



Australian Government

Department of Health and Aged Care

Quality improvement in residential aged care

2 November 2023

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Introduction and overview

- Why quality improvement matters
- How the Commission supports quality improvement
- Improvement science — Plan, Do, Check, Act approach
- Using data for improvement
- Case study: Residency by Dillons Fremantle
- Case study: Cooinda Coonabarabran
- Hot topics – live question and answer session



Why quality improvement matters

- For older people receiving care:
 - Safe
 - Effective
 - Caring
 - Person-centred
- For providers and staff delivering care:
 - Well-led
 - Sustainable
 - Equitable
 - Experience



“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skilful execution; it represents the wise choice of many alternatives.”

William A Foster





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How the Commission supports quality improvement

1800 951 822

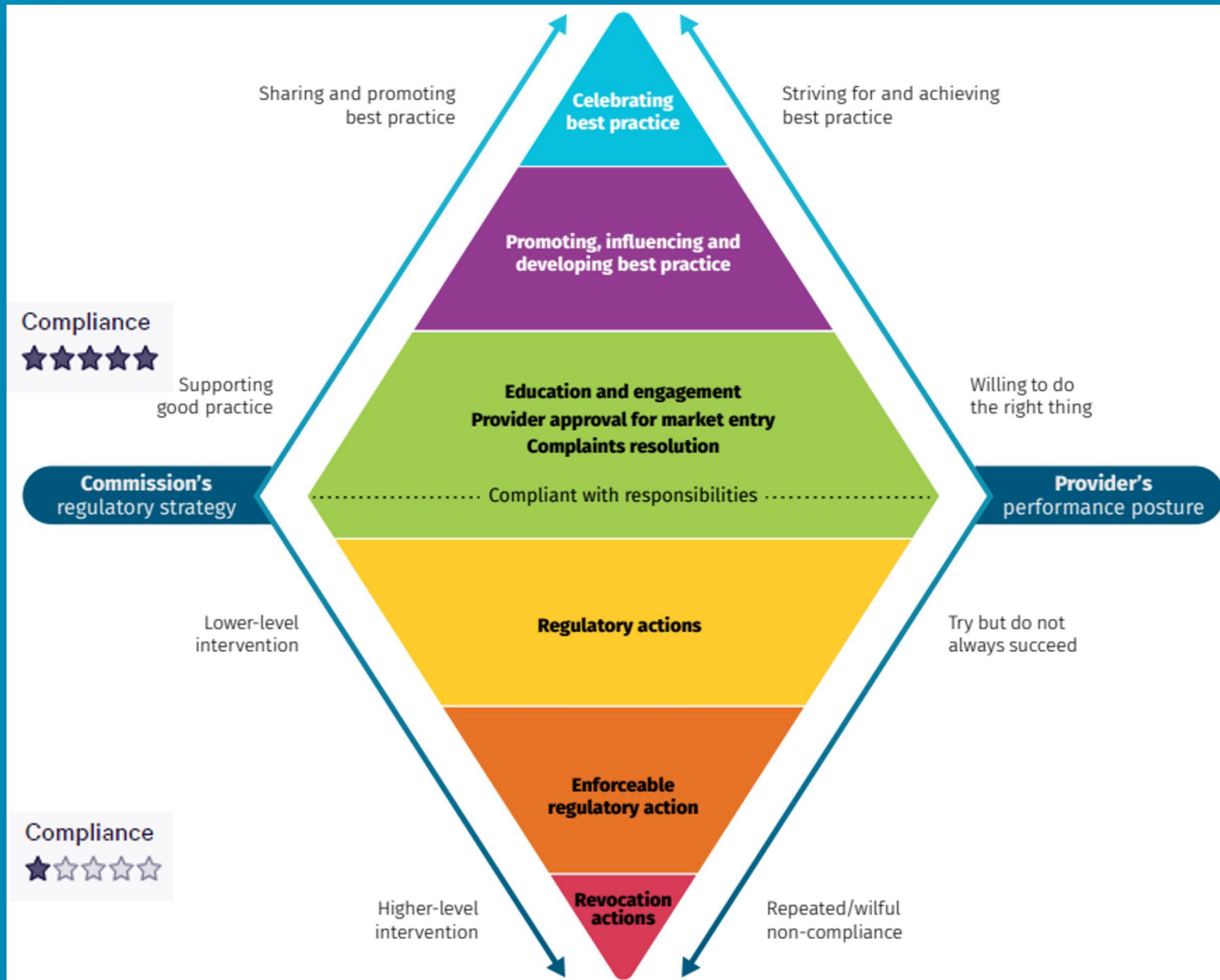
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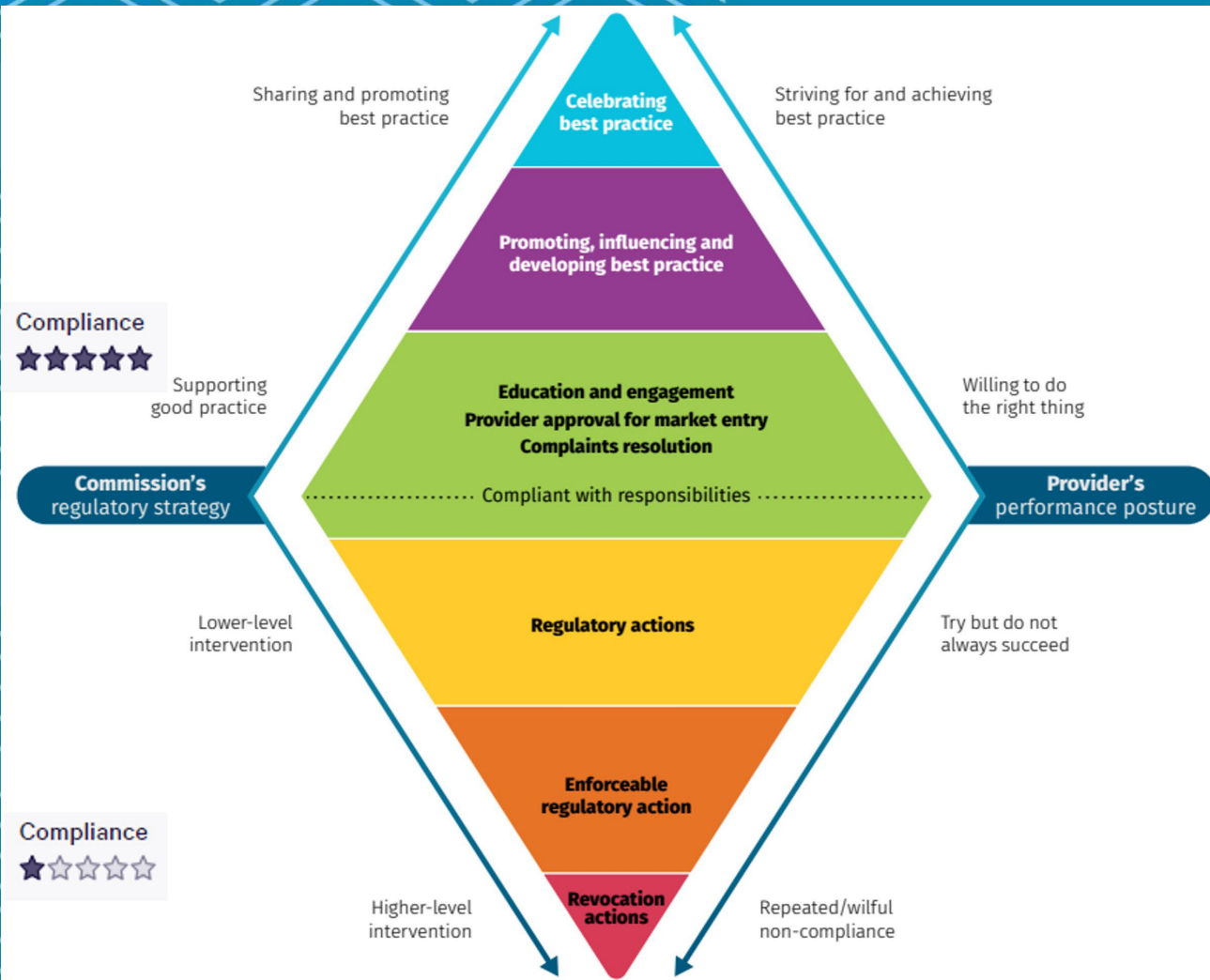
Commission Compliance Activities

