Australian Government
Department of Health and Aged Care

National Aged Care Mandatory Quality Indicator Program (QI Program)

Frequently Asked Questions

Table of Contents

1.0 About the QI Program

What are the QI Program quality indicators?

All approved providers of residential care services must collect data across the eleven quality indicators:

- pressure injuries
- physical restraint
- unplanned weight loss
- falls and major injury
- medication management
- activities of daily living
- incontinence care
- hospitalisation
- workforce
- consumer experience; and
- quality of life.

Which residential aged care services are required to participate in the QI Program?

The QI Program is mandatory for all Commonwealth subsidised residential aged care providers, including residential respite services.

The following services are excluded from the QI Program:

- flexible care including transition care
- the Short-Term Restorative Care Programme
- Multi-Purpose Services Program
- the National Aboriginal and Torres Strait Islander Flexible Aged Care Program; and
- the Innovative Care Program.

Is the QI Program still mandatory if state or territories report similar data?

Yes. All Australian Government subsidised residential aged care providers are required to collect and report quality indicator data. This ensures the QI Program data is nationally consistent and enables services to measure and monitor their performance against national averages.

Where can I find additional information and support?

The QI Program Manual 3.0 – Part A (Manual) includes definitions and instructions on how to collect and submit quality indicator data. A range of QI Program support materials, such as QI Program Manual 3.0 – Part B, are available on the department's website.

Is the QI Program mandatory for home care services?

No. Currently home care services are not included in the QI Program. The QI Program is mandatory for all Commonwealth subsidised residential aged care providers.

Why aren't GPs required to report on quality indicators?

QI Program data must be collected and reported by residential aged care providers. Providers and care teams (including GPs) should use the QI Program data to engage in continuous quality improvement and work together to achieve better care outcomes. This includes using QI Program data to support the delivery of better care and to develop care management plans. A range of QI Program materials are available for services, allied health and medical professionals on the department's website.

Are care recipients receiving residential respite included in the QI Program?

Yes. Care recipients receiving residential respite must be included in QI Program data collection if they reside at the service during the selected assessment period and do not meet exclusion criteria.

Exclusion criteria for each quality indicator are detailed in the Manual.

Are care recipients receiving end-of-life care included in the QI Program?

Care recipients receiving end-of-life care must be included in QI Program data collection for each of the quality indicators except for unplanned weight loss and activities of daily living. Care recipients receiving end-of-life care are excluded from any form of assessment that is not received as part of good care during this stage of life. Services are required to report the number of care recipients excluded from the unplanned weight loss and activities of daily living quality indicators because they are receiving end-of-life care.

For the purposes of the QI Program, end-of-life care is the terminal phase of life, where death is imminent and likely to occur within three months. This is sometimes referred to as *actively dying.*

Is medical documentation required to show a care recipient is receiving end-of-life care?

Medical documentation is not required to be provided as part of data submission under the QI Program. However, in accordance with Section 88 of the *Aged Care Act 1997* and the *Records Principles 2014*, approved providers must retain medical records, progress notes and other clinical records of care recipients, including those related to a care recipient receiving end-of-life care.

Is consent required from care recipients to collect QI Program data?

Approved providers must seek the consent of care recipients for the assessments of pressure injuries and unplanned weight loss. If care recipients withhold consent to be assessed for these quality indicators, this must be recorded and the number reported as part of the QI Program.

Are all care recipients for each quality indicator required to be assessed on the same day?

No. The Manual provides guidance on when and how quality indicator data collection should take place each quarter. It is important the requirements outlined in the Manual for each quality indicator are followed. Approved providers are free to select dates and time periods that best suit their service.

Is there a template to support recording data for each quality indicator?

Yes. Data recording templates for each quality indicator are available on the department's website. The templates automatically calculate and summarise QI Program data for submission through the My Aged Care provider portal's Quality Indicator tile. Instructions on how to use the data recording templates are provided within each template.

Are residential aged care services able to use their own templates to record QI Program data?

Yes. Residential aged care services may use their own templates to collect quality indicator data providing the definitions and instructions defined in the Manual are adhered to.

Are comments required in the data recording template for all quality indicators?

Comments are only required in the data template for the unplanned weight loss and activities of daily living quality indicators. Approved providers must note in the template care recipients who were excluded because they did not have quality indicator data recorded, including the reason why the data was not collected.

Comments for the remaining quality indicators are optional and typically used to note information to help services interpret their reports.

Approved providers must ensure the information compiled or derived in accordance with these requirements does not contain personal identifiable information about any of the care recipients.

What happens when care recipients are absent from the service for assessment periods?

All care recipients must be included in the QI Program data collection if they reside or are receiving respite at the service during the selected assessment period and do not meet exclusion criteria. Exclusion criteria for each quality indicator are detailed in the Manual.

When and where do I submit the QI Program data?

QI Program data must be collected and entered through the My Aged Care provider portal every quarter based on the financial year calendar. Providers must submit quality indicator data no later than the 21st day of the month after the end of each quarter. QI Program data cannot be submitted late, and extensions are not permitted. This includes services submitting their data through a benchmarking company.

