and responds to their changing needs and preferences.	• 3 (3)(c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. • 2 (3) The organisation demonstrates the following: – 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.	Align	

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.7	Palliative care and end-of-life care	The older person's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed, and their dignity is preserved. The older person's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life. **Note:** These actions apply to providers according to their service context and the services being delivered.	5.7.2	The provider supports the older person, their family, carers and substitute decision maker, to: a. continue end-of-life planning conversations b. discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions c. review advance care planning documents to align with their current needs, goals and preferences. **Action updated to improve clarity and reduce repetition.**	• 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 3 (3)(c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.	Clarify	Clarified to include a specific action for providers to **support** the older person **approaching the end of life** and substitute decision-maker, with family and carers if they choose, to have **advance care planning conversations** and review documents to align them with their needs, goals and preferences.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.7	Palliative care and end-of-life care	The older person's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed, and their dignity is preserved. The older person's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life. **Note:** These actions apply to providers according to their service context and the services being delivered.	5.7.3	The provider uses its processes from comprehensive care, to plan and deliver palliative care that: a. prioritises the comfort and dignity of the older person b. supports the older person's spiritual, cultural, and psychosocial needs c. identifies and manages changes in pain and symptoms d. provides timely access to specialist equipment and medicines for pain and symptom management e. communicates information about the older person's preferences for palliative care and the place where they wish to receive this care to workers, their carers, family and others f. facilitates access to specialist palliative care and end-of-life health professionals when required g. provides a suitable environment for palliative care h. provides information about the process when a person is dying and about loss and bereavement to family and carers. **Action update to reduce repetition.**	• 1 (3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified to include actions for providers to use processes from comprehensive care, **to plan and deliver end-of-life care** and specifies what this should include.

Standard 5: Clinical Care

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
5.7	Palliative care and end-of-life care	The older person's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed, and their dignity is preserved. The older person's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life. **Note:** These actions apply to providers according to their service context and the services being delivered.	5.7.4	The provider implements processes in the last days of life to: a. recognise that the older person is in the last days of life and respond to rapidly changing needs b. ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day c. provide pressure care, oral care, eye care and bowel and bladder care d. recognise and respond to delirium e. minimise unnecessary transfer to hospital, where this is in line with the older person's preferences.	• 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 3 (3)(c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.	Clarify	Clarified to include a specific action for providers to **implement processes** in **the last days of life**, and specifies what this should include.