- Risk profiling and targeting
- Site audits
- Investigations
- Case management
- Directions and notices



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Commission Quality Improvement Initiatives

- 'To Dip or Not To Dip' Antimicrobial Stewardship
- Pharmacy Outreach Program
- Food, Nutrition and Dining Experience
- Infection Prevention and Control
- Restrictive Practices
- SIRS Insights
- ALIS modules are regularly being created and updated
- Webinar series, including 'Complaints and Continuous Improvement in Practice'



Aged Care Quality and Safety Commission

Sector performance report

April – June 2023



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Engage
Empower
Safeguard



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Engage
Empower
Safeguard

Serious Incident Response Scheme (SIRS)
Insights Series: Report 1 - 2023

Unreasonable use of force: Notifications of resident to resident incidents.





Evaluation helps us understand our impact and how we can better support providers.

We review our regulatory activities and data to find opportunities to improve our own practices and feed back intelligence to providers on risks we are seeing. For example:

- Better targeting data for food spot checks
- SIRS Insights Reports.

We also survey:

- Providers and complainants about our complaints processes
- Providers about our site visits.

Antimicrobial stewardship quality improvement in 12 residential aged care facilities: Implementation outcomes of "To Dip or Not to Dip"

Antimicrobial stewardship quality improvement in 12 residential aged care facilities: Implementation outcomes of "To Dip or Not to Dip"

Use 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36, 38, 40, 42, 44, 46, 48, 50, 52, 54, 56, 58, 60, 62, 64, 66, 68, 70, 72, 74, 76, 78, 80, 82, 84, 86, 88, 90, 92, 94, 96, 98, 100

Introduction

Low-rate urine dipstick testing between two has been shown to be common in aged care. It is a significant, yet modifiable, driver of antibiotic use. To Dip or Not to Dip (TDND) was designed as a highly successful implementation pilot that reduced antibiotic prescribing for urinary tract infection (UTI) treatment and prophylaxis in care homes in England and is now widely implemented across the UK. In October 2021, the Commission launched TDND resources adapted from the UK campaign to

support improvement in UTI management in Australian residential aged care services.

Aims and methods

The aim of the project was to evaluate the feasibility and usability of TDND resources by involving nurses and pharmacists at pilot sites to shape their implementation approach using interviews at baseline and three months. Surveys of urine dipstick testing practice and antibiotic prescribing activity were also undertaken.

Surveys of urine dipstick testing practice

A diagnosis of UTI should not be made on the basis of a urine dipstick test result. Dipstick testing in asymptomatic residents is not recommended. This results in frequent detection of asymptomatic bacteriuria (ASB), a condition that does not require antibiotic treatment. ASB is frequently misdiagnosed as UTI. Diagnosis of UTI should be made by taking into consideration a person's clinical signs and symptoms, one of a clinical protocol supports this.

Dipsticks are performed to monitor for as part of a check-up, even if they have no symptoms.

Dipsticks are routinely performed after a resident has completed antibiotic treatment for UTI.

Residents and families are told if dipsticks to find the cause of a problem, even if they don't think there is a clinical need.

It is not necessary when a resident is not being treated for UTI.

No one can tell you when a resident has a UTI without a test.