What happens if there is an issue uploading data before the due date?

It is the responsibility of providers to ensure QI Program data is submitted accurately and on time according to the requirements of the Manual.

Providers should work on proactive submission schedules to ensure support issues can be resolved by the My Aged Care service provider and assessor helpline. If you require assistance submitting QI data, please contact the My Aged Care service provider and assessor helpline on 1800 836 799.

Is it compulsory to set targets?

No. Setting a target or benchmark for each quality indicator is optional.

However, setting targets can assist with continuous quality improvement at your organisation. A target rate for each quality indicator provides an opportunity to identify a minimum level of improvement. A significant change, either below or above set targets, should prompt analysis to identify possible opportunities for quality improvement.

How will providers be kept accountable for quality improvement?

The QI Program aims to support providers to measure and monitor their performance, support continuous quality improvement and contribute to improved health and wellbeing outcomes for care recipients. A range of resources to support providers to engage in quality improvement are available on the department's website, including the QI Program Manual 3.0 – Part B.

Aged care providers are expected to meet responsibilities set out in the Aged Care Quality Standards, including improving the delivery of care and services.

The Aged Care Quality and Safety Commission independently accredits, assesses and monitors the performance of residential aged care services against the Standards, and may also use quality indicator data to guide these regulatory activities.

What quality indicators contribute to the Star Ratings?

Pressure injuries, physical restraint, unplanned weight loss, falls and major injury and medication management currently inform the Quality Measures rating. The Quality Measures Ratings contributes to a service's Overall Star Rating. For more information please see the Star Ratings website.

Do the quality indicators apply to in-home aged care?

The current QI Program does not apply to in-home aged care. The department is working to progress quality indicators specific to in-home aged care, with updates to be communicated in advance to the sector through regular department channels.

Where can I find additional information and support?

The Manual includes definitions for each quality indicator and instructions on how to collect and submit quality indicator data. A range of QI Program support materials, such as QI Program Manual 3.0 – Part B, are available on the department's website.

2.0 Pressure injuries

Which classification system is used to report pressure injuries?

The ICD-10-Australian Modified (AM) pressure injury classification system outlined in the *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 2019* is the pressure injury classification system used for the purposes of the QI Program.

Who should undertake observation assessments for pressure injuries?

A full-body observation assessment should be conducted for each care recipient by someone who understands the ICD-10-AM and has knowledge to do so accurately and safely. Approved providers must consult with a suitably qualified health practitioner if there is uncertainty about the presence or stage of a pressure injury.

What if a care recipient does not provide consent to undergo an observation assessment for pressure injuries?

Care recipients who withhold consent to undergo an observation assessment for pressure injuries must be excluded from the pressure injuries quality indicator and recorded in the total number of care recipients who withheld consent.

What if a care recipient has more than one pressure injury?

All pressure injuries must be assessed and the presence of a pressure injury, as well as the presence of a pressure injury at each stage must be recorded against each of the six stages. The quality indicator does not require you to report the number of pressure injuries a care recipient has overall or against each stage, only whether one (or more) has been observed.

Are pressure injuries acquired outside the service counted?

Yes. Providers must record each care recipient with one or more pressure injuries that were acquired outside of the service during the quarter against the sub-category, and as part of the total number of care recipients with one or more pressure injuries.

3.0 Physical restraint

What is physical restraint?

The Quality of Care Principles 2014 (Quality of Care Principles), define restrictive practices as any practice or intervention that has the effect of restricting the rights or freedom of movement of a care recipient.

The QI Program physical restraint quality indicator measures and reports data relating to all restrictive practice, excluding chemical restraint. This include physical restraint, mechanical restraint, environmental restraint and seclusion, as defined in the Quality of Care Principles.

How is physical restraint data collected?

The collection of physical restraint data involves a single three-day record review for each care recipient every quarter. The date must be varied and unpredictable to staff directly involved in care. The assessment period will include the selected collection date and the two days before – this must be the same three days for all care recipients at the service. Details of all relevant definitions, collection and reporting requirements for physical restraint are detailed in Section 9.0 of the QI Program Manual 3.0 – Part A (the Manual).

If equipment is used to protect a care recipient from harm is this considered physical restraint?

Yes, this is included in the physical restraint quality indicator. This is consistent with restrictive practice legislation, defining this as mechanical restraint – as outlined on Section 9.0 of the Manual.

Mechanical restraint is any practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour is considered physical restraint. This does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient.

If a care recipient has requested bed rails, are these still included in the physical restraint count?

Yes. All listed forms of restrictive practice in the Manual, including instances the care recipient or their representative instigate or request the restrictive practice, are considered physical restraint for the purposes of the QI Program.

If a care recipient is immobile, is this classified as physical restraint?

If there is no practice or intervention that has the effect of restricting the rights or freedom of movement of a care recipient, it is not physical restraint. However, if a care recipient requires a mobility aid and the aid is taken away from them to limit their movement this would be considered physical restraint.

What is a secure area?

A secure area is any area of a facility a care recipient is prevented from leaving freely by means of locked doors, gates, keypads or other mechanism.

