www.pwc.com.au

Expansion of quality indicators for residential aged care

Summary report
July 2022

pwc

ROSA

The University Of Queensland
AUSTRALIA

Table of contents

Disclaimer

This summary report (this document) is not intended to be used by anyone other than the Department of Health and Aged Care (the Department).

We prepared this summary report solely for the Department's use and benefit in accordance with and for the purpose set out in the Work Order with the Department dated 23 September 2021. In doing so, we acted exclusively for the Department and considered no-one else's interests.

We make no representation concerning the appropriateness of this document for anyone other than the Department. If anyone other than the Department chooses to use or rely on it they do so at their own risk.

Liability limited by a scheme approved under Professional Standards legislation.

Acknowledgements

PwC would like to thank aged care stakeholders, including residential aged care services, peak bodies and older Australians, for the time, expertise and lived experience provided throughout the consultation process. We would also like acknowledge the contribution from residential aged care services that participated in the quality indicator pilot.

Finally, our appreciation goes to the representatives of organisations in the Technical Expert Group convened for the project, who provided technical and clinical advice on quality indicator development at multiple stages of the project.

Contact us

If you have any questions about this report, please contact the Department of Health and Aged Care Quality and Assurance Division via email at QPSec@health.gov.au.

Quality indicators have been developed to guide the further expansion of the QI Program in residential aged care

Project partners

The Australian Government Department of Health and Aged Care (the department) engaged a consortium consisting of PricewaterhouseCoopers (PwC), the Centre for Health Services Research at the University of Queensland (UQ CHSR) and the Registry of Senior Australians (ROSA) to assist in the development of quality indicators for residential aged care. The project will guide the further expansion of the National Aged Care Mandatory Quality Indicator Program (QI Program).

The project commenced in September 2021 and was completed in June 2022.

Project objectives

The overall aims of the project are to:

- identify, assess, consult on, and pilot quality indicators across four quality of care domains and examine the use of assessment tools for consumer experience and quality of life (CEQOL)
- provide a high quality and reliable basis to guide further expansion of the QI Program
- support the development of materials for implementation of additional quality indicators within the QI Program.

Project outcomes

The outcomes of the project are to:

- consolidate insights generated through the evidence review, stakeholder and technical expert consultations, and the pilot process
- provide the department with an evidence base to support consideration of potential quality indicators to include in an expanded QI Program.

QI Program

The expansion of the QI Program with additional evidence-informed quality indicators will support continuous service-level quality improvement, and in time, help older Australians and their families make more informed decisions about residential aged care.

The Royal Commission into Aged Care Quality and Safety acknowledged the value of the QI Program and recommended implementing additional quality indicators and consumer experience and quality of life measures in residential aged care.

QI Program objectives:

- to provide older people with information about the quality of aged care services when making choices about their care
- to support aged care services to measure, monitor, compare and improve the quality of their services
- to provide the government with system-level measures of quality in aged care and an evidence-base to inform policy and regulation.

The project consisted of four phases, commencing with an evidence review of national and international literature

Overview of project phases

	Activities & timing	Objective of the phase
Phase 1	**Project plan and initiation** *Sep 2021 – Oct 2021*	Development of a project plan detailing the project approach and scope, including governance arrangements, and detailed project phasing.
Phase 2	**Review of evidence** *Sep 2021 – Oct 2021*	A rapid targeted review of national and international literature to identify quality of care domains and associated quality indicators for assessment and ranking.
	Consultation *Nov 2021 – Feb 2022*	Consultation to gather feedback on the preferred potential quality of care domains and quality indicators, followed by input from technical experts.
Phase 3	**Pilot** *Jan 2022 – Apr 2022*	Recruitment of a nationally representative sample and development of supporting resources to conduct a six-week pilot to test the selected quality indicators.
Phase 4	**Analysis to inform implementation** *May 2022 – Jun 2022*	Pilot data analysis, user experience testing, and technical expert input to inform implementation of potential quality indicators in the QI Program.

Evidence review

A rapid, targeted review of national and international literature was undertaken to identify evidence-based quality of care domains and quality indicators. Each quality of care domain was ranked based on feasibility, scientific acceptability, importance, usability, attribution and value to the QI program.

Consumer experience and quality of life (CEQOL) measures were excluded from the evidence review due to work previously completed by Flinders University which identified validated CEQOL tools in aged care.

The methodology, analysis and findings of the evidence review are synthesised in the Expansion of the residential aged care quality indicators – Evidence review summary report.

Outcomes

The review identified 175 quality indicators across 13 quality of care domains (presented below in alphabetical order). The top 8 ranked domains (highlighted) and 104 associated quality indicators were presented at stakeholder consultation.

Behavioural symptoms	Mortality
Cognition	Medications (not already included)
Continence	Pain
Depression	Palliative care
Function and activities of daily living	Service delivery and care planning
Hospitalisation	Wait times
Infection control	

Consultations were held with a range of aged care stakeholders and technical experts

Aged care stakeholder consultations

Older Australians, their families and representatives, residential aged care providers, peak bodies, government agencies and individual aged care, health and medical professionals were invited to provide feedback on quality of care domains and quality indicators they found most meaningful and useful for quality improvement. Consultations informed the selection of quality of care domains, quality indicators and CEQOL assessment tools for pilot.

Outcomes of the virtual aged care stakeholder consultations

From 1 November – 16 December 2021, a total of 31 residential aged care virtual consultations were conducted with 412 stakeholders:

- 20 workshops across the eight quality of care domains
- 4 workshops specifically for older Australians, their families and representatives
- 4 workshops focused on the CEQOL assessment tools
- 3 workshops with aged care peak bodies, the department's Sector Reference Group and the Consumer Reference Group.