Always + frequently + sometimes - never

Fig. 1. Baseline

Frequency	Residents with symptoms of UTI	Residents without symptoms of UTI
Always	10	10
Frequently	20	20
Sometimes	30	30
Never	40	40

Fig. 2. Follow-up

Frequency	Residents with symptoms of UTI	Residents without symptoms of UTI
Always	5	5
Frequently	15	15
Sometimes	25	25
Never	55	55

*TDND clinical pathway and not implementation (2021/22)

Antibiotic audits

12 services contributed data at baseline and 3 months, 6 services contributed 6-month data prior to finalisation of the TDND project. At any point in time, up to 100 residents out of 100 were on an oral antibiotic, with UTI a common reason for antibiotic prescribing (Fig. 3).

Fig. 3. Oral antibiotic prescribing for UTI versus other indications

Time Point	Residents on antibiotics for UTI	Residents on antibiotics for other indications
Baseline	10	10
3 months	15	15
6 months	20	20

Common reasons for inappropriate prescribing were antibiotic initiation by residents with no documented signs or symptoms, for ASB, or for durations in excess of guidelines with no documentation of clinical reason for continuation. Audit improvements were seen in prescribing appropriateness by indication and duration of UTI treatment (Fig. 4) and by indication for prophylaxis antibiotics used to prevent infection (Fig. 5).

Fig. 4. Antibiotic prescribing appropriateness for UTI treatment

Time Point	Residents on antibiotics for UTI treatment
Baseline	10
3 months	15
6 months	20

Fig. 5. Antibiotic prescribing appropriateness for UTI prophylaxis

Time Point	Residents on antibiotics for UTI prophylaxis
Baseline	10
3 months	15
6 months	20

Prescribing for these conditions is not recommended. This results in frequent detection of asymptomatic bacteriuria (ASB), a condition that does not require antibiotic treatment. ASB is frequently misdiagnosed as UTI. Diagnosis of UTI should be made by taking into consideration a person's clinical signs and symptoms, one of a clinical protocol supports this.

Pilot sites

Pilot sites were Queensland and four in Victoria. There was a mix of metropolitan (7) and rural services (5). Service sizes ranged from 40 to 160 beds (median 76 beds).

The project was launched in October 2021 and completed in July 2022. COVID-19 lockdowns were delayed implementation at some sites. Face-to-face case-based education was delivered by pharmacists at 10 sites. The clinical pathway was implemented in 11 of 12 sites.

Project interviews

Baseline

Nurses, clinicians and pharmacists were interviewed about why they participated.

44 We have to think of the future and measure antibiotics are used appropriately. I have been leaving my hat out for many years to find ways to change practice. (Nurse)

44 Staff seem to jump on to every symptom rather than looking for something else. We do a dipstick, and I light up like a Christmas tree. We should be asking 'Do you have symptoms?' (Pharmacist)

When asked about urine dipstick testing practice, nurses provided the following responses.

44 Often, it's a case of nurses not wanting to miss something as they want to be thorough. There is this attitude of better to be safe than sorry. They don't want to get things wrong. (Nurse)

It's very hard to get the labs to do the dipstick. It's not written policy or process, but we just do it. (Nurse)

Follow-up

Follow-up interviews were conducted from March 2022 to June 2022. In the pilot, pharmacists delivered case-based education. Feedback from pharmacists and nurses reflected strong appreciation of the resources.

44 (TDND) made the principles easy to grasp. The fact that it was produced by government and based on research, evidence, has a very professional look. (Pharmacist)

We use the protocol (clinical pathway) when determining whether a



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Improvement science: Plan, Do, Check, Act approach