For the purposes of the QI Program, restraint through the use of a secure area is environmental restraint. As defined in the *Quality of Care Principles 2014*, environmental restraint is a practice or

intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour.

Are care recipients who are immobile and in a secure area included in reporting of physical restraint?

All care recipients in a secure area, including those who are immobile, must meet the definition of restraint to be included in reporting of physical restraint.

A secure area is included as an environmental restraint when it restricts, or involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour.

QI Program reporting includes care recipients physically restrained as well as the sub-category of care recipients physically restrained exclusively through the use of a secure area.

Are care recipients in a memory support unit, secure or locked area included in reporting of physical restraint?

All care recipients in a secure area, such as a locked memory support unit, must meet the definition of restraint to be included in reporting of physical restraint.

A memory support unit, secure or locked area is included as an environmental restraint when it restricts, or involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour.

QI Program reporting includes care recipients physically restrained as well as the sub-category count of care recipients physically restrained exclusively through the use of a secure area.

4.0 Unplanned weight loss

What is the guidance relating to clothing when weighing care recipients?

It is important to record the weight for each care recipient residing at the service, using a calibrated scale, and to weigh care recipients:

- at or around the same time each month
- at around the same time of the day; and
- wearing clothing of a similar weight (e.g. a single layer without coats or shoes).

Can the same measurements that were taken for significant weight loss be used for consecutive unplanned weight loss?

Finishing weights for the previous quarter ('previous weight') and current quarter may have already been recorded for each care recipient as part of assessments and measurements made for significant unplanned weight loss. The same finishing weights can be used for consecutive unplanned weight loss and do not need to be collected again.

Is there a minimum weight loss requirement in order for the weight loss to be recorded?

There is no minimum weight loss requirement for weight loss to be recorded. The starting, middle and finishing weight of each care recipient assessed for unplanned weight loss, including weight loss of any amount, must be recorded.

For the purposes of the QI Program, approved providers of aged care must report the number of care recipients who experienced:

- significant unplanned weight loss (5% or more); and
- consecutive unplanned weight loss of any amount.

If a care recipient loses weight but has been prescribed a weight loss strategy, should their weight loss be counted?

For the purposes of the QI Program, unplanned weight loss is where there is no written strategy or ongoing record relating to planned weight loss for the care recipient.

If a care recipient has a written record from a medical doctor or dietitian, which includes intentional weight loss (e.g. body fat or fluid), this weight loss will not be counted as unplanned weight loss, because it does not meet the definition.

If a care recipient loses weight during a hospital stay, is this counted?

For the purposes of the QI Program, unplanned weight loss is where there is no written strategy or ongoing record relating to planned weight loss for the care recipient. Therefore, if the care recipient is admitted to hospital and experiences unplanned weight loss it is to be recorded.

If the care recipient was hospitalised and as a result were not assessed for unplanned weight loss because they did not have the required weight records this should be recorded in the comments as to why the weight recording/s are absent (e.g. the care recipient was hospitalised).

Are care recipients receiving end-of-life care counted for unplanned weight loss?

Care recipients who are receiving end-of-life care are not required to be weighed and are excluded from the unplanned weight loss quality indicator. Approved providers must record the total number of care recipients excluded because they are receiving end-of-life care.

Are respite care recipients residing for short periods counted for unplanned weight loss?

All care recipients receiving residential respite must be included in the QI Program data collection if they reside at the service during the selected assessment period and do not meet exclusion criteria. Exclusion criteria for each quality indicator are detailed in the QI Program Manual 3.0 – Part A.

5.0 Falls and major injury

How do providers choose the collection date for falls and major injury?

Data collection for falls and major injury involves a single review of the care records of each care recipient for the three months comprising the quarter. For this reason, the review must take place after the end of the quarter and before data submission (due on the 21st day of the month after the end of the quarter).

All falls are recorded in the incident management system, is this acceptable to use for the falls data?

If the data is accurate, collected and submitted exactly as prescribed by QI Program Manual 3.0 – Part A (the Manual), data in incident management systems can be used for purposes of the QI Program. The QI Program records care recipients who experienced a fall (one or more) during the quarter as opposed to total number of falls.

If a care recipient is found on the ground following an unwitnessed fall, should this be counted and recorded for the falls and major injury quality indicator?

For the purposes of the QI Program, a fall is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level. All falls at the service during the quarter should be recorded, including where a care recipient is found on the ground after an unwitnessed fall.

If a care recipient places themselves on the ground to enable them to do other things, is this classified as a fall?

No. A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.

If a fall takes place outside of a provider's care or facility should this be recorded?

No. Falls, and falls resulting in major injury, that occurred while the care recipient was away from the service and not under direct supervision of service staff are not included.

A care recipient fell once with no injury and a second time resulting in major injury, how is this recorded?

Approved providers must record whether each care recipient experienced one or more falls at the service during the quarter. They must additionally record whether each care recipient experienced one or more falls resulting in major injury at the service during the quarter. A care recipient who experiences a fall and then another fall resulting in major injury must be recorded as both having a fall and having a fall resulting in major injury.

Is a head laceration from a fall considered a major injury?