Outcomes of the written aged care stakeholder consultations

From 24 November to 15 December 2021, three consultation surveys, tailored to audiences, were published to seek written stakeholder feedback. A total of 80 written responses were received from stakeholders:

- 27 from older Australians, their families and representatives
- 30 from residential aged care service providers
- 23 from peak bodies, government and other agencies.

Nine organisations provided standalone written submissions outside the survey process.

Pre-pilot Technical Expert Group consultation

The pre-pilot Technical Expert Group (TEG) meeting sought technical feedback on quality of care domains and quality indicators identified through the evidence review and the findings from the aged care stakeholder consultation process. The quality of care domains were: functions and activities of daily living, continence, hospitalisation, pain, workforce (identified through stakeholder consultations) and consumer experience and quality of life.

TEG advice refined the identified quality indicators with respect to their technical specifications - including definitions, data capture tools, frequency of data collection, exclusion criteria, and appropriateness to take forward.

The TEG consisted of individual clinical experts and representatives from the department and aged care, health and medical professional organisations, including:

- Aged Care Quality and Safety Commission
- Aged Care Workforce Industry Council
- Australian College of Nursing
- Australian Commission on Safety and Quality in Health Care
- Australian Institute of Health and Welfare (AIHW)
- Australian Medical Association
- Australian Pain Society
- Australian Physiotherapy Association
- Continence Australia
- Dietitians Australia
- Expert psychiatrist
- Flinders University
- Macquarie University
- Occupational Therapy Australia
- Pharmaceutical Society of Australia
- Registry of Senior Australians
- Royal Australian College of General Practitioners
- Rural Doctors Association of Victoria
- University of Queensland
- Wounds Australia

Outcomes of the Pre-pilot Technical Expert Group consultation

Quality indicators identified through the evidence review were supported, however the technical experts recognised elements of the identified indicators need to be tailored in line with stakeholder feedback and to support the QI Program.

Feedback provided by the TEG informed the selection of quality indicators by the department for the pilot.

Drawing on consultation findings, the Department selected six quality indicators to pilot in residential aged care

Department presentation

In February 2022, the consortium presented to the department a summary of the findings from the evidence review and stakeholder and TEG consultations. The purpose of the presentation was to inform the department's selection of potential quality indicators and CEQOL measures for pilot.

The session included representatives from the department, the Aged Care Quality and Safety Commission, the AIHW, as well as the PwC consortium.

Outcomes of the Department presentation

Six quality indicators were selected to pilot. The domains and associated quality indicators are provided in Table 1.

Table 1: Quality indicators selected for pilot

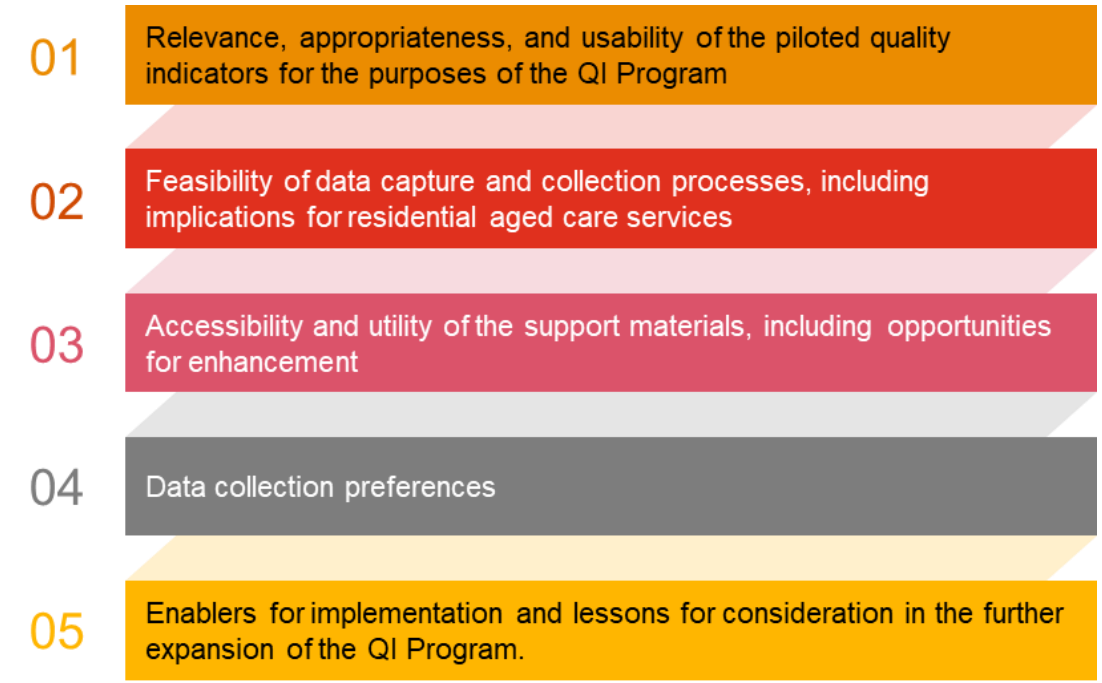
Domain	Pilot quality indicators
Activities of daily living (ADLs)	Percentage of care recipients whose activities of daily living function has declined
Continence	Percentage of care recipients with incontinence associated dermatitis (IAD)
Hospitalisation	Percentage of care recipients who presented to hospital
Workforce	Percentage of staff turnover
Consumer experience	Percentage of care recipients who report 'good' or 'excellent' experience of the service
Quality of life	Percentage of care recipients who report 'good' or 'excellent' quality of life

Pilot

A six-week pilot was held between 21 March to 29 April 2022 to test the evidence-informed quality indicators and CEQOL measures, in a nationally representative sample of 131 residential aged care services.