Presented by:
Katharine Silk



Enablers for success

Leadership and governance

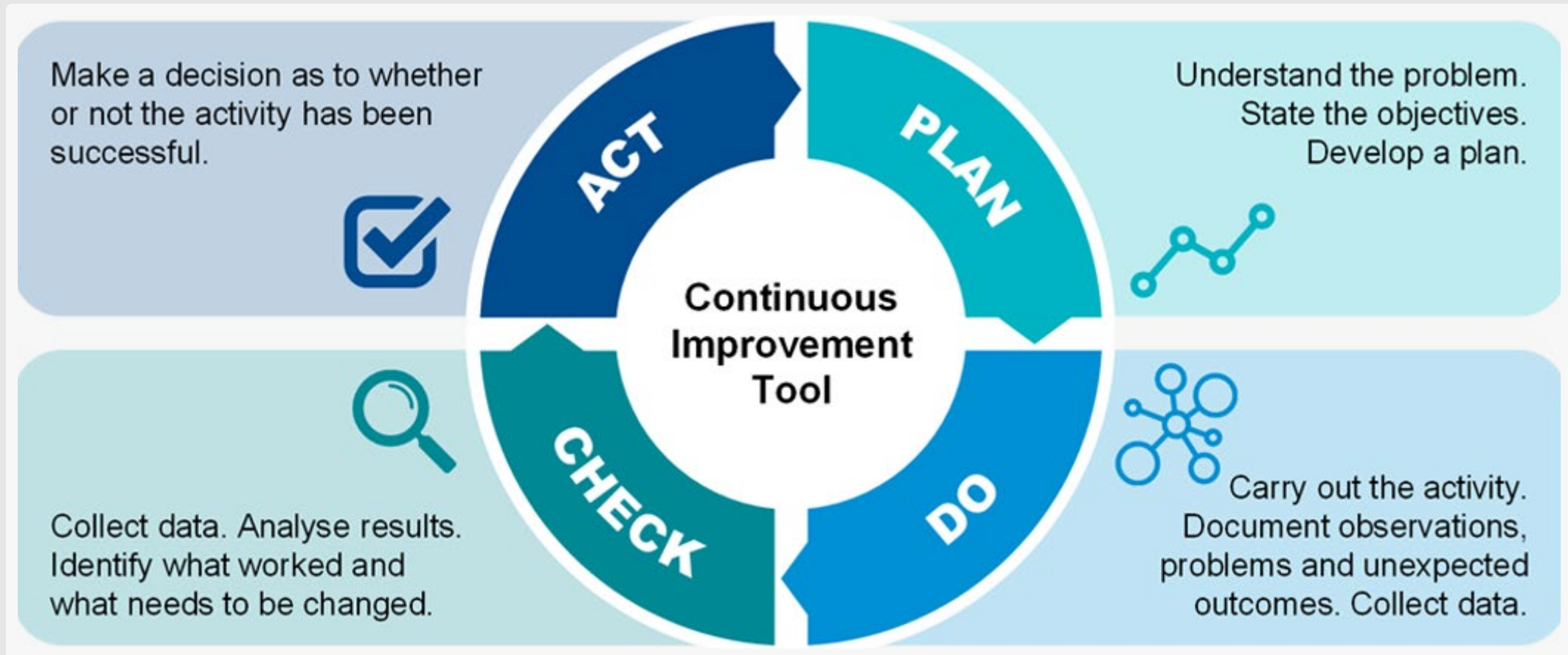
- Organisational endorsement
- Authority to make change happen

Improvement culture, behaviour and skills

- Responsive to feedback
- No blame culture
- Training and capability building
- Continuous efforts to implement change
- Involved and engaged staff (champions)
- Sharing and celebrating success