If the head laceration resulting from the fall is accompanied by any of the following, it is considered a major injury:

- bone fractures
- joint dislocations
- closed head injuries with altered consciousness; and/or
- subdural haematoma.

If the head laceration resulting from the fall is **not** accompanied by any of the above, it is **not** considered a major injury.

Are deceased residents included in the falls and major injury quality indicator?

For the purposes of the QI Program, data collection is a single review of the care records of each care recipient for the entire quarter If a care recipient passes away during the quarter, they are included in the data collection for the duration of the quarter before they passed away. Care recipients who were absent from the service for the entire quarter are excluded.

6.0 Medication management

What is a medication?

For the purposes of the QI Program, medication is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical and/or mental welfare of people. It includes prescription and non-prescription medicines, including complementary health care products.

Can providers rely on pharmacy reports for quality indicator data collection?

Pharmacy reports should be maintained as accurate and up-to-date records and may therefore be used for the polypharmacy count of prescribed medications.

Records of administration of antipsychotic medications, however, will be held only within the service's medication charts and/or administration records. Pharmacy reports can therefore not be used for the antipsychotics category of the medication management quality indicator.

How are PRN and non-PRN medications distinguished?

PRN medications are to be distinguished according to the definition used across aged care, health and medicine in Australia. PRN stands for 'pro re nata' which means 'as required'. PRN medications are administered when a care recipient may require an occasional dose of medication or may require an additional dose between regularly prescribed doses.

PRN medications are typically listed in a separate section in medication charts to distinguish from medications that need to be given regularly.

Polypharmacy

What is polypharmacy and why is it important?

For the purposes of the QI Program, polypharmacy is defined as the prescription of nine or more medications to a care recipient. Regular monitoring of polypharmacy is important because polypharmacy has been associated with harms such as adverse drug events, cognitive decline, and hospitalisation.

Are there certain medications that are excluded from the count of medications for polypharmacy?

Yes. While any medication with an active ingredient is counted in the polypharmacy quality indicator, there are exceptions which must not be included in the count of medications. These include:

- lotions, creams or ointments used in skin and wound care
- dietary supplements, including Ensure
- oral administered vitamins, minerals and herbal medicines, including homeopathic preparations
- short-term medications, such as antibiotics or temporary eye drops; and
- PRN medications.

Are medicated creams such as those for rashes or thrush included in the count for polypharmacy?

Lotions, creams or ointments used in skin and wound care are not included in the count of medications for the polypharmacy quality indicator, even if some may contain active ingredients. This includes medicated creams for rashes or thrush.

Are vitamin injections, such as Vitamin B12, included in the count of medications for polypharmacy?

Dietary supplements, including those containing vitamins are excluded from the medications count for the polypharmacy quality indicator. Injections, such as Vitamin B12, are classified as a medicine (chemical substance), not a dietary supplement for ingestion. Consequently, vitamin injections should be included in the count of medications for polypharmacy.

Is oxygen therapy counted as a medication?

No, oxygen is not counted as a medication within the medication management quality indicator.

Are products like Metamucil or Movicol to be counted as medications?

Dietary supplements such as Metamucil are generally excluded from the count of medications for polypharmacy. It is important to note, long term use of Movicol is included in the medication count. Short-term or PRN use is not included in the count of medication.

Are non-prescribed medicines such as saline nasal spray and sodium bicarb mouth wash counted as a medication?

Short-term medications and PRN medications, which may include mouthwashes and nasal sprays, are not to be included in the count of medications for polypharmacy.

Are medications with more than one active ingredient counted as more than one medication for polypharmacy?

For the purposes of the QI Program, any medication with an active ingredient is counted for polypharmacy, except for those listed as exclusions. Data is not collected on the number of active ingredients within a single medication. A single medication with more than one active ingredient is counted as one medication for the polypharmacy quality indicator.

A care recipient was on leave with family on the collection date, are they excluded from the count for polypharmacy?

Only care recipients who were a hospital admitted patient on the collection date are excluded from the polypharmacy category of the medication management quality indicator. All other care recipients are included.

Antipsychotics

Is there a list of antipsychotic medications counted for antipsychotics?

The following non-exhaustive list of antipsychotic medications is available in the QI Program Manual 3.0 – Part B. The list will be updated periodically as indicated by evolving clinical evidence.

- Amisulpride
- Asenapine
- Chlorpromazine
- Droperidol
- Haloperidol
- Olanzapine
- Periciazine
- Risperidone
- Ziprasidone
- Aripiprazole
- Brexpiprazole
- Clozapine
- Flupentixol
- Lurasidone
- Paliperidone
- Quetiapine
- Trifluoperazine
- Zuclopenthixol

Does a care recipient need to have a specific diagnosis of psychosis to be counted?

The medication charts and/or administration records of all care recipients residing at the service during the seven-day assessment period must be included and reviewed for antipsychotic medications. Care recipients who receive an antipsychotic medication during the seven-day assessment period are recorded. Of the care recipients who received antipsychotic medication, providers must additionally record the care recipients who have a medically diagnosed condition of psychosis.

Are psychotropics such as antidepressants counted as antipsychotics?