The key objectives of the pilot were to examine the objectives listed in Figure 1.

Figure 1: Pilot objectives

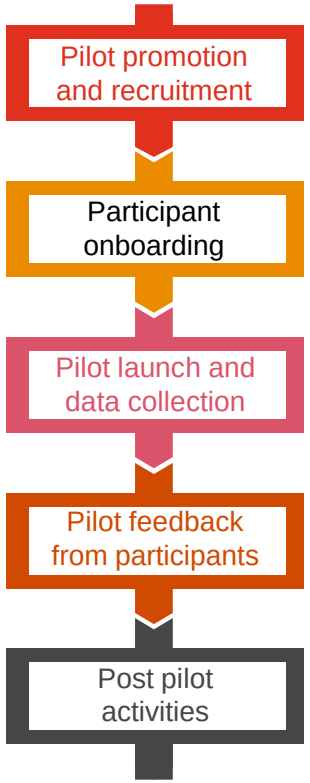


A pilot tested the quality indicators in a nationally representative sample of residential aged care services

Pilot

Five key stages in the pilot methodology were developed, accompanied by several activities, including participant support, data collection and obtaining pilot feedback from pilot participants. The key stages of the pilot included:

Figure 2: Pilot methodology key stages



Sep – Dec 2021
Pilot promotion via multiple communication channels, with a stratification approach to recruit a nationally representative sample of residential aged care services.

Jan – Mar 2022
Development of support materials, design and build of data reporting portal, and participant onboarding.

Mar – Apr 2022
Launch of the six-week pilot to collect quality indicator data for entry in the data reporting portal.

Mar – May 2022
Collection of ad hoc feedback from pilot participants, as well as formal feedback through pilot feedback surveys.

May – Jun 2022
Analysis of initial findings and further consultation with technical experts to seek feedback on pilot results.

Pilot

Sampling approach

A purposive sample stratification approach was developed with the selected sampling frame based on targets informed by the national distribution of service subpopulation groups, derived using AIHW and Welfare GEN Aged Care Data.

The sampling approach ensured recruitment of a nationally representative sample was achieved from the population of approximately 2,700 services in Australia, including those with diverse characteristics – geography (e.g. metropolitan, rural or remote), jurisdiction (e.g. New South Wales, Victoria etc.), provider size (e.g. number of places, number of employees, number of services provided), service type and structure (e.g. religious, charitable, private, government based).

Pilot promotion and recruitment

A range of recruitment activities built stakeholder awareness of the pilot, with advertising materials disseminated through various communications channels, including:

- the PwC pilot website
- the department's aged care sector newsletter
- the department's Engagement Hub
- direct email to Aged Care Engagement Database subscribers and to services who submitted an expression of interest to participate in the 2019 residential aged care quality indicator pilot
- targeted recruitment of underrepresented subpopulation groups
- advertising using PwC consortium networks (e.g. direct email and LinkedIn posts).

185 services registered to participate in the pilot, 131 services submitted data

Pilot

Pilot participation

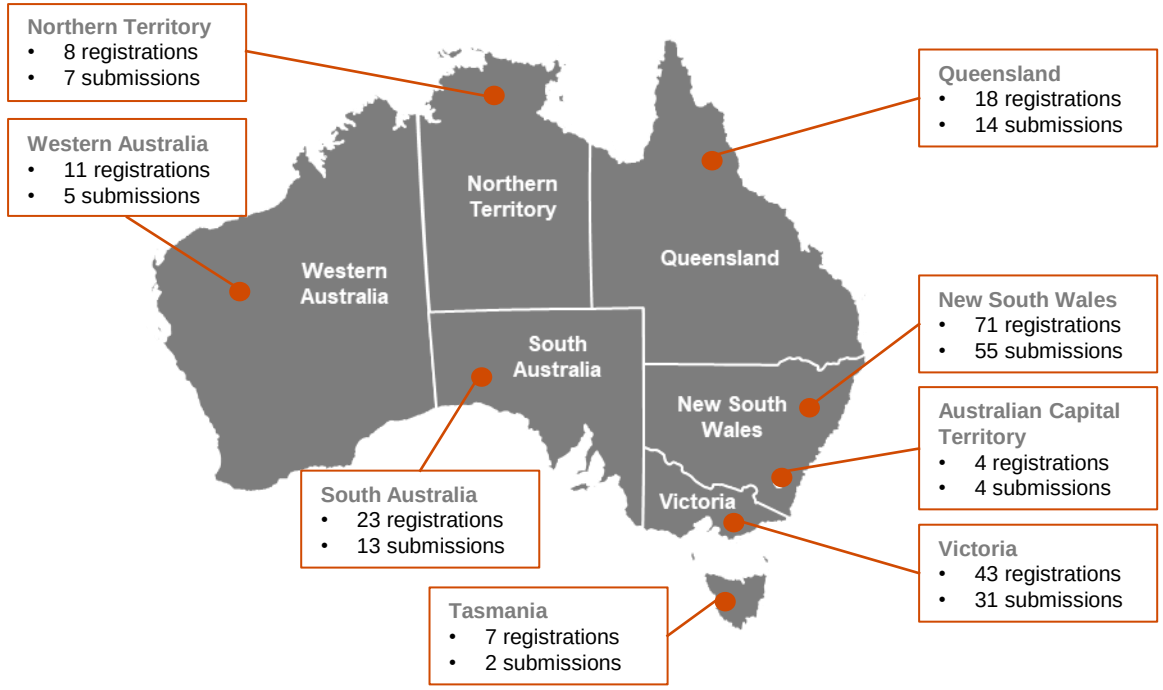
There were 185 services who registered to participate in the residential aged care quality indicator pilot. Despite regular contact to provide ongoing coaching and support, 28 services formally withdrew from the pilot. The majority of services cited the impacts of the COVID-19 pandemic as the reason for withdrawal. The other services cited staff turnover and conflicting priorities as key reasons for withdrawal.
In addition, 26 services remained registered in the pilot but did not submit any data.