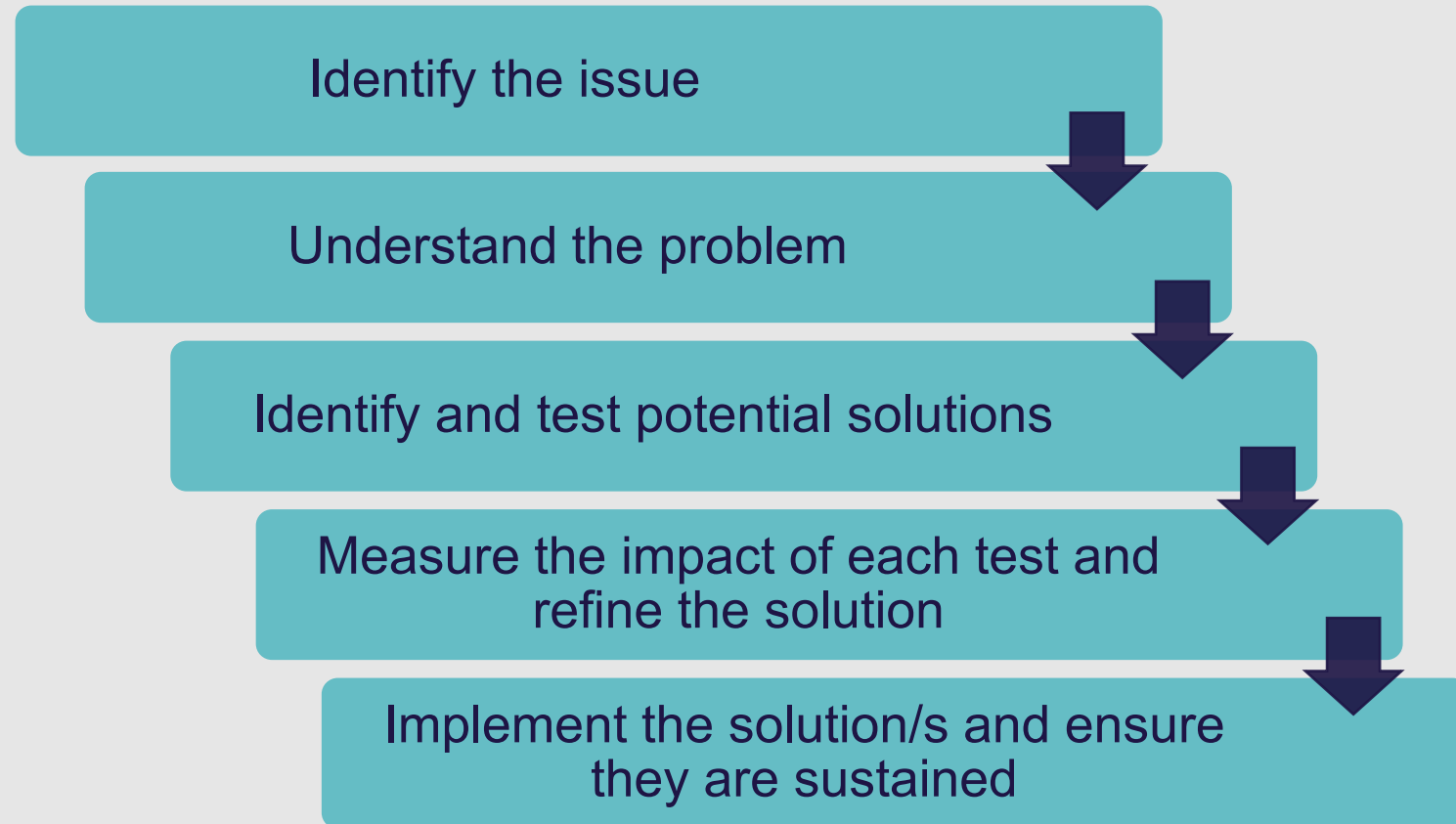


‘Plan, Do, Check, Act’ approach to quality improvement





Key steps for quality improvement





Practical tips for quality improvement

- Keep changes small and time-limited
- Use measures that are suitable for outcomes
- Focus on issues that matter most to residents and staff
- Co-design solutions
- Build in mechanisms to engage staff and residents in the process.