Standard 6: Food and Nutrition

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
6.1	Partnering with older people on food and nutrition	The provider partners with older people to provide a quality food service which includes appealing and varied food and drinks and an enjoyable dining experience.	6.1.1	The provider partners with older people on how to create an enjoyable food, drinks and dining experience at the service.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity. • 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. • 8 (3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.	New/ enhanced	Introduces a new action to **partner** with older people on how to **create an enjoyable food**, **drinks and dining experience** at the service.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.1	Partnering with older people on food and nutrition	The provider partners with older people to provide a quality food service, which includes appealing and varied food and drinks and an enjoyable dining experience.	6.1.2	The provider implements a system to monitor and continuously improve the food service in response to: a. the satisfaction of older people with the food, drink and the dining experience b. older people's intake of food and drink to ensure it meets their nutritional needs (including review of identified unplanned weight loss and malnutrition identified in Standard 5) c. the impact of food and drink on the health outcomes of older people d. contemporary evidence based practice regarding food and drink.	• 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity. • 6 (3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. • 8 (3)(c) Effective organisation wide governance systems relating to the following: (ii) continuous improvement (vi) feedback and complaints. • 8 (3)(d) Effective risk management systems and practices, including but not limited to the following: (i) managing high-impact or high-prevalence risks associated with the care of consumers (ii) identifying and responding to abuse and neglect of consumers (iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system.	New/ enhanced	Introduces a new action to **monitor and continuously improve** the food service, and specifies what this should include.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.2	Assessment of nutritional needs and preferences	The provider understands the specific nutritional needs of older people and assesses each older person's current needs, abilities and preferences in relation to what and how they eat and drink. **Note:** 'Clinical and other physical issues' may include consideration of a person's oral health, ability to chew and swallow, the impact of medications on appetite, seating and positioning requirements for eating and drinking, dexterity, physical assistance needed to eat and drink, etc.	6.2.1	As part of assessment and planning, the provider assesses and regularly reassesses each older person's nutrition, hydration and dining needs and preferences. The assessment considers: a. the specific nutritional needs of older people, including a focus on protein and calcium rich foods b. the older person's dining needs c. what the older person likes to eat and drink d. when the older person likes to eat and drink e. what makes a positive dining experience for the older person f. clinical and other physical issues identified that impact the older person's ability to eat and drink.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 2 (3)(b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. • 2 (3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. • 3 (3)(b) Effective management of high-impact or high-prevalence risks associated with the care of each consumer. • 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity. • 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function.	Clarify	Clarified to include more specific requirements regarding nutrition and hydration, including actions to assess and **regularly reassess** each older person's nutrition, hydration and **dining needs** and preferences, their **dining experience**, and their **ability** to eat and drink.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.3	Provision of food and drink	Older people receive food and drinks that meet their nutritional needs, are appetising and flavoursome, have variation and choice about what they eat and drink and are able to eat and drink as much as they want.	6.3.1	Menus (including for texture modified diets): a. are designed in partnership with older people b. are developed with the input of chefs/cooks and an Accredited Practising Dietitian, including for older people with specialised dietary needs c. are regularly changed, include variety and enable older people to make choices about what they eat and drink d. enable older people to meet their nutritional needs e. are reviewed at least annually through a menu and mealtime assessment by an Accredited Practising Dietitian.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity.	New/ enhanced	New/enhanced requirements regarding **development and review of menus, in partnership with older people and relevant health professionals**.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.3	Provision of food and drink	Older people receive food and drinks that meet their nutritional needs, are appetising and flavoursome, have variation and choice about what they eat and drink and are able to eat and drink as much as they want.	6.3.2	For each meal, older people can exercise choice about what, when, where and how they eat and drink.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity.	New/ enhanced	New/enhanced requirement for older people to exercise **choice** about **what, when, where and how they eat and drink**.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.3	Provision of food and drink	Older people receive food and drinks that meet their nutritional needs, are appetising and flavoursome, have variation and choice about what they eat and drink and are able to eat and drink as much as they want.	6.3.3	Meals, drinks and snacks provided to older people (including where older people have specialised dietary needs or need support to eat): a. are appetising and flavourful b. are served at the correct temperature and in an appealing way, including the presentation of texture modified foods using tools such as molds c. are prepared and served safely d. meet each older person's assessed needs e. are in accordance with each older person's choice f. reflect the menu.	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity.	Clarify	Clarified to include **specific requirements** regarding provision of **meals, snacks and drinks**. The action was updated due to: word omission

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.3	Provision of food and drink	Older people receive food and drinks that meet their nutritional needs, are appetising and flavoursome, have variation and choice about what they eat and drink and are able to eat and drink as much as they want. **Notes:** • 'Prepared and served safely' refers to food and drink being prepared in line with the applicable food safety requirements and specialised dietary requirements, but also served to older people in a way that is safe for them (e.g., to prevent older people from burning themselves, etc.). • It is intended that older people have opportunities to be safely involved in the preparation of food and drink. This is not explicitly drawn out here as it is expected to be covered by Action 7.1.1(f).	6.3.4	Older people are offered and able to access nutritious snacks and drinks (including water) at all times.	• 4 (3)(f) Where meals are provided, they are varied and of suitable quality and quantity.	New/ enhanced	New/enhanced requirement for providers to **offer and enable access to nutritious snacks and drinks** (including water) **at all times**.