A total of 131 services provided quantitative pilot data by submitting quality indicator results through the data reporting portal. 86 services submitted qualitative pilot data by answering one or more of the pilot feedback surveys.

Figure 3: Pilot participation

Pilot

Figure 4: Location of pilot participants



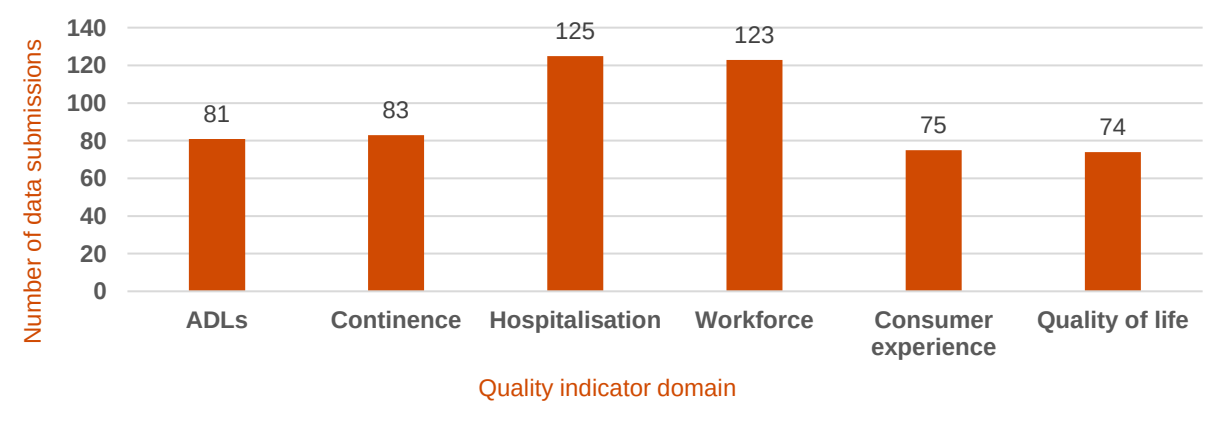
Data collection

During the pilot, participating services were asked to collect data for each eligible care recipient at their service for all pilot quality indicators. In addition to providing quantitative data, pilot participants were also asked to provide written feedback on their pilot experiences, focusing on the relevance, appropriateness and feasibility of the pilot quality indicators, usefulness of the pilot support materials and experiences using the data reporting portal.

Participating services reported quality indicator data, and provided feedback on the support materials, service reports, and overall pilot

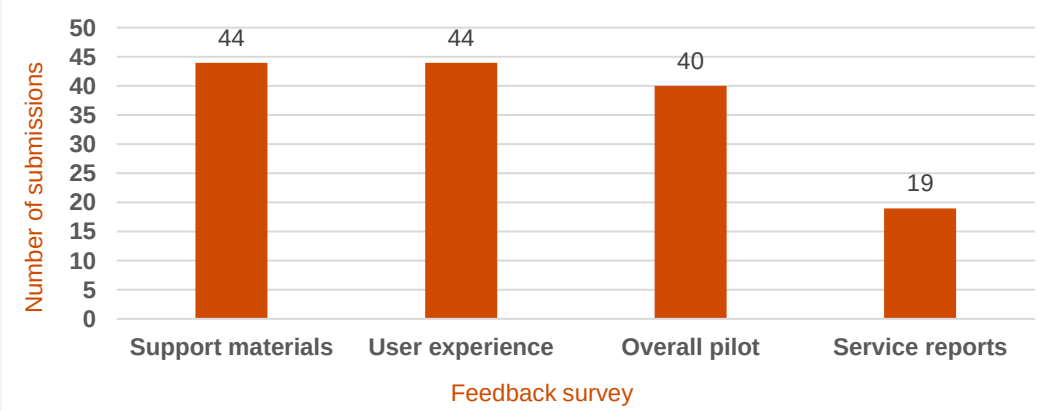
Pilot

Figure 5: Number of data submissions for each quality indicator



Pilot

Figure 6: Number of pilot feedback submissions by feedback survey



Synthesis of pilot data

Key insights from quantitative and qualitative data were synthesised for each quality indicator:

- The quantitative findings for each quality indicator were calculated using all 131 data submissions received during the pilot to understand prevalence, distribution frequency, mean and median to guide assessment for suitability for inclusion in the QI Program.
- Variations in the sample composition from demographic targets were identified during analysis and implications were considered (however no statistical weighting was applied).
- The quantitative data was interpreted as an approximation of the range of results that may be received against each quality indicator to indicate whether this has the potential to support the QI Program objectives, namely:
  - enabling services to monitor their performance and engage in continuous quality improvement
  - providing consumers with comparable information about quality in aged care.
- Quantitative data was analysed alongside the qualitative results to assist in the evaluation of whether each pilot quality indicator could be suitable for future inclusion in the QI Program.