Using data for improvement

Presented by:
Victoria Angel

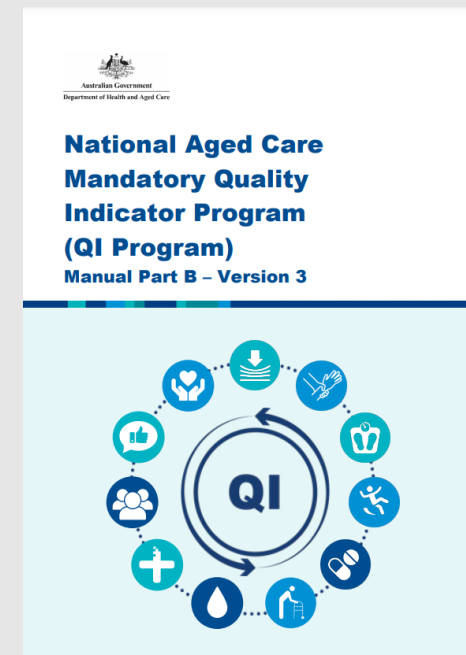


Supporting resources

Star Ratings Improvement Manual:
A provider's guide to improving quality

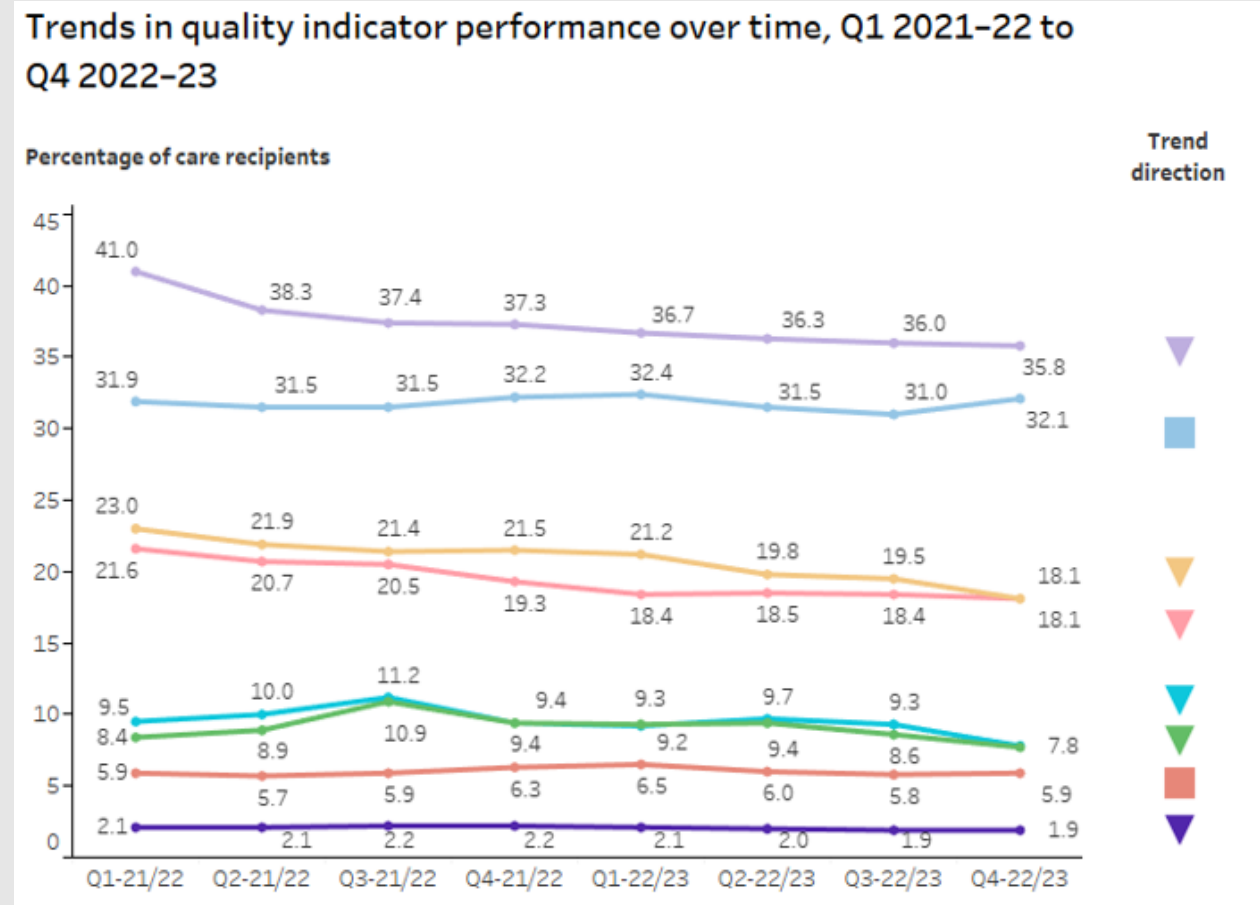


QI Program Manual – Part B
Example tools, guidance and resources to
support continuous quality improvement