Standard 6: Food and Nutrition

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.4	Dining experience	Older people are supported to eat and drink. The dining experience meets the needs and preferences of older people to support social engagement, function and quality of life.	6.4.1	The provider supports older people to eat and drink, including by: a. making sufficient workers available to support older people to eat and drink b. prompting and encouraging older people to eat and drink c. identifying older people who require support to safely eat or drink d. physically supporting older people who require support to safely eat and drink as much as they want, at their preferred pace.	• 7 (3)(a) The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.	Clarify	Clarified to include **sufficient workers available** to prompt and support older people eat and drink.
6.4	Dining experience	Older people are supported to eat and drink. The dining experience meets the needs and preferences of older people to support social engagement, function and quality of life.	6.4.2	The dining environment supports reablement, social engagement and a sense of belonging and enjoyment.	• 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function. • 5 (3)(b) The service environment: (i) is safe, clean, well maintained and comfortable; and (ii) enables consumers to move freely, both indoors and outdoors.	Clarify	Clarified requirement to specify that the **dining environment** supports a sense of belonging, social engagement, **reablement** and **enjoyment**.

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
6.4	Dining experience	Older people are supported to eat and drink. The dining experience meets the needs and preferences of older people to support social engagement, function and quality of life.	6.4.3	There are opportunities for older people to share food and drinks with their visitors.	N/A	New/ enhanced	New/enhanced requirement for providers to ensure there are opportunities for older people to **share food and drinks with their visitors**.

Standard 7: The Residential Community

Final Draft Revised Aged Care Quality Standards (strengthened Quality Standards) Released 14 December 2023					Aged Care Quality Standards (Quality Standards) in effect www.agedcarequality.gov.au/providers/standards		
Outcome #	**Outcome**	**Outcome statement**	**Action #**	**Action**	**Relevant Quality Standard(s) reference(s)**	**Analysis finding**	**Rationale & key concepts**
7.1	Daily living	Older people receive services and supports for daily living that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.1	The provider supports and enables older people to do the things they want to do, including to: a. participate in lifestyle activities that reflect the diverse nature of the residential community b. promote their quality of life c. minimise boredom and loneliness d. maintain connections and participate in activities that occur outside the residential community e. have social and personal relationships f. contribute to their community through participating in meaningful activities that engage the older person in normal life.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions; and (iv) make connections with others and maintain relationships of choice, including intimate relationships. • 1 (3)(d) Each consumer is supported to take risks to enable them to live the best life they can. • 4 (3) The organisation demonstrates the following: – 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life. – 4 (3)(b) Services and supports for daily living promote each consumer's emotional, spiritual and psychological wellbeing.	Clarify	Clarified to include specific requirements to **minimise boredom and loneliness**.

Standard 7: The Residential Community

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
				Note: Action 7.1.1(f) is intended to enable older people to participate in activities that would be a normal part of their life at home. For example, helping with meal service, setting tables, doing laundry, arranging flowers, etc.	• 4 (3)(c) Services and supports for daily living assist each consumer to: (i) participate in their community within and outside the organisation's service environment; and (ii) have social and personal relationships; and (iii) do the things of interest to them.		
7.1	Daily living	Older people receive services and supports for daily living that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.2	The provider has processes to identify, monitor and record older people's function in relation to activities of daily living.	• 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.	Clarify	Clarified to include **identify, monitor and record** older people's function **in relation to activities of daily living**.

Standard 7: The Residential Community

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
7.1	Daily living	Older people receive services and supports for daily living that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.3	The provider implements strategies to protect the physical and psychological safety of older people.	• 1 (3)(f) Each consumer's privacy is respected and personal information kept confidential. • 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life. • 4 (3)(b) Services and supports for daily living promote each consumer's emotional, spiritual and psychological wellbeing.	Clarify	Clarified to include action to include **strategies** to protect physical and **psychological safety** of older persons.
7.1	Daily living	Older people get services and supports for daily living that optimise their quality of life promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.4	Older people have control over who goes into their room and when this happens.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (vi) make connections with others and maintain relationships of choice, including intimate relationships. • 1 (3)(f) Each consumer's privacy is respected and personal information kept confidential.	Existing legislation	Provisions in existing legislation speak partially to the key concepts in relation to older people having **control** over **who enters their room and when**. Provisions in existing legislation speak partially to the key concepts in relation to **exercising choice**: • *User Rights Principles 2014* • *Charter of Aged Care Rights 2014*