Support materials were developed to assist services; however, it was noted that certain limitations still impacted the pilot

Pilot

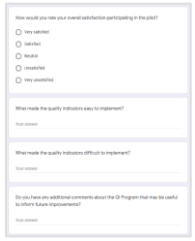
Pilot support materials

A range of support materials were developed to support and encourage services' participation in the pilot. In addition, a dedicated telephone hotline and mailbox was established to coach services and provide ongoing pilot support.

Pilot handbook

Frequently asked questions

Quick reference guides

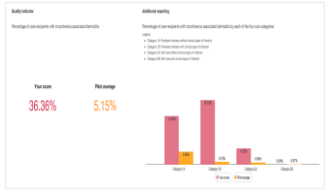


Feedback surveys

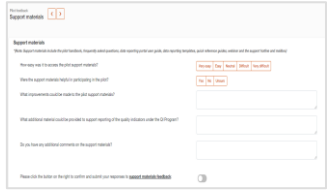
Data collection templates

Pilot webinar

Data reporting portal



Service reports



User experience survey

Pilot

Pilot limitations

- **The COVID-19 Omicron wave** in early 2022 and the associated workforce challenges experienced by the aged care sector resulted in increased demands on staff to manage outbreaks and widespread staff shortages across the sector impacting pilot participation rates.
- **Data collection immaturity** limits analysis of distribution variation, establishment of reference ranges and drawing conclusions on the relative performance of demographic groups.
- **The constraints of a single six-week pilot** mean it was not possible to test whether quality indicator results changed when participants became more familiar with quality indicator specifications and assessment tools.
- **Voluntary pilot participation** may contribute to recruitment of participants with characteristics different from the broader cohort of services who chose not to participate. Approximately 20 per cent of registered services reported they participated in the 2020 residential aged care quality indicator pilot, reducing any potential bias or over-weighting of services who have previous experience with a pilot.

Activities of daily living: Percentage of care recipients whose activities of daily living (ADLs) function has declined

Overview of activities of daily living

Function and activities of daily living (ADLs) can be used to measure people's ability to move and care for themselves.

All 24 quality indicators identified in the evidence review were determined to have sufficient information to assess against the assessment criteria and present to stakeholders for feedback.

Stakeholders supported a quality indicator for ADLs and feedback suggested two assessment tools to be used for the pilot, including the Collin-Modified Barthel Index (MBI-C) and Shah-Modified Barthel Index (MBI-S).

Quality indicator reporting

Care recipients whose ADLs function declined between their first and second MBI assessment.

Additional reporting

- Care recipients assessed for the ADLs quality indicator.
- Care recipients with a score of 0 in their first MBI assessment.

Exclusions

Care recipients who:

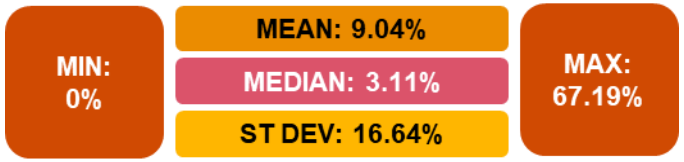
- withheld consent to undergo two ADL assessments
- were receiving end of life care
- were absent from the service.

Table 2: Key findings from the pilot

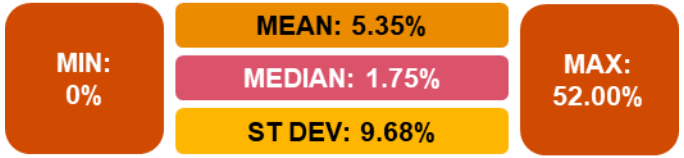
Quality indicator measure	Tool	Mean
Percentage of care recipients whose ADL function has declined.	MBI-C	9.04%
Percentage of care recipients whose ADL function has declined.	MBI-S	5.35%

Additional reporting measure	Tool	Mean
Percentage of care recipients with a MBI score of 0 in their first assessment.	MBI-C	7.72%
Percentage of care recipients with a MBI score of 0 in their first assessment.	MBI-S	7.11%

Percentage of care recipients with ADL decline (Collin) (n = 46)



Percentage of care recipients with ADL decline (Shah) (n = 35)



Summary of findings

- 2,665 care recipients were assessed using the MBI-C assessment tool, with 9.04 per cent experiencing a 1 point or more decline.
- 1,569 care recipients were assessed using the MBI-S assessment tool, with 5.35 per cent experience a 5 point or more decline.
- The threshold for decline using MBI-C may be more sensitive than the MBI-S, as the MBI-C resulted in a larger average and median decline than the MBI-S.
- Participants were more supportive of the MBI-C tool with 84 per cent of services reporting it was easy to understand and complete
- Of pilot survey respondents, the majority were supportive of quarterly reporting on ADLs with quality indicator data available through existing care records and systems.
- One third of survey respondents did not recognise the quality indicator provided meaningful information to guide service-level improvement or actionable insights to improve an individual's care.
- Further information and resources are crucial to increase understanding of the quality indicator and quality improvement activities to support care recipient's ADLs.
- Based on pilot results, the ADLs quality indicator has reasonable prevalence and range of results with the potential to produce data to allow services to monitor performance, support continuous quality improvement and to provide older Australians with information about the quality of aged care services.

Continence: Percentage of care recipients with incontinence associated dermatitis (IAD)

Overview of continence

Continence is the ability to control the bladder and bowel. Incontinence is the loss of bladder and bowel control.

Of the 24 quality indicators identified in the evidence review, 17 were determined to have sufficient information to assess against the assessment criteria and present to stakeholders for feedback.