No. Psychotropic medications are a broader class of medications than antipsychotics. The QI Program only requires recording of antipsychotic medications received during the seven-day assessment period, irrespective of diagnosis. Care recipients with a medically diagnosed condition of psychosis who received an antipsychotic are then recorded as an additional sub-category within the antipsychotics category of the medication management quality indicator.

Are antipsychotics counted according to what is administered or what is prescribed?

All care recipients who receive an antipsychotic medication must be recorded. Providers must review each care recipient's medication charts and/or administration records for the seven-day assessment period and record whether each care recipient received an antipsychotic medication. This includes PRN medications.

How are care recipients who received antipsychotics on more than one occasion during the seven-day assessment period reported?

The antipsychotics category of the medication management quality indicator collects data on the percentage of care recipients who received antipsychotic medications. If a care recipient receives an antipsychotic medication on more than one occasion during the seven-day assessment period, they are recorded once as receiving an antipsychotic medication.

Are PRN and one-off antipsychotic doses counted?

Yes. Each care recipient's medication charts and/or administration records must be reviewed for the seven-day assessment period and recorded if they received an antipsychotic medication. For the antipsychotic medication indicator only, this includes PRN medications.

Are prescribed antipsychotics recorded against both medication management categories?

Yes. If a care recipient is prescribed an antipsychotic medication, whether it be for the treatment of a diagnosed condition of psychosis or not, this should be included in the count of medications for the polypharmacy quality indicator as well as the antipsychotics quality indicator. It is important to note, reporting for the polypharmacy indicator does not include short-term or PRN use of antipsychotics or other medications.

Should providers aim to have zero care recipients receiving antipsychotic medication?

No. Antipsychotic medications are appropriate when used in the treatment of chronic mental health conditions such as schizophrenia and to manage psychosis, including psychosis which can be associated with health conditions such as delirium.

Individuals with dementia may also develop psychotic symptoms and benefit short-term from antipsychotic medication if other non-pharmacological measures have not been effective.

Can care staff select the collection date?

No. The collection date must not be identified to, or conducted by, staff directly involved in care.

7.0 Activities of daily living

What is considered a decline in ADLs?

For the purposes of the QI Program, decline in ADLs is defined as a decline in the ADL assessment total score of 1 or more points. This is determined by comparing the ADL assessment total score from the current quarter with the previous quarter. Both ADL assessment total scores must be available to provide this result.

Which assessment tool is used to measure activities of daily living for each care recipient?

The Barthel Index of Activities of Daily Living is the assessment tool used to measure activities of daily living (ADLs) for the purposes of the QI Program. The assessment tool is included in Appendix A of the QI Program Manual 3.0 – Part A (the Manual).

Who should conduct the ADL assessment?

The ADLs assessment should be conducted by staff who understand the Barthel Index of Activities of Daily Living tool and are familiar with the care recipient being assessed. Assessment scoring is based on the care recipient's actual performance over the previous 24–48 hours and established using the best available evidence, including existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing is not required.

When should we complete the assessments for this quality indicator?

The ADL assessment for each care recipient is to be conducted around the same time each quarter.

How many assessments are required within the quarter for each care recipient?

A single assessment for each care recipient is completed around the same time every quarter and compared to their ADL assessment total score from the previous quarter to determine decline.

Do we need to undertake direct testing for the ADL assessment?

No. The ADL assessment can be completed using existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing of the care recipient is not required.

How should performance be assessed when conducting an ADL assessment?

The ADL assessment (the Barthel Index of Activities of Daily Living) scoring is based on the care recipient's actual performance over the previous 24–48 hours, noting longer periods will be relevant for some items (e.g. bowel and bladder) and should be informed using the best available evidence.

How do providers report quality indicator data when an ADL assessment score for the previous quarter is not available?

Care recipients who do not have a previous ADL assessment total score are reported as an exclusion. Providers must include comments as to why the previous ADL assessment total score is absent.

It is important to note, providers must conduct an ADL assessment for each care recipient residing at the service. This assessment total score will support reporting on the ADLs quality indicator in the following quarter.

If the care recipient does not have an ADL assessment total score for the previous quarter are they excluded?

Each care recipient residing at the service must be assessed for the ADL quality indicator. Care recipients who do not have an ADL assessment total score recorded for the previous quarter:

- will not be reported in the number of care recipients assessed; and
- will be reported as an exclusion with comments explaining why the ADL assessment total score for the previous quarter is absent (e.g. new admission to the service).

It is important to note, providers must conduct an ADL assessment for each care recipient residing at the service. This assessment total score will support reporting on the ADLs quality indicator in the following quarter.

How should the score for stairs be recorded in a service with no stairs?

A care recipient's performance for each of the ten items, including the use of stairs, of the Barthel Index of Activities of Daily Living is established using the best available evidence. This can include using existing knowledge of the care recipient obtained through routine personal care, asking the care recipient, referring to care records or by direct observation. Direct testing of a care recipient's ability to use stairs is not required. If evidence is not available to establish a care recipient's ability to use stairs the relevant item on the ADL assessment receives a null score.

8.0 Incontinence care

Which assessment tool is used to collect information on incontinence associated dermatitis (IAD)?