Standard 7: The Residential Community

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
7.1	Daily living	Older people get services and supports for daily living that optimise their quality of life promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.5	Older people can entertain their visitors in private.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (iv) make connections with others and maintain relationships of choice, including intimate relationships. • 1 (3)(f) Each consumer's privacy is respected and personal information kept confidential. • 5 (3)(a) The service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function.	Clarify	Clarified to include action for older persons to be able to **entertain visitors in private**.
7.1	Daily living	Older people get services and supports for daily living that optimise their quality of life promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.	7.1.6	Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (iv) make connections with others and maintain relationships of choice, including intimate relationships.	Clarify	Clarified to include older persons can have relationships and engage in sexual activity **free from judgement**.

Standard 7: The Residential Community

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
7.2	Transitions	Older people experience a well-coordinated transition to or from the provider for planned and unplanned transitions. There is clear responsibility and accountability for an older person's care and services between workers, health professionals and across organisations.	7.2.1	The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that: a. use of hospitals or emergency departments are recorded and monitored b. there is continuity of care for the older person c. older people, their family and carers as appropriate, are engaged in decisions regarding transfers d. receiving family, carers, health professionals or organisations are given timely, current and complete information about the older person as required e. when the older person transitions back to the service, their care and services are reviewed and adjusted as needed.	• 1 (3)(c) Each consumer is supported to exercise choice and independence, including to: (i) make decisions about their own care and the way care and services are delivered; and (ii) make decisions about when family, friends, carers or others should be involved in their care; and (iii) communicate their decisions. • 2 (3)(a) Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services. • 3 (3)(e) Information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. • 4 (3)(d) Information about the consumer's condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.	Clarify	The strengthened Standards are clarified to include specific actions for providers to implement **processes for transitioning older people** from hospitals, other care services, and stays in the community.

Standard 7: The Residential Community

Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
7.2	Transitions	Older people experience a well-coordinated transition to or from the provider for planned and unplanned transitions. There is clear responsibility and accountability for an older person's care and services between workers, health professionals and across organisations.	7.2.2	The provider facilitates access to services offered by health professionals, other individuals or organisations when it is unable to meet the older person's needs.	• 2 (3)(c) Assessment and planning: (ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services. • 4 (3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life. • 4 (3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.	Clarify	Clarified to include specific requirements to **facilitate access** to services offered by health professionals, other individuals or organisations **when it is unable to meet the older person's needs**- this extends beyond existing responsibilities for timely referrals.

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Outcome #	Outcome	Outcome statement	Action #	Action	Relevant Quality Standard(s) reference(s)	Analysis finding	Rationale & key concepts
7.2	Transitions	Older people experience a well-coordinated transition to or from the provider for planned and unplanned transitions. There is clear responsibility and accountability for an older person's care and services between workers, health professionals and across organisations.	7.2.3	The provider maintains connections with specialist health services, including specialist dementia care services, and accesses these services as required. **Note:** While there are some actions relevant to ensuring continuity of care when coordinating with, and transferring older people between, others involved in the older person's care as part of Outcome 3.4, this outcome describes additional/increased expectations about this applicable to residential services, where providers are entirely responsible for the older person's care and services (noting that, under the proposed new Support at In-Home Aged Care Program, older people are likely to have multiple providers involved in delivery of their care and services).	• 3 (3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: (i) Is best practice; and (ii) tailored to their needs; and (iii) optimises their health and wellbeing. • 3 (3)(d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. • 3 (3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services. • 4 (3) The organisation demonstrates the following: – 4 (3)(e) Timely and appropriate access to individuals, other organisations and providers of care and services.	Clarify	Clarified to include a specific action for the provider to **maintain connections** with **specialist services**, including **dementia care services**.

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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