Stakeholders supported a quality indicator for continence, noting continence care is within the control of services.

Quality indicator reporting

Care recipients with IAD, reported against sub-categories:

- 1A: Persistent redness without clinical signs of infection
- 1B: Persistent redness with clinical signs of infection
- 2A: Skin loss without clinical signs of infection
- 2B: Skin loss with clinical signs of infection.

Additional reporting

- Care recipients assessed for the continence quality indicator.
- Care recipients with incontinence.

Exclusions

Care recipients who:

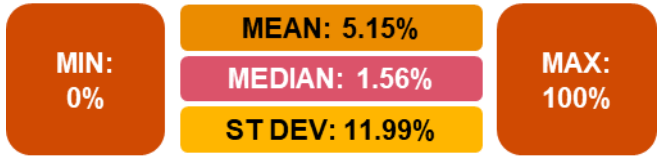
- withheld consent to undergo an assessment for IAD
- were absent from the service.

Table 3: Key findings from the pilot

Quality indicator measure	Mean
Percentage of care recipients with incontinence associated dermatitis (IAD).	5.15%

Additional reporting measures	Mean
Percentage of care recipients with IAD who have 1A persistent redness without clinical signs of infection.	3.66%
Percentage of care recipients with IAD who have 1B persistent redness with clinical signs of infection.	0.78%
Percentage of care recipients with IAD who have 2A skin loss without clinical signs of infection.	0.64%
Percentage of care recipients with IAD who have 2B skin loss with clinical signs of infection.	0.07%

Percentage of care recipients with IAD (n = 83)



Summary of findings

- Of the 4,409 care recipients assessed for continence, 5.15 per cent of care recipients had IAD.
- When considering the 77.60 per cent of care recipients assessed who had incontinence, the proportion of those with IAD rose to 6.63 per cent.
- There was recognition that assessment should be part of routine care for care recipients with incontinence. Support was provided to exclude continent care recipients from an IAD observational assessments.
- Services reported the IAD assessment tool (Ghent Global IAD Categorisation Tool) was easy to understand (96 per cent agreed). The IAD tool was recognised as supporting internationally agreed definitions of IAD severity as developed by international experts.
- Most pilot survey respondents agreed the quality indicator provided meaningful information to guide service-level improvement (67 per cent of pilot survey respondents agreed, 7 per cent unsure) and actionable insights to improve an individual's care (64 per cent agreed, 8 per cent unsure).
- Training and guidance materials provide an opportunity to drive focus and improve skills in reliably and accurately diagnosing and staging IAD and to outline the clinical expertise require to undertake assessment.
- Based on pilot results, the continence quality indicator has reasonable prevalence and range of results with the potential to produce data to allow services to monitor performance, support continuous quality improvement and to provide older Australians with information about the quality of aged care services.

Hospitalisation: Percentage of care recipients who presented to hospital

Overview of hospitalisation

Hospitalisations are admissions to hospitals to receive treatment, which can be planned or unplanned.

Of the eight quality indicators identified in the evidence review, five were determined to have sufficient information to assess against the assessment criteria and present to stakeholders for feedback.

Stakeholders supported a quality indicator for hospitalisation noting admissions to hospital and emergency department presentations may be preventable if people receive the right care services.

Quality indicator reporting

Care recipients with one or more hospital presentations.

Additional reporting

- Care recipients assessed for the hospitalisation quality indicator.
- Care recipients with one or more emergency department presentations without hospital admission.
- Care recipients with one or more hospital admissions.
- Care recipients who only attended hospital for planned admissions.

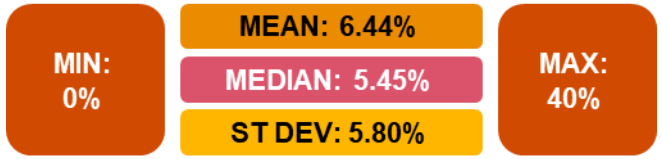
Exclusions

Care recipients who were absent from the service.

Table 4: Key findings from the pilot

Quality indicator measure	Mean
Percentage of care recipients who presented to hospital.	6.44%
Additional reporting measure	**Mean**
Percentage of care recipients who had one or more emergency department presentations without hospital admission.	3.11%
Percentage of care recipients who had one or more hospital admissions.	4.26%
Percentage of care recipients who only attended hospital for planned hospital admissions.	1.58%

Percentage of care recipients who presented to hospital (n = 125)



Summary of findings

- 7,412 care recipients were assessed for hospitalisation, with 6.44 per cent of care recipients presenting to hospital during the assessment period.
- 98 per cent of services indicated data for this quality indicator was available through existing care records or systems, with 70 per cent of services collecting and monitoring hospitalisation data prior to the pilot.
- Pilot survey respondents reported quarterly reporting of the hospitalisation quality indicator would be feasible for their organisation (71 per cent agreed, 16 per cent unsure).
- There was strong support to reframe this quality indicator to record emergency department presentations or unplanned hospitalisations, noting;
  - one third of pilot survey respondents did not recognise the current quality indicator as providing meaningful information to guide service-level improvement
  - only 37 per cent of respondents agreed the current quality indicator provided actionable insights to improve an individual's care (21 per cent unsure).
- Training and guidance materials provide an opportunity to increase understanding of the utility of the quality indicator in supporting quality improvement.
- The pilot range of results, including the prevalence and variation in reported values, was lower than expected when comparing to other available data sets on hospitalisation. However, this may be partially explained by sample bias (e.g. higher quality services in the sample) and the pilot reporting period.