Using data to identify and monitor quality improvement

- Collect, track and analyse both quantitative and qualitative data
- Use both clinical and administrative data; and resident/ staff feedback
- Use GPMS to set up QI targets and display data trends
- 'Time series analysis' is the gold standard for using data for improvement;
 - using small amounts of data collected and displayed frequently.



Case Study: Residency by Dillons Fremantle

Presented by:

Nikita Divekar, Quality & Lifestyle Manager &

Jessica Patil, Executive Director of Quality, Innovation and Marketing

Case study: Residency by Dillons Fremantle

Plan

My Engaging Talent

In the beauty of a flower, we see the strength of a leader, the creativity of an artist, and the connection of women everywhere.



Case study: Residency by Dillons Fremantle

Do

My Engaging Talent

Encouraging individuals to pursue or maintain their skills and interests through peer-to-peer leadership activities.



Case study: Residency by Dillons Fremantle

Check

My Engaging Talent

Observation



Engagement from Residents



Feedback



"I'm pleased that the residents find my classes enjoyable. This keeps me engaged in the planning process, and I'm excited about organising next month's event."

Case study: Residency by Dillons Fremantle

Check

My Engaging Talent

Other activities coordinated and led by residents:

- Bingo
- Cooking class
- Garden Club
- Fitness class
- Flower arranging
- Music performances



"It gives me a great deal of satisfaction organising these concerts for the residents. It's a wonderful feeling when residents approach me personally to express their gratitude for my efforts. It fills me with a sense of pride."

Case study: Residency by Dillons Fremantle Act

My Engaging Talent

The program successfully enhanced emotional well-being, social interaction, and community building among residents.



Case Study: Cooinda Coonabarabran

Presented by:

Naomi Taylor, Operations Manager

Case study: Cooinda Coonabarabran

Plan



Case study: Cooinda Coonabarabran

Do

- Opened our new state-of-the-art kitchen
- Menu review involving consumers and a qualified dietician
- Support Services Supervisor – qualified Chef
- Our cooks now dress as chefs
- Foodie Fridays dining experience
- Increased compliments
- Our Operations Manager was successful in receiving a scholarship to attend IHHC NACI Aged Care Food conference
- Our attraction rate for kitchen staff has increased by 35%

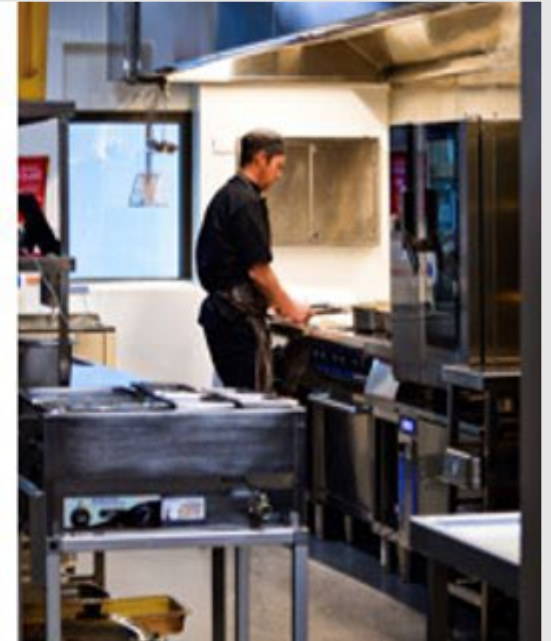


Case study: Cooinda Coonabarabran

Check



Case study: Cooinda Coonabarabran Act



Case study: Cooinda Coonabarabran





Hot topics and live questions





Paula Jones



agedcareengagement.health.gov.au



Phone **1800 200 422**
(My Aged Care's free call phone line)