The Ghent Global IAD Categorisation Tool is the classification system used to collect information on IAD for the purposes of QI Program. This tool is included in Appendix B of the QI Program Manual 3.0 – Part A (the Manual).

How many categories of IAD are reported against?

There are four sub-categories of IAD under the Ghent Global IAD Categorisation Tool to be reported against for the purposes of the QI Program. This includes:

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

Who should undertake observational assessments for IAD?

Incontinence related care and skin integrity should be monitored as part of the care recipient's routine personal care (e.g. bathing and toileting). Diagnosis and categorisation of IAD should be conducted by staff who understand the Ghent Global IAD Categorisation Tool and have the necessary skills, training and experience to do so accurately and safely. It may be appropriate for a personal care worker to observe for signs of redness or skin loss as part of routine care and if identified, escalate to trained staff for further assessment. Services must consult with a suitably qualified health practitioner if there is uncertainty about the presence or severity of IAD.

When should care recipients be assessed for IAD?

Incontinence related care and skin integrity should be monitored as part of the care recipient's routine personal care (e.g. bathing and toileting). For the purposes of the QI Program, a single IAD assessment is completed for each care recipient with incontinence around the same time each quarter. Any care recipients with incontinence who experience IAD must be reported.

When is a care recipient considered to have incontinence?

For the purposes of the QI Program, a care recipient has incontinence if bladder incontinence occurs more than once a day, or bowel incontinence more than once a week.

Incontinence is any accidental or involuntary loss of urine from the bladder (urinary incontinence) or faeces from the bowel (faecal incontinence). Incontinence can range in severity from a small leak to complete loss of bladder or bowel control.

In addition, for the purposes of the QI Program, a care recipient has incontinence if they require urinary catheters for passing urine.

How are care recipients with catheters assessed and recorded?

For the purposes of the QI Program, a care recipient has incontinence if they require urinary catheters for passing urine.

Incontinence related care and skin integrity should be monitored as part of the care recipient's routine personal care (e.g. bathing and toileting). For the purposes of the QI Program, a single IAD assessment is completed for each care recipient with incontinence, including those with catheters, around the same time each quarter. Any care recipients with incontinence, including those with catheters, who experience IAD must be reported.

If the care recipient did not have incontinence, do they still need to be assessed for IAD?

No. For the purposes of the QI Program, care recipients who do not have incontinence are excluded from IAD assessment, and reported separately.

Is IAD acquired outside of the service counted?

Yes. Approved providers must record each care recipient with IAD that was acquired outside of the service during the quarter as part of the total number of care recipients with IAD and against the four sub-categories IAD acquired outside of the service is not reported separately.

9.0 Hospitalisation

What is an emergency department presentation?

For the purposes of the QI Program, an emergency department presentation occurs when a care recipient presents to an emergency department or urgent care centre.

When should data be collected for the hospitalisation quality indicator?

The collection date must take place in the 21 days after the end of the quarter, in order to review records for the entire quarter.

Are admissions to hospital reported as part of the hospitalisation quality indicator?

- Yes. Care recipients who had one or more emergency department presentations or hospital admissions during the quarter are included as part of the additional reporting requirements for the hospitalisation quality indicator.
- For the purposes of the QI Program, a hospital admission occurs when a care recipient is accepted by a hospital inpatient speciality service for ongoing management. This includes all admissions; planned or unplanned of any length (e.g. same day or overnight).

Are medical appointments at a hospital reported as part of the hospitalisation quality indicator?

No. Medical appointments at a hospital are not reported as part of the hospitalisation quality indicator. However, if a care recipient is admitted to hospital after the medial appointment they should be included in the additional reporting requirements for the hospitalisation quality indicator.

Are planned presentations to the emergency department reported as part of the hospitalisation quality indicator?

Yes. For the purposes of the QI Program, an emergency department presentation occurs when a care recipient presents to an emergency department or urgent care centre, whether planned or unplanned.

Are GP referrals to the emergency department reported as part of the hospitalisation quality indicator?

Yes. For the purposes of the QI Program, an emergency department presentation occurs when a care recipient presents to an emergency department or urgent care centre, irrespective of the type of referral.

Should we avoid sending care recipients to the emergency department or hospital?

- No. Hospitalisation is recognised as an important and necessary element of care, including for older Australians. Aged care services should never avoid or prevent hospital transfer or emergency department presentation if it is required.
- The purpose of the hospitalisation quality indicator is to support quality improvement by enabling providers to identify and monitor emergency department presentations that could be avoided with appropriate care.

10.0 Workforce

Are all staff working at our residential aged care service included in workforce quality indicator reporting?

No. For the purposes of the QI Program, workforce quality indicator reporting includes:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care staff or assistants in nursing.

Are part-time, labour hire or agency staff included in workforce quality indicator reporting?

Yes. For the purposes of the QI Program, workforce quality indicator reporting includes all types of employment (e.g. permanent, part-time, labour hire and agency) for the following:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care staff or assistants in nursing.

Are there definitions for the staff included in the workforce quality indicator reporting?

Yes. Definitions provided in Section 18.0 of the QI Program Manual 3.0 – Part A (the Manual), include:

- **Service managers** is defined as staff who manage the operations of a residential aged care service. This includes leading staff teams to ensure the provision of quality care, in line with the aged care standards.
- **Nurse practitioners** is defined as staff who are registered as nurse practitioners with the Nursing and Midwifery Board of Australia.
- **Registered nurses** is defined as staff who are registered as registered nurses with the Nursing and Midwifery Board of Australia.
- **Enrolled nurses** is defined as staff who are registered as enrolled nurses with the Nursing and Midwifery Board of Australia.
- **Personal care staff** is defined as staff who provide personalised care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan.
- **Assistants in nursing** is defined as staff who provide personalised nursing care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan.

Who is considered ‘employed staff’?

For the purposes of the QI Program, staff are considered employed when they have worked at least 120 hours in the previous quarter.

However, additional reporting includes staff who worked any hours during the previous quarter as:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care staff or assistants in nursing.

When is an employed staff member counted as ‘turnover’ for data collection?

For the purposes of the QI Program, a staff member is considered to have stopped working if they have a period of at least 60 consecutive days in the quarter in which they have not worked as a:

- service managers
- nurse practitioners or registered nurses
- enrolled nurses; and
- personal care staff or assistants in nursing.

Is leave or promotion treated different for ‘turnover’?

No. A staff member is considered to have stopped working if they have a period of at least 60 consecutive days in the quarter in which they have not worked. This includes leave (planned or unplanned) or promotion.

The purpose of the workforce quality indicator is to support quality improvement through promoting continuity of care. Continuity of care and meaningful relationships with staff are crucial element for a care recipient’s wellbeing in residential care.

Can we use our own staff records to collect this data?

Yes. Services are encouraged to use or adapt existing staff records to collect and report workforce quality indicator data providing information is sufficient, accurate and in accordance with the Manual.

How do we report staff employed across multiple services?

If a staff member works across multiple services, they will be assessed and reported against each relevant service, in line with the definitions provided in the Manual.

How do we report staff working multiple roles within a service?

If a staff member works in more than one outlined role, they will be assessed and reported against each relevant outlined role, in line with the definitions provided in the Manual.

11.0 Consumer experience

Which assessment tool is used to collect information on consumer experience?

The Quality of Care Experience Aged Care Consumers (QCE-ACC) is a six question assessment tool used in the QI Program to collect and report on the consumer experience of care recipients at the service during the quarter. This tool is included in Appendix C of the QI Program Manual 3.0 – Part A (the Manual).

When should we use different versions of the QCE-ACC?

For the purposes of the QI program, the QCE-ACC:

- Self-completion version can be offered to care recipients with no or mild cognitive impairment. Services are encouraged to facilitate anonymous, self-completion of the QCE-ACC where possible.
- Interviewer facilitated version can be offered to care recipients who require additional support to complete the assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the care recipient complete the QCE-ACC by using the interview-facilitated version.
- Proxy-completion version can be offered to care recipients with moderate or severe cognitive impairment who are unable to complete the QCE-ACC independently or with assistance from an interviewer. An informal carer or person who knows the care recipient well and interacts them regularly can complete the QCE-ACC on behalf of the care recipient by using the proxy-completion version.

Is it mandatory for care recipients to complete the QCE-ACC each quarter?

No. For the purposes of the QI Program services are required to offer care recipients the appropriate version of the QCE-ACC every quarter. Services may wish to remind care recipients to complete the QCE-ACC however they should not be pressured or forced to do so.

Care recipients who do not choose to complete the QCE-ACC for an entire quarter are reported as an exclusion.

Is anonymous collection of the QCE-ACC required?

Services are encouraged to facilitate anonymous self-completion of the QCE-ACC, where possible. This approach will help services collect the most accurate feedback to guide quality improvement.

When should a new care recipient be offered the QCE-ACC?

All care recipients, including new care recipients, should be offered the appropriate version of the QCE-ACC at around the same time every quarter. The QCE-ACC is based on the quality of care experience at the time of administration of the QCE-ACC.

How can we support care recipients who speak languages other than English to complete the QCE-ACC?

The interviewer facilitated version can be offered to care recipients who require additional support to complete the QCE-ACC assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the care recipient complete the QCE-ACC by using the interview facilitated version.

Can a staff member act as a proxy for care recipients who cannot complete the QCE-ACC self-completion or interview facilitated versions?

Yes. If a suitable informal carer is not available to support proxy completion of the QCE-ACC, a staff member could act as proxy for the care recipient if they know them well. Ideally the proxy assessor should answer based on their own knowledge of the care recipient and their quality of care experience at the time that the QCE-ACC is administered.

If a care recipient is unable to complete the QCE-ACC due to cognitive impairment, are they excluded?

No. A QCE-ACC assessment must be offered to each care recipient for completion, around the same time every quarter. Providers should support care recipients with cognitive impairment to access the most appropriate version of the QCE-ACC (self-completion, interview facilitated or proxy-completion).

Exclusions for the consumer experience quality indicator include:

- care recipients who were absent from the service for the entire quarter, and
- care recipients who did not choose to complete the consumer experience assessment for the entire quarter.

How do we report care recipients who did not choose to complete the consumer experience assessment?

For the purposes of the QI Program, care recipients and their proxies who did not choose to complete the QCE-ACC for the entire quarter are excluded and reported separately.

Do we need to pay a licensing fee to use the QCE-ACC tool?

No. Aged care providers do not need to pay a licensing fee to use the QCE-ACC tool for the purposes of collecting and reporting quality indicator data for the QI Program. The intellectual property rights contained within the QCE-ACC materials and tools are owned by Flinders University and have been licensed to the Department of Health and Aged Care. By using the QCE-ACC tool you are agreeing not to alter the instrument wording, content and presentation in any way without permission from Flinders University.

How can providers support anonymous data collection for consumer experience using the data recording templates?

The data recording templates are intended as a working resource to support data collection within a service. Services may wish to use internal reference numbers to track the number of consumer experience assessments received to support internal auditing processes. Personal information or unique reference numbers are not required when submitting data as part of quarterly QI Program reporting.

12.0 Quality of life

Which assessment tool is used to collect information on quality of life?

The Quality of Life Aged Care Consumers (QOL-ACC) is a six question assessment tool used in the QI Program to collect and report on the quality of life of care recipients at the service during the quarter. This tool is included in Appendix D of the QI Program Manual 3.0 – Part A (the Manual).

When should we use different versions of the QOL-ACC?

For the purposes of the QI program, the QOL-ACC:

- Self-completion version can be offered to care recipients with no or mild cognitive impairment. Services are encouraged to facilitate anonymous, self-completion of the QOL-ACC where possible.
- Interviewer facilitated version can be offered to care recipients who require additional support to complete the assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the care recipient complete the QOL-ACC by using the interview-facilitated version.
- Proxy-completion version can be offered to care recipients with moderate or severe cognitive impairment who are unable to complete the QOL-ACC independently or with assistance from an interviewer. An informal carer or person who knows the care recipient well and sees them regularly can complete the QOL-ACC on behalf of the care recipient by using the proxy-completion version.

Is it mandatory for care recipients to complete the QOL-ACC each quarter?

No. For the purposes of the QI Program services are required to offer care recipients the appropriate version of the QOL-ACC every quarter. Services may wish to remind care recipients to complete the QOL-ACC however they should not be pressured or forced to do so.

Care recipients who do not choose to complete the QOL-ACC for an entire quarter are reported as an exclusion.

Is anonymous collection of the QOL-ACC required?

Services are encouraged to facilitate anonymous self-completion of the QOL-ACC, where possible. This approach will help services collect the most accurate feedback to guide quality improvement.

When should a new care recipient be offered the QCE-ACC?

All care recipients, including new care recipients, should be offered the appropriate version of the QOL-ACC at around the same time every quarter. The QOL-ACC is based on the quality of care experience at the time of administration of the QOL-ACC.

How can we support care recipients who speak languages other than English to complete the QOL-ACC?

The interviewer facilitated version can be offered to care recipients who require additional support to complete the QOL-ACC assessment (e.g. support with reading the questions or writing responses). A staff member, informal carer or relative can assist the care recipient complete the QOL-ACC by using the interview facilitated version.

Can a staff member act as a proxy for care recipients who cannot complete the QOL-ACC self-completion or interview facilitated versions?

Yes. If a suitable informal carer is not available to support proxy completion of the QOL-ACC, a staff member could act as proxy for the care recipient if they know them well. Ideally the proxy assessor should answer based on their own knowledge of the care recipient and their quality of care experience at the time that the QOL-ACC is administered.

If a care recipient is unable to complete the QOL-ACC due to cognitive impairment, are they excluded?

No. A QOL-ACC assessment must be offered to each care recipient for completion, around the same time every quarter. Providers should support care recipients with cognitive impairment to access the most appropriate version of the QOL-ACC (self-completion, interview facilitated or proxy-completion).

Exclusions for the quality of life quality indicator include:

- care recipients who were absent from the service for the entire quarter, and
- care recipients who did not choose to complete the quality of life assessment for the entire quarter.

How do we report care recipients who did not choose to complete the quality of life assessment?

For the purposes of the QI Program, care recipients and their proxies who did not choose to complete the QOL-ACC for the entire quarter are excluded and reported separately.

Do we need to pay a licensing fee to use the QOL-ACC tool?

No. Aged care providers do not need to pay a licensing fee to use the QOL-ACC tool for the purposes of collecting and reporting quality indicator data for the QI Program. The intellectual property rights contained within the QOL-ACC materials and tools are owned by Flinders University and have been licensed to the Department of Health and Aged Care. By using the QOL-ACC tool you are agreeing not to alter the instrument wording, content and presentation in any way without permission from Flinders University.

How can providers support anonymous data collection for quality of life using the data recording templates?

The data recording templates are intended as a working resource to support data collection within a service. Services may wish to use internal reference numbers to track the number of quality of life assessments received to support internal auditing processes. Personal information or unique reference numbers are not required when submitting data as part of quarterly QI Program reporting.