Workforce: Percentage of staff turnover

Overview of workforce

The aged care workforce is critical to providing quality services to meet the needs of older Australians.

While no quality indicators with sufficient information were found during the evidence review, stakeholder feedback strongly supported the inclusion of a workforce quality indicator within the QI Program.

Quality indicator reporting

Turnover of staff at the service:

- facility manager
- a nurse practitioner or registered nurse
- enrolled nurse
- personal care worker.

Additional reporting

- Staff employed at the start of the assessment period.
- Staff who stopped working during the assessment period.

Exclusions

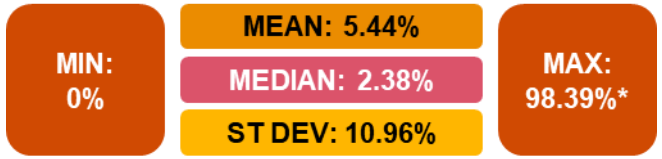
Nil.

Table 5: Key findings from the pilot

Quality indicator measure	Mean
Percentage of staff turnover.	5.44%

Additional reporting measure	Mean
Percentage of staff employed as a facility manager who stopped working during the assessment period.	4.47%
Percentage of staff employed as a nurse practitioner or registered nurse who stopped working during the assessment period.	6.73%
Percentage of staff employed as an enrolled nurse who stopped working during the assessment period.	3.65%
Percentage of staff employed as a personal care worker who stopped working during the assessment period.	5.29%

Percentage of staff turnover (n = 123)



** Only one service reported above 50 per cent. Once this outlier is removed, the maximum reported value is 50.00 per cent*

Summary of findings

- Of the 5,614 staff assessed for workforce, 5.44% stopped working during the assessment period.
- 87 per cent of services indicated quality indicator data was available through existing records or systems, though only 41 per cent of services reported collecting and monitoring workforce data prior to the pilot.
- Pilot survey respondents reported quarterly reporting of the workforce quality indicator would be feasible for their organisation (60 per cent agreed, 14 per cent unsure).
- Overall, it was agreed the workforce roles piloted provided a good starting point by recording the turnover of staff who most interact with the care recipient day-to-day. It was recognised that continuity of care was important to the experience and wellbeing of older Australians.
- Training and guidance materials provide an opportunity to increase understanding of the utility of the quality indicator, noting only 21 per cent of pilot survey respondents agreed the measure provided meaningful information to guide service-level improvement (17 per cent unsure) and actionable insights to improve an individual's care (21 per cent agreed, 18 per cent unsure).
- Based on pilot results, the workforce quality indicator has reasonable prevalence and range of results with the potential to produce data to allow services to monitor performance, support continuous quality improvement and to provide older Australians with information about the quality of aged care services.

Consumer experience: Percentage of care recipients who reported ‘good’ or ‘excellent’ experience of the service

Overview of consumer experience

Information on consumer experience is crucial in capturing the voice of older Australians.

Consumer experience assessment tools identified through an evidence review undertaken by Flinders University were presented during stakeholder consultations. Stakeholders supported the inclusion of a consumer experience quality indicator and favoured the Quality of Care – Aged Care Consumers (QCE-ACC) tool.

Quality indicator reporting

Care recipients who reported ‘Good’ or ‘Excellent’ experience of the service using the Quality of Care Experience – Aged Care Consumers (QCE-ACC).

Additional reporting

- Care recipients assessed for the consumer experience quality indicator.
- Care recipients who reported consumer experience (QCE-ACC six question survey), against scoring categories through:
  - self-completion
  - interviewer administered completion
  - proxy-completion.

Exclusions

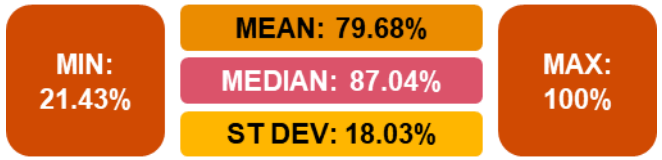
- Care recipients who withheld consent.
- Care recipients who were absent from the service.

Table 6: Key findings from the pilot

Quality indicator measure	Mean
Percentage of care recipients who report 'good' or 'excellent’ experience of the service.	79.68%

Additional reporting measure	Mean
Percentage of care recipients who report 'excellent’ experience of the service.	53.15%
Percentage of care recipients who report 'good' experience of the service.	26.55%
Percentage of care recipients who report 'moderate' experience of the service.	16.42%
Percentage of care recipients who report 'poor' experience of the service.	3.70%
Percentage of care recipients who report 'very poor' experience of the service.	0.19%

Percentage of care recipients who reported ‘good’ or ‘excellent’ consumer experience (n = 75)



Summary of findings

- 2,449 care recipients were assessed for consumer experience, with close to 80 per cent reporting 'good' or 'excellent' experience of the service.
- Higher than expected prevalence of 'good' and 'excellent' results and limited variation between services were reported. While these may be suitable for quality indicator implementation, over time these may need to be revised based on future analysis of cumulative results.
- The variation in pilot results confirm data should be reported separately across self-completed, interview administered and proxy-completed completed assessments for accurate comparison and interpretation.
- 80 per cent of services were collecting and monitoring consumer experience data prior to the pilot, with 49 per suggesting quarterly reporting of this quality indicator was feasible for their organisation (24 per cent were unsure).
- To address feedback to support anonymity and decrease collection burden, reporting should capture the total number of care recipients offered an assessment and the responses received.
- Most pilot survey respondents agreed the quality indicator provided meaningful information to guide service-level improvement (80 per cent agreed, 11 per cent unsure) and actionable insights to improve an individual’s care (72 per cent agreed, 9 per cent unsure).
- Enhancements to supporting materials would further support implementation (e.g. digital survey forms to auto-calculate survey scored, detailed survey administration instructions for interviewers and proxies).

Quality of life: Percentage of care recipients who reported ‘good’ or ‘excellent’ quality of life

Overview of quality of life

Quality of life refers to a person’s perception of their position in life taking into consideration their environment and their goals, expectations, standards, and concerns.

Quality of life assessment tools identified through an evidence review undertaken by Flinders University were presented during stakeholder consultations. Stakeholders supported the inclusion of a quality of life quality indicator and favoured the Quality of Life – Aged Care Consumers (QOL-ACC) tool.

Quality indicator reporting

Care recipients who reported ‘Good’ or ‘Excellent’ quality of life using the Quality of Life – Aged Care Consumers (QOL-ACC).

Additional reporting

- Care recipients assessed for the quality of life quality indicator.
- Care recipients who reported quality of life (QOL-ACC six question survey), against the scoring categories, through:
  - self-completion
  - interviewer administered completion
  - proxy-completion.

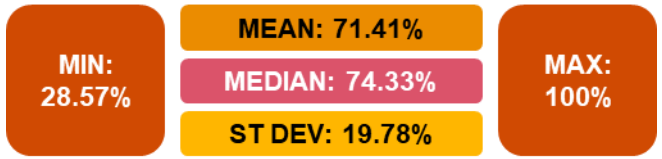
Exclusions

- Care recipients who withheld consent.
- Care recipients who were absent from the service.

Table 7: Key findings from the pilot

Quality indicator measure	Mean
Percentage of care recipients who report 'good' or 'excellent' quality of life.	71.41%
Additional reporting measure	**Mean**
Percentage of care recipients who report 'excellent' quality of life.	40.96%
Percentage of care recipients who report 'good' quality of life.	30.45%
Percentage of care recipients who report 'moderate' quality of life.	22.24%
Percentage of care recipients who report 'poor' quality of life.	5.77%
Percentage of care recipients who report 'very poor' quality of life.	0.57%

Percentage of care recipients who reported ‘good’ or ‘excellent’ quality of life (n = 74)



Summary of findings

- Of the 2,441 care recipients assessed for quality of life, over 70 per cent of care recipients reported ‘good’ or ‘excellent’ quality of life.
- Similar to consumer experience, the results show a higher than expected prevalence of 'good' and 'excellent’ scores and limited variation between services. While these may be suitable for quality indicator implementation, over time these may need to be revised based on future analysis of cumulative results.
- The variation in pilot results confirm data should be reported separately across self-completed, interview administered and proxy-completed completed assessments for accurate comparison and interpretation.
- 69 per cent of services were collecting and monitoring quality of life data prior to the pilot, with 50 per cent suggesting quarterly reporting of this quality indicator was feasible for their organisation (22 per cent were unsure).
- To address feedback to support anonymity and decrease collection burden, reporting should capture the total number of care recipients offered an assessment and the responses received.
- Most pilot survey respondents agreed the quality indicator provided meaningful information to guide service-level improvement (70 per cent agreed, 13 per cent unsure) and actionable insights to improve an individual’s care (70 per cent agreed, 14 per cent unsure).
- Enhancements to supporting materials would further support implementation (e.g. digital survey forms to auto-calculate survey scored and detailed survey administration instructions for interviewers and proxies) with consideration required for implementing independent assessors to reduce completion bias.

The pilot outcomes were shared, test and validated with technical experts to identify barriers and enablers to support potential future implementation

Quality indicator assessment

A consolidation process was undertaken to bring together the evidence developed through the course of the project. To support this process, additional input was sought from technical experts to validate pilot findings and the overall analysis of each quality indicator. This informed an assessment of each quality indicator's ability to support the objectives of the QI Program, as well as its readiness for implementation.

Two ratings were used:

The quality indicator is suitable to support the QI Program's objectives and is ready to move into the implementation phase

The quality indicator is not suitable to support the QI Program's objectives or requires substantial additional work for it to be ready to move into the implementation phase

The assessment was conducted against revised quality indicator specifications, developed using pilot feedback and technical expert guidance.

It is anticipated that any future inclusion of these quality indicators as part of the QI Program, would be supported by several preparatory activities to ensure successful implementation, including:

- communication and engagement activities with residential aged care services to support introduction of any new quality indicators
- revisions to the existing QI Program resources
- continued development of mechanisms and capacity building initiatives to support residential aged care services to reliably collect quality indicator data
- maturation and analysis of data over time to inform trend analysis, comparison between services and granular public reporting.

Quality indicator assessment

Table 8: Assessment of post-pilot revised quality indicators against QI Program objectives and their implementation readiness

Quality indicator	Quality indicator assessment
Percentage of care recipients who experienced a decline in activities of daily living	→
Percentage of care recipients who experienced incontinence associated dermatitis	→
Percentage of care recipients who had one or more emergency department presentations	→
Percentage of staff turnover	→
Percentage of care recipients who report 'good' or 'excellent' experience of the service	→
Percentage of care recipients who report 'good' or 'excellent' quality of life	→

Project conclusion

The findings from this project will inform Ministerial decision on the additional quality indicators to be included in the QI Program expansion.

As the QI Program in Australia continues to evolve and mature, this potential expansion presents an opportunity to further support older Australians to make informed choices about their care and residential aged care services to continue improving the quality of their services.

Thank you

www.pwc.